

**MEETING OF THE REGIONAL  
SOCIAL MOBILIZATION ADVISORY GROUP  
KAMPALA, UGANDA, DECEMBER 11-15, 1997**

Georges A Collinet

BASICS Technical Directive 000-AF-59-011  
USAID Contract Number HRN-C-00-93-00031-00

## TABLE OF CONTENTS

ACRONYMS	v
EXECUTIVE SUMMARY	1
PURPOSE OF VISIT	2
BACKGROUND	2
ACTIVITIES	2
Overview	2
Activities Report	3
Discussions	3
Plan of Action	5
CONCLUSION AND RECOMMENDATIONS	7
APPENDIXES	
Appendix A	List of Participants
Appendix B	Agenda
Appendix C	Summary of the Proceedings and Recommendations from the 2 <sup>ND</sup> Meeting of the Regional Social Mobilization Advisory Group
Appendix D	Implementation of EPI in African Region in 1997
Appendix E	Polio Eradication in Africa Questions and Answers
Appendix F	Social Mobilization for Immunization Progress Report 1997
Appendix G	National Perspectives Uganda Addressing Rumors
Appendix H	National Perspectives Ethiopia
Appendix I	National Perspectives Angola
Appendix J	Meeting Notes and Overheads
Appendix K	Presentation Georges Collinet
Appendix L	UNICEF's Sara Communication Initiative

## ACRONYMS

AFP	Acute Flaccid Paralysis
AIDS	Acquired Immunodeficiency Syndrome
BASICS	Basic Support for Institutionalizing Child Survival Project
BCG	Bacillus of Calmette and Guerin (tuberculosis vaccine)
CFR	Case Fatality Ratio
DPT	Diphtheria, Pertussis, and Tetanus vaccine
DT	Diphtheria and Tetanus Toxoid combination vaccine (for use in young children)
EMRO	Eastern Mediterranean Regional Office of World Health Organization
EPI	Expanded Program on Immunization
EPIINFO	Statistical analysis computer program
EU	European Union
GP	General Practitioner
HIV	Human Immunodeficiency Virus
ICC	Interagency Coordinating Committee
IPC	Interpersonal Communication
KAP	Knowledge, Attitude, and Practices
MOH	Ministry of Health
MSH	Management Sciences for Health
NCA	National Control Authority
NGO	Non-governmental Organization
NID	National Immunization Day
NIW	National Immunization Week
NT	Neonatal Tetanus
OAU	Organization for National Unity
OPV	Oral Polio Vaccine
PEI	Polio Eradication Initiative
SAVP	South African Vaccine Producers
SNID	Sub-national Immunization Day
TFI	Task Force on Immunization
TT	Tetanus Toxoid
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VOA	Voice of America
WHA	World Health Assembly
WHO	World Health Organization
WHO/AFRO	World Health Organization Africa Regional Office
WR	World Health Organization Country Representative

## EXECUTIVE SUMMARY

BASICS consultant, Georges Collinet, attended the 2<sup>nd</sup> Meeting of the Regional Social Mobilization Advisory Group held in Kampala, Uganda, from December 11-13, 1997. The objectives of the meeting were to

- Review progress and problems of social mobilization implementation related to immunization and polio eradication in Africa in 1997,
- Propose activities on social mobilization and NIDs to be implemented in 1998,
- Review the role and responsibilities of partners and donors

The meeting was attended by representatives of immunization programs in Angola, Botswana, Ethiopia, and Uganda as well as WHO, UNICEF and BASICS representatives (see Appendix A). After a regional overview of EPI in the African region and a discussion of the role of social mobilization in EPI, the progress made in 1997 was reviewed, including discussion of the polio eradication initiative (Kick Polio Out of Africa) and presentations on country experiences in social mobilization for NIDs in Ethiopia, Uganda and Angola.

The meeting identified a number of activities to be implemented in the coming months at various levels and reviewed the major obstacles to successful implementation of these activities. One of the main actions discussed is the need for better use of mass media to promote highly visible events. These include the Kick Polio Out of Africa project, cartoons or puppet TV programs to be adapted and broadcast locally in the style of the cartoon series "Sara" (see Appendix L), and a song competition on polio eradication, to be organized in the countries participating in polio eradication.

Three focus areas were chosen from the summary of main issues (see pages 17-22, Appendix C): research and evaluation, resistance to immunization, and promoting EPI with NIDs. Sub-groups were formed to discuss these subjects and propose a discussion agenda for the Task Force for Immunization Meeting that followed this Social Mobilization Meeting.

At the end of the meeting, a review of the needed resources and support for social mobilization to implement the plan of action for 1998 was conducted. It was agreed that a follow up meeting, with all the participants, should be held in the very near future to assess and implement the decisions that were taken during the 5th Meeting of the Task Force on Immunization in Africa (TFI) and the 4th Meeting of the Regional Inter-Agency Coordination Committee (ARICC).

## **PURPOSE OF THE VISIT**

The purpose of this assignment was to attend the 2<sup>nd</sup> Meeting of the Regional Social Mobilization Advisory Group to review the progress made and constraints encountered in implementing social mobilization for polio eradication and EPI in 1997, and agree on social mobilization activities to be implemented in 1998. The author was specifically asked to present on capacity building for social mobilization in Africa and the possible utilizations of the media to address the issues (see Appendix K)

## **BACKGROUND**

This meeting was the second meeting of the Advisory Group on Social Mobilization, which first met in Brazzaville, Congo, from February 4-6, 1997. This group was formed to meet the identified need for an advisory group to help plan and implement inter-agency social mobilization activities responding to the African region wide Polio Eradication Initiative launched in 1995 and committed to the eradication of polio in Africa by the year 2000.

## **ACTIVITIES**

### **Overview**

A regional overview was presented by Dr. Okwo Bele of WHO/AFRO who said that even though the number of polio cases in sub-Saharan Africa were small (10-20,000 cases) compared to measles (10 million cases with 450,000 deaths,) a strategy to boost routine immunization had to be implemented. There was a stagnant level of coverage, even in countries that dutifully immunized their populations. Central and West Africa, for example, did not show well (40 - 50 percent coverage), with little improvement in sight. The question is how to mobilize more effectively and how to convey to the public the importance of total elimination of polio and the need to continue to try to achieve high levels of routine immunization.

According to Andrew Lobanov of WHO/AFRO/Uganda, only 10 percent of polio cases are reported in Africa, hence the importance of improving disease surveillance and reporting and the need to create better NID strategy. In 1996, 25/31 countries achieved over 80 percent coverage. In 1997, 7 out of 15 countries achieved more than 80 percent. But for various reasons, primarily campaign fatigue, some countries, including South Africa, saw lower coverage in the second round than in the first round in 1997.

For more background information see Appendixes D (Implementation of EPI in African Region in 1997), E (Polio Eradication in Africa Questions and Answers), and F (Social Mobilization for Immunization Progress Report 1997)

## **Activities Reports**

The participants from Uganda, Ethiopia, and Angola reported on their campaigns to eradicate poliomyelitis in their countries. For more information, see Appendixes G (National Perspectives Uganda Addressing Rumors), H (National Perspectives Ethiopia), and I (National Perspectives Angola)

## **Discussions**

### ***Targets***

Can the targets for regional polio eradication be reached

- by 1999 in Southern and Eastern Africa?
- by 2000 in Central and West Africa?
- by 2001 for countries with difficult to reach populations or conflicts?

### ***How to reach these goals by the year 2000***

The meeting identified a number of activities to be implemented in the coming months at various levels. These include

- Provide advice to immunization programs that will permit the total elimination of polio in Africa by the year 2000,
- Use the latest shipment of OPV vaccine, when available,
- Inform mothers about and confirm that mothers can return to health centers or vaccination posts for the second round of NIDs each year and for other routine immunization services,
- Establish campaigns targeting specific activities depending on a country's particular circumstances,
- Strengthen social mobilization,
- Reach out to and engage people in remote and endemic areas,
- Keep routine immunization at a high level, and
- Increase AFP surveillance

It became evident that in order to achieve these goals, the 1998 program should increase the EPI coverage by increasing the demand for vaccination. A review of the major obstacles was necessary. These obstacles are identified as:

- Target audience suffering from “message fatigue,”
- Too few in target audience are aware of importance of immunization programs,
- Need to target high risk areas, which are usually in difficult to reach or insecure areas,
- Rumors and misinformation need to be addressed and dispelled, i.e. vaccine will kill you, immunization program is a “cover” for research project, etc.,
- Need to address problems of resistance from educated people and community leaders/influential people, counter the inaccurate advice or lack of advice from doctors, and overcome the unreliability of the cold chain,
- NIDs should not be viewed as a substitute for routine immunization, target audience needs to understand and realize this, and
- Declining commitment from all sectors, and fading support for EPI

### *Questions*

- What media to use?
- How to reach different age groups, cultural/ethnic groups, and religious sects?
- How to work in insecure areas?
- An estimated one out of 10 vaccinations fail, therefore, how to target the information when adverse events, reactions, or death occur during vaccination program? What should be done through social mobilization to address this problem?
- How to remedy the damage to credibility of social mobilization and vaccinations/immunization programs caused by outbreak of the disease in areas of high immunization coverage and/or with cases of polio in immunized children?
- How to get health workers and government officials to understand why all these efforts are made to eradicate poliomyelitis instead of other more prevalent diseases, such as malaria or AIDS, and how to convince communicators?

- Despite the reduced interest at the top, how to ensure partnerships in order to get everybody involved, from the leaders in the government to the social workers in the field?
- How to increase funding and resources for social mobilization?

The agenda, meeting notes, and presentation notes can be found in Appendixes B, C, and J

### **Plan of Action**

Discussion during the meeting centered on three subjects taken from the highlighted issues (see Summary of Main Issues, Table 1)

- Research and evaluation,
- Resistance to immunization interventions and tools, and
- Promoting EPI with NIDs

Three sub-groups were formed to discuss these subjects and to propose a discussion agenda for the Task Force for Immunization Meeting that followed this Social Mobilization Meeting (See Appendix K for sub group presentations )

Summary of Main Issues  
Draft, day one 12/11/97

Section Number	Highlighted Issue
1 1 8	Damage to credibility of social mobilization caused by outbreaks of disease in areas of high immunization coverage and cases of polio in immunized children
1 1 8	Important that NIDs are not seen as a substitute for routine immunization
1 2	Falling commitment, fading support for EPI- how to inject new momentum?
1 2	Better address resistance to immunization in advance of NIDs
1 3	Lack of coordination on programme advocacy, global, national, etc
1 3	Too little time to evaluate impact of social mobilization, or to pretest materials or even to organize social mobilization properly
1 3 2	Problem when communicators (health promoters, educators) themselves are not convinced
1 3 4	Problems with resistance from educated people
1 3 4	Counter advice from doctors or no advice from doctors
1 3 5	Lack of participatory planning biggest problem
1 3 5	Rhetoric of integration NID and routine, but reverse in real practice
1 3 6	Conflict is preventing active mobilization in many more countries- how to make progress under conditions of conflict?
1 3 7	What immunization messages to be conveyed to the community and when?
1 4 1	Chronic resistance to immunization is not receiving sufficient attention when planning subsequent rounds example of Uganda
1 5	How to integrate new messages on measles control and new vaccines with polio messages
2 1 4	How to explain booster policy
2 1 4	How to improve coverage in urban areas
2 1 4	How to explain NID in relation to EPI routine
2 1 4	How to convince intellectuals
2 1 4	Need for strong terms of reference for the ICCs
2 3 4	Need to evaluate the cost benefit of expensive mobilization materials, ie T-shirts, and methods, ie theatre
2 3 4	Formative research needed to stop wasting money
2 4 2	Need to define benefits to the community of reporting disease
2 4 2	Incentives to reward disease reporting
2 4 2	To whom should the community report?
2 4 2	Need lay case definition
2 4 2	Just a few diseases in a community surveillance 'package' which ones?

Table 1

## CONCLUSION AND RECOMMENDATIONS

At the end of the meeting, a review of the needed resources and support for social mobilization to implement the plan of action for 1998 was conducted. For a complete list of the meeting recommendations in the areas of support, coordination and funding see Appendix C.

One of the main actions discussed is the need for better use of mass media to promote highly visible events. These include the Kick Polio Out of Africa project, cartoons or puppet TV programs to be adapted and broadcast locally in the style of the cartoon series "Sara," and a song competition on polio eradication, to be organized in the countries participating in polio eradication. The latter could be broadcast throughout Africa via international radio and TV stations.

These actions can successfully promote vaccination campaigns throughout Africa in an unprecedented way. They can also strengthen communications between health workers, government officials and the public. This linkage will be a major element for the successful eradication of poliomyelitis in the African sub-continent by the year 2000.

The need for all the participants at the conference to stay in touch and communicate often with each other was emphasized.

A follow-up meeting, with all the participants, should be held in the very near future, to assess and implement the decisions that were taken during the 5th Meeting of the Task Force on Immunization in Africa (TFI) and the 4th Meeting of the Regional Inter-Agency Coordination Committee (ARICC).

## **APPENDIXES**

**APPENDIX A**  
**List of Participants**

## List of Participants and Countries Represented

Ms Grace Kagundu, WHO-AFRO

Dr Okwo Bele, WHO-AFRO

Ms Erma Manoncourt, UNICEF/Headquarters

Neil McKee, UNICEF Africa (Nairobi)

Andrew Lobanov, WHO-AFRO

Apollinaire Gahungu, Channel Africa/Ambassador Kick Polio Out of Africa

Modibo Dicko, WHO-AFRO/Mali

Dr H Njiru, WR-Uganda

John Lloyd, WHO-EPI/Geneva

Paulina Pereira Semedo, EPI-Angola

Flavienne Issembé, WHO-AFRO

Botswana (2)

Uganda (2)

Ethiopia (1)

Georges Collinet, BASICS

**APPENDIX B**  
**Agenda**

## 2nd Meeting of the Regional Social Mobilisation Advisory Group

Nile Hotel, Kampala, Uganda December 11 - 13 1997

### *Agenda*

#### Thursday, 11 December

08 30 - 09 00 Registration  
09 00 - 09 30 Welcome remarks (Dr H Njie, WR Uganda)  
Introduction of participants  
Review of the objectives and Agenda (Kagondy)  
Nomination of chairpersons and rapporteurs

#### *Vision of social mobilisation for EPI in the African region*

09 30 - 09 45 Overview of EPI in the African region goals and progress achieved (Okwo Bele)  
09 45 - 10 00 Role of social mobilisation in EPI and priority needs to be addressed in 1998 (Manoncourt, Kagondy)  
10 00 - 10 30 Discussion  
10 30 - 11 00 **Break**

#### *Review progress made in 1997 and way forward polio eradication & EPI*

*Discuss achievements, constraints and what needs to be done differently*

#### *Polio eradication initiative Kick polio out of Africa*

11 00 - 11 30 Polio eradication progress and challenges (Lobanov)  
11 30 - 12 00 Regional advocacy and social mobilisation for polio eradication (Kagondy, Lloyd)  
12 00 - 12 30 Discussion  
12 30 - 14 00 **Lunch**

#### *Social mobilisation for NIDs country experience*

14 00 - 14 30 Overview of national social mobilisation (Kagondy)  
→ 14 30 - 14 45 Social mobilisation strategies (Ethiopia)  
→ 14 45 - 15 00 Addressing rumours and wrong messages (Uganda)

15 00 - 15 30 Discussion  
15 30 - 16 00 **Break**

**Social mobilisation for disease surveillance**

16 00 - 16 30 Advocacy, Social mobilisation and IEC needs  
(AFRO, UNICEF)

16 30 - 17 30 Discussion

17 30 - 17 45 Wrap-up

**Adjourn**

**Friday, 12 December**

**Social mobilisation for routine immunisation**

08 30 - 08 45 Increasing and maintaining high coverage (Botswana)

08 45 - 09 00 Using NIDs social mobilisation mechanisms to strengthen  
routine immunisation (Kagondou, MacKee)

09 00 - 09 15 Quality of services issues for social mobilisation  
(Okwo Bele)

09 15 - 09 45 Discussion

***Monitoring and evaluation of social mobilisation***

09 45 - 10 00 How effective are social mobilisation strategies  
and messages  
What are the research needs for social mobilisation?  
(UNICEF)

10 00 - 10 30 Discussion

10 30 - 11 00 **Break**

***Plan of activities for 1998***

11 00 - 12 30 Review draft proposal (Lobanov Kagondou)

12 30 - 14 00 **Lunch**

14 00 - 16 00 Group work to detail 1998 activities  
group 1 Regional advocacy activities

16 00 - 16 30	group 2 Country level support activities <b>Break</b>
16 30 - 17 30	Presentations by groups
17 30 - 18 00	Discussion
18 00 - 18 15	Wrap -up
	<b>Adjourn</b>

**Saturday, 13 December**

***Capacity building for social mobilisation in the African region***

09 00 - 09 15	What is needed to build capacity for social mobilisation? (Kagonda)
09 15 - 09 45	Discussion
09 45 - 10 30	Coordination issues
10 30 - 11 00	<b>Break</b>
11 00 - 12 30	Conclusions and recommendations Wrap-up
	<b>Adjourn</b>

**APPENDIX C**  
**Summary of the Proceedings and Recommendations**  
**from the 2<sup>ND</sup> Meeting of the Regional Social Mobilization**  
**Advisory Group**

**Second Meeting of the Regional Social Mobilisation  
Advisory Group  
11-13 December, 1997  
Nile Hotel, Kampala, Uganda**

---

**1 INTRODUCTION**

The second meeting of the Regional Social Mobilisation Advisory Group was held at the Nile Hotel, Kampala, from 11 to 13 December, 1997. The participants at the meeting comprised representatives from the key EPI partners as well as social mobilisation focal persons from selected countries.

**2 OBJECTIVES OF THE SECOND MEETING**

- 1 Review progress made in 1997 with social mobilisation for polio eradication and EPI in general, achievements and constraints
- 2 Agree on social mobilisation activities to be implemented in 1998 for polio eradication and other EPI activities
- 3 Agree on the roles and responsibilities of the partners in the implementation of the activities

**3 RECOMMENDATIONS**

The meeting recommendations can be grouped into three main areas: support for the social mobilisation plan of the working group, coordination and funding.

**3.1 Support for the social mobilisation plan to**

- 1 Support development of regional strategies for advocacy, social mobilisation and communication for EPI
- 2 Strengthen national capacity in social mobilisation and advocacy
- 3 Support advocacy process in problem countries
- 4 Use NIDs to promote routine immunisation by
  - using the second round of polio NIDs for communication on routine EPI over a longer period (e.g. 1-2 weeks)
  - allowing countries to adapt the policies as they see necessary
  - developing clearer messages for communities and health workers on NIDs vs routine EPI, answering the questions why? when? and where?
  - being more consistent in selecting and using outreach sites in successive NIDs to avoid confusing the public
- 5 Develop appropriate communication strategies to strengthen surveillance systems targeted at medical professionals and other health staff, traditional healers, community members and families
- 6 Ensure integration of social mobilisation activities into overall EPI planning
- 7 Strengthen capacity and technical support through
  - training
  - country exchange

- support to countries in difficult circumstances
- 8 Support and reinforcement for regional advocacy activities, e.g. football

### **3.1 Coordination**

- 1 Recognise and support the social mobilisation advisory group as a working group of the TFI and to work in close coordination
- 2 Strengthen inter-agency coordination

### **3.2 Funding**

- 1 Governments should participate in the funding of EPI and polio NIDs
- 2 Donors should allow utilisation of funds according to country needs
  - Provide timely funding to facilitate strengthening of communication strategies

## **4 KEY ACTION AREAS**

### **1 Research, evaluation, communication and co-ordination**

- 1 Develop communication research guidelines
  - 11 Enhance exchange of experience
  - 111 Capacity building for communication
- 2 Interventions and tools to address resistance to immunization and maintaining credibility
    - 1 Design TV and radio talk-show for Uganda and Kenya
    - 11 Hold a private meeting with the MOH, external experts and the rumour mongers
    - 111 Create a cartoon/puppet character and produce a video based on this character
- 3 Promoting routine EPI with NIDs and community surveillance
    - 1 Hold a workshop to review the status of the communication and commission guidelines, with participants drawn from most of the partners in immunisation activities
    - 11 Prepare a communication guide focussing on surveillance, routine immunisation and NIDs
- 4 Focus support on countries in difficult circumstances

## **5 SUMMARY OF PROCEEDINGS KEY ISSUES**

A summary of some key issues raised in the meeting are listed below

- Damage to credibility of social mobilisation caused by outbreaks of disease in areas of high immunisation coverage and cases of polio in immunized children
- Importance of ensuring that NIDs are not seen as a substitute for routine immunisation
- Falling commitment and fading support for EPI need to find a strategy to inject new momentum
- Need to identify and address resistance to immunisation prior to NIDs
- Lack of co-ordination on programme advocacy, global, national, etc

- Too little time to evaluate impact of social mobilisation, to pretest materials, or even for proper organisation of social mobilisation activities
- Problems arising when communicators (health promoters, educators) are not convinced
- Problems with resistance from educated people
- Counter advice or no advice from doctors
- Lack of participatory planning
- Plenty of rhetoric on the integration of NIDs with routine immunisation, but reverse is practised
- Conflict is preventing active mobilisation in many countries Need to devise means that enable progress under conditions of conflict
- Need to identify the immunisation messages to be conveyed to the community and appropriate times for communication
- Chronic resistance to immunisation is not receiving sufficient attention during planning for subsequent rounds
- Need to integrate new messages on measles control and new vaccines with polio message
- Need to explain booster policy
- Strategy required to improve coverage in urban areas
- Relationship between NIDs in relation to EPI routine should be explained
- A strategy needed to convince intellectuals
- Need for strong terms of reference for ICCs
- Need to evaluate the cost effectiveness of expensive mobilisation materials and methods
- Formative research needed to facilitate better fund management
- Need to define benefits of reporting disease to the community
- Incentives to reward disease reporting should be identified
- Need for lay case definition
- Which diseases should be included in a community surveillance 'package'?
- More basic communication materials to be used for community surveillance
- It is better to utilise the same outreach sites during two to five year periods
- Not enough evaluation is done to check the effectiveness of current strategies
- More effective means of mobilisation must be devised for countries of central and western Africa with low immunization coverages
- How can we convey disease elimination messages to people so that they understand the continuing role of routine immunisation?

## 6 SUMMARY OF PROCEEDINGS PRESENTATIONS AND DISCUSSION

### Vision of social mobilisation for EPI in the Africa region

#### 6.1 *Overview of EPI in the African region goals and progress achieved* *Dr Okwo Bele, WHO-AFRO*

##### *Presentation*

- Regional strategies for the period focussed on advocacy, strengthening, surveillance, supplemental immunisation strategies and targeting of activities by block. Social mobilisation was aimed at sustaining EPI and polio eradication
- The status of major diseases in sub-Saharan Africa may be summarised as follows
  - 10 million cases of measles and 450000 deaths, more than half the global total
  - 100,000 NT deaths
  - 10,000-20,000 polio cases
- Current strategy aims to boost routine immunization <1yr coverage to minimise the duration of NIDs. However, levels of coverage have stagnated, even in the best-performing countries. Eastern and southern Africa show the best performance. Coverage is poor in central and west Africa, 40-50% coverage and little improvement. More effective means of mobilisation must be devised
- Routine measles immunization reduces the disease over 10 years, but supplemental campaigns eliminate the disease. How can we increase the coverage of routine immunization to back up the campaigns which can not be indefinitely repeated? How can we convey disease elimination messages to people so that they understand the continuing role of routine immunization?
- Major areas of action should be centred around ways to increase routine coverage (i.e. advocacy, fund raising) and surveillance, i.e. find community-based ways to increase reporting of cases
- On the issue of NIDs, there is need to
  - tackle fatigue,
  - initiate measles control/elimination operations,
  - identify appropriate modes of communication to raise public awareness on measles,
  - how to convey need to limit age groups to target,
  - target high risk areas
- Most cases and deaths are reported in the more difficult countries, where coverage is poor, and there is need to develop special strategies to overcome these problems
- When reviewing the resources required/available, there is need to evaluate the following
  - The cost of social mobilisation
  - The social mobilisation expert resources that can be identified in the region
  - The power of national first ladies to move national resources to EPI
  - Means of ensuring sustainability in a conflicting world

### ***Discussion***

- Damage to credibility of social mobilisation caused by outbreaks of disease in areas of high immunization coverage and cases of polio in immunized children
  - Limit of effectiveness of vaccines 80%

- Herd immunity induced by high immunization coverage
- Pools of unprotected children  $80\%$  effectiveness x  $80\%$  coverage =  $60\%$  protection
- Campaigns to reduce pools of unprotected children and to catch children missed by immunization
- Important that NIDs are not seen as a substitute for routine immunization
  - Highly effective additional, booster doses
  - Devise ways to convey these messages in a simple way, a formidable challenge

**6.2 Role of social mobilisation in EPI and priority needs to be addressed in 1998**  
*Ms Erma Manoncourt, UNICEF & Ms Grace Kagundu, WHO-AFRO*

**Presentation**

- There is evidence of falling commitment and fading support for EPI, and, therefore, a need to identify ways to inject new momentum To this end, areas that require further examination are as follows
  - How to sell the good news of achievements
  - How to promote routine immunization in the shadow of NIDs
  - Identify any opportunities that are lost, e.g. inter-sectoral support is often lost after campaigns
  - Need to accelerate surveillance with community support
  - How to address resistance to immunization in advance of NIDs
  - Need for better research and monitoring to assess impact, to define reasons for resistance and to target interventions more effectively
  - Need to distinguish different forms of social mobilisation, targets and methods

**Discussion**

The experience of some countries and programmes in the region was presented as follows

**1 Uganda**

- Lack of coordination on programme advocacy, global, national etc due to
  - i problematic link between HIV communication and NID communication,
  - ii competition between simultaneous messages,
  - iii too many new messages for the same target public
- Resources for social mobilisation not enough and provided too late Often, there is too little time to evaluate impact of social mobilisation, to pretest materials or even to organise social mobilisation properly It is also proving difficult to communicate reasons for conducting two rounds per year

**2 Botswana**

- Using existing traditional institutions/structures for reaching grassroots with messages
- Resistant groups are also present, but ministerial directives are used to force compliance
- There are limited outbreaks and, therefore, few communication problems of this sort
- Problems occur when communicators (health promoters, educators) themselves are not convinced

### 3 Angola

- Accessibility problems result in low coverage, but have reinforced the cold chain and have increased technical capacity to conduct immunization
- There are some districts without pre-existing immunization services
- A measles campaign is being prepared
- There is an obvious need to do something all the time, not just during a single campaign event
- The government is interested in the programme
- There are some pockets of resistance, but working with community leaders, radio, theatre (district touring theatre) and TV

### 4 Ethiopia

- There are some problems emanating from resistance from educated people and counter-advice or lack of advice from doctors
- There is also some lack of coordination and disagreement between parties on how to coordinate NIDs

### 3 UNICEF

During an earlier meeting, UNICEF communication officers presented the following observations

- The lack of participatory planning is a major problem
- There is some ignorance of the reasons for focussing on polio and the NID strategy
- Lack of interaction between health and communications people persists
- NIDs draw focus away from EPI, potentially damaging routine services
- The integration of the NID & routine immunisation strategies is discussed frequently but not practised
- The decline in the momentum of communication activities is clearly related to armed conflict and political instability. There is need to devise means of maintaining progress under conditions of conflicts, which are present in several countries. For example
  - i activities planned for March 1997 in difficult countries were cancelled due to armed conflicts,
  - ii plans for football activities were interrupted due to conflict in Brazzaville

**There is also need to identify appropriate messages to be conveyed to the communities and suitable times and venues, e.g. use of the second NIDs round to deliver routine EPI**

First Ladies are respected in many countries and should be used to create permanent interest in immunisation

Members of local communities must also be convinced of the safety of the injections used for immunisation

Pledge for safe injections - we the people, we the health workers but need to define a safe injection in minds of the people

## Polio eradication initiative Kick polio out of Africa

### 6.3 Polio eradication progress and challenges Dr Andre Lobanov

#### *Presentation*

- Polio cases in Africa represent 50% of the global total. Reported cases are still only 10% of all cases occurring. Improving the quality of disease surveillance is a priority.
- Progress of NIDs
  - In 1996, 25 out of 31 countries achieved over 80% coverage
  - In 1997
    - 36 countries conducted NIDs, of which seven countries held NIDs for the first time
    - 14 out of 16 countries that reported NIDs results achieved more than 80% coverage
    - Some countries, e.g. South Africa, saw lower coverage in second round NIDs compared to the first round, primarily as a result of fatigue
- Key problems of advocacy and social mobilisation are as follows
  - i Reduced involvement of heads of state
  - ii Wrong messages and rumours, the causes of which may be
    - spontaneous e.g. cases in immunized children,
    - political motives,
    - religious resistance, evident in several countries,
    - medical practitioners resistance and non involvement
- Chronic resistance to immunization is not receiving sufficient attention when planning subsequent rounds. For example, in Uganda
  - Five highly populated districts (14% of target population) with chronic poor performance
  - 500,000 children, 59-64%, immunized during NIDs, over 200,000 during each round
  - 67% coverage during routine immunization in these districts
  - high risk of outbreak and risk of international transmission
- The impact of NIDs on the disease was demonstrated
  - number of specimens inadequate to document polio free status
  - Non-polio AFP rates (based on 1/100000 <16yrs), expect 2756 AFP, but receive 274 so 12 per cent reporting
  - There is need to use surveillance to focus activities on areas where wild virus circulates (and mop up)
  - Regional targets for polio-free status
    - by 1999 southern and eastern,
    - by 2000 central and west,
    - by 2001 four difficult countries

#### *Discussion*

- Why use NIDs in both low incidence and high incidence countries?
  - South Africa and neighbouring countries will soon stop holding NIDs

- The absence of reported cases does not guarantee a low incidence, especially since surveillance is still weak
- There is still the risk of the spread of viruses between countries
- Reservoirs of viruses can cause scattered cases and therefore it is inadvisable to mop up too early
- Why not stop NIDs and rely on surveillance and mop up in southern and eastern Africa?
  - Previous outbreaks (e.g. in Namibia in 1994) suggest a continuing risk
  - Kenya has not yet effected an acceptable standard for surveillance
  - The organisation is anxious not to jeopardize the global programme by stopping too soon
- WHO's objective for surveillance standards is to have 100% reporting levels within local communities
- The lifespan of the wild virus ranges from hours to days, depending on local environmental conditions
- In resistant areas, it is pointless to mop-up. Research to determine the reasons for resistance should be the priority
- There is need to find ways to incorporate new messages on measles control and new vaccines with polio messages

#### **NIDs National perspectives**

#### **6.4 Uganda Addressing rumours Mr P Kagwa**

##### ***Presentation***

The most common rumours are as follows

- The polio vaccine is contaminated with HIV
- The government is using the programme to try and reduce the number of children qualifying for free primary education
- The vaccine has side effects similar to those associated with BCG in 1989
- Deaths of children have coincided with NIDs
- HIV originated from the smallpox immunisation campaign
- The programme is aimed at the elimination of black races
- Prophets have seen visions of God forbidding immunization
- NIDs are motivated by political elections

Community members acceptance of immunisation is also affected by the following factors

- Fear of unknown consequences
- Fear of overdose of multiple doses
- Loss of confidence because of disease in vaccinated children
- Polio is not considered to be a priority problem
- The reason for immunising those who are fully immunized is not understood
- Some religious customs forbid consumption of medicines

Those responsible for the rumours include

- health workers,
- politicians,
- conservative, traditional groups,
- religious fundamentalists,
- a professor of medicine who claims he has cure for AIDS,
- intelligencia,
- media groups,
- community leaders and traditional healers

The reasons for the genesis and spreading of the various rumours include

- limited involvement of health workers,
- ignorance,
- disgruntled politicians,
- financial greed,
- inadequate funding of mobilizers who were then de-mobilised,
- inadequate knowledge and training of mobilizers,
- concept of booster not understood or supported by health workers,
- NIDs timed with HIV vaccine trials and Universal Primary Education (UPE)

The strategy that has been initiated to overcome the impact of the rumours includes the following activities

1 Advocacy

- Parliamentarians met with religious leaders, GPs and opinion leaders
- Strengthened alliance of multi-sectoral planning groups
- Sensitization of government ministries
- Mobilizers equipped with more training

2 Community mobilisation

- Film van shows (there is need for more films on immunization)
- Traditional leaders supporting immunization
- Religious leaders wrote letters asking their churches to support NIDs

3 Involvement of health workers

4 Mass media programmes

- Use of polio sufferers in discussion programmes
- 'Phone-in' for radio and TV (good but risky)
- Meetings with the press
- Frequent press conferences
- Use of channels that had already given out counter messages

5 Sensitization meetings in difficult districts

- Community seminars

- Health workers, politicians, etc , publicly immunizing their children
- Translate materials in 11 languages to overcome the English language barrier
- Preparation of question and answer materials

Success is limited, particularly in affluent, educated areas

### ***Discussion***

- Who pays for use of private media? WHO budget paid The government is reluctant to contribute but can be persuaded Newspapers are free and supportive Free airtime given by the electronic media
- Rotary assisted in mobilisation and made a work plan
- Issues that require priority attention are as follows
  - Method to explain booster policy
  - Strategy to improve coverage in urban areas
  - Strategy to reach the most resistant people
  - Strategy to convince intellectuals
  - More films on EPI and polio
  - Need to explain NIDs in relation to EPI routine
  - Resources for mobilisation activities

## **6 5 *Ethiopia Social mobilisation strategies for NIDs Mr M Idris***

### ***Presentation***

The NID coverage targets were exceeded in rural districts and an overall coverage of 88% was achieved Other achievements of the NID are that it brought everyone together and helped identify future partners

The administrative structure and activities of the strategy were as follows The national inter-sectoral social mobilisation committee collaborated with committees at each level to plan and implement the various activities

### **1 National level activities**

- Letters sent to all collaborators
- Press conference
- The Prime Minister addressed the parliamentarians
- A statement by WHO
- 400 Rotary presidents met in Addis and were addressed by the President
- The launch day was declared a national holiday

### **2 Mass media**

- Radio and TV spots
- A 15 minute TV documentary in 3 languages

### 3 Print media

- Supplements on OPV
- Newspaper articles
- Posters, calendars, leaflets, booklets and a vaccination guide
- An image of an inverted baby with the slogan "No, I will not be born until polio is eradicated "
- Stamped messages on letters planned for the next year

### 4 Orientation programmes

- Religious groups- 400,000 who were supportive
- Media professionals
- The military provided a helicopter to help distribute leaflets

### 5 Launch ceremony

- 20 child polio victims presented a bouquet to the President
  - Children's songs
  - Speeches
  - 300 children marched three kilometres to the stadium
  - Rotarians organised a football match and large banner was used
- 
- Recommendations for future activities include
    - Action to solve shortages of transport and personnel
    - Improve regional involvement
    - The National Committee should involve the Prime Minister's office

### *Discussion*

- Politicians are difficult to get hold of, but if pushed, they may agree and their impact is very strong
- There is need for strong terms of reference for the ICCs

## 6.6 *Angola Social mobilisation in difficult circumstances Ms P Semedo*

### *Presentation*

In 1997, NIDs were affected by security problems, including those of land mines and bombs. Accessibility also presents a major problem. 32% of the population reside in districts that are difficult to reach, half of the total number of districts.

The EPI is the only programme permitted to go anywhere in the country but low levels of routine immunization coverage persist. The current target is 2.6 million children.

Key aspects of the social mobilisation strategy are as follows:

- Forward planning
- Training in social mobilisation at all levels
- Prior contact with political leaders
- Timely distribution of social mobilisation materials
- Pre-launch ceremony using radio and TV

- Special social mobilisation activities for groups without access to radio and TV
- Leaflets designed specifically for each ethnic group
- Use of Portuguese as a common language
- Intensification of social mobilisation in days preceding the NID
- Extensive use of megaphones by teams during the NIDs

In areas that are hard to reach, efforts are also made to

- provide timely information to communities,
- define vaccination posts,
- involve church leaders,
- use community theatre (less expensive in Angola than in Uganda),
- use of local languages,
- ensure that the date of the NIDs is never postponed

Lessons learned from past activities are as follows

- People identify caps with military police
- Symbols on T-shirts are identified with the government
- Tunics are suitable means of identifying vaccinators
- Although the national football team carried the logo there were no sponsors

### *Discussion*

- There is need to evaluate the cost-benefit ratio of expensive mobilisation materials and methods (i.e. T-shirts and theatre) To this end, the following should be addressed
  - Formative research is required to improve cost effectiveness
  - There is political pressure to buy materials
  - Materials such as T-shirts are useful as incentives
  - When there is limited time to take action, some materials are easy and quick to produce
  - Identification of vaccinators
  - Huge amount of waste has been experienced by UNICEF
  - There is need to find sponsors for these materials
  - Funds ought to be shifted from purchase of materials to training
  - Donors often specify materials Donors should be persuaded to describe a range of suitable options
- There is a need to assess the strategic mix of channels of communication For example, theatre may be the best way to communicate in hard to reach areas but it is a costly medium and it is difficult to control quality

### **Social mobilisation for disease surveillance**

#### **6.7 Community surveillance experience in Uganda Dr J Mugisha**

Progress on activities within the trial district is as follows

- 1 Community reporting
  - There is need for mobilisation activities that will ensure that
    - 1 health workers begin to report the cases they see,

11 lay members of the community are aware and involved

2 Building local capacity within decentralisation to

- sensitise community through use of a manual,
- make appropriate modifications to the manual for them,
- prepare monthly reports

3 Responsibilities of community members

- To detect and report disease and death
- To pass on information about prevention
- To refer sick children to health units
- To train other key informants

4 Supervision by health unit

- To date, there is no formal link between the health unit and community informants
- Currently, no reporting by health units in the study district

**Discussion**

- There is need for better definition of the wider benefits to the community when members report the disease. The only benefit that has been communicated so far is that feedback is provided, patients are referred and, therefore, deaths may be reduced. Incentives to reward disease-reporting should be considered
- The issue of whom community members should report to should be addressed. It is unlikely that they will report if the health unit does not
- The role of the health unit should be clarified to encourage the community to detect and report disease
- The working group should consider whether to concentrate on surveillance in certain countries with few cases reported instead of conducting NIDs, so that NIDs are justified
- There is need for a strategy to communicate surveillance concepts to health staff and to the community
  - Need lay case definition
  - Include just a few diseases in a community surveillance 'package'
  - Two different messages to the two groups - guides were distributed
    - 1 For clinicians: difficult language and requires no diagnostic judgment
    - 11 For communities: Health workers and lay people are 'communities'
  - Need to analyse local interpretations of different kinds of paralysis. For example, in Ethiopia polio is not considered to be a disease but the result of a curse

**Social mobilisation for routine immunisation**

**6.8 Botswana: increasing and maintaining high coverage**

In Botswana, EPI includes Hepatitis B vaccination activities. The programme aims at sustainability through the following objectives and activities:

- Attaining self sufficiency in procurement

- Health education and communication
- Ensuring adequate manpower
- Refresher training for health workers
- Integrated infrastructure - static, mobile and private services (practitioners offer vaccines free of charge but charge for needles)
- Development of policy guidelines, including a guide for private practitioners
- Maintaining political commitment to provide a favourable environment
- Participatory planning to promote ownership, use of local resources and avoiding duplication
- Monitoring to identify new needs

Constraints that have been encountered include

- discrepancy in immunization policies,
- non-adherence to the schedule, children brought for immunisation at the wrong time,
- false contraindications applied by health workers,
- resistance that stems from religious beliefs,
- cultural beliefs such as witchcraft,
- poor planning

NIDs enhance routine immunisation activities because

- they encourage inter-sectoral participation,
- they raise visibility of health among leaders,
- revitalise village health committees since members are encouraged to participate in planning
- they promote the sharing of resources to improve efficiency

NIDs-related activities should include the following

- Use of existing structures and staff for NIDs
- Regular press briefings on immunization coverage status
- Evaluations of the effect of NIDs on routine coverage
- Opportunities to solicit funding support

### *Discussion*

- Planning is often too rushed and better planning is needed
- There is not enough evaluation to check effectiveness of the strategies
- Did NIDs reduce performance of EPI? It is difficult to explain the NIDs in relation to routine immunisation but they relate polio eradication to smallpox which is well understood
- How did Botswana explain the measles campaign in selected districts to people?
  - Districts at risk for measles deaths are well known and accepted
  - The measles campaign was really difficult because health workers had to be transferred from routine immunisation activities
  - This year's measles campaign was a pilot project which will be expanded next year
- This is an opportunity to restructure EPI, particularly to absorb NIDs
- Lack of drugs at health centre reduces utilization of health services and frustrates social mobilisation for routine immunization
  - There are still opportunities to raise immunization coverage where utilization of health services is high

- Even when access to fixed services is easy, immunization coverage remains low
- There is need for joint planning of services in the health unit so that drugs and vaccine supply is integrated and all services can be offered
- Social mobilisation cannot compensate for certain factors such as effects of decentralisation, unpaid salary and other motivational factors

### **EPI in context of programme communication**

#### **6 9 Development Communication model Mr P Kagwa**

#### **6 10 The three pronged strategy Mr N McKee, UNICEF**

##### **Presentation**

- The three-pronged strategy focuses on
  - i advocacy,
  - ii social mobilisation (partnership development and participation, community mobilisation),
  - iii programme communication
- Experiences in advocacy reveal the following
  - Strategies must always change
  - Political support is important at the start, thereafter it is hard to sustain visibility
  - Patronage by the national first lady does not work in every country
  - More use should be made of the press, radio and TV
  - Information devices for inter-personal communication, such as pocket cards, are important
- Social mobilisation
  - Participatory planning is important at all levels, and should include
    - meetings involving both national ministries and NGOs,
    - problem analysis with opportunities to express individual perceptions and for group work,
    - allocation of resources and activities (e.g. in Uganda and Zambia),
    - UNICEF uses the “VIPP” method (visualization in participatory programmes)
    - Decentralized decision-making is more effective
    - Partners and allies should be rewarded, given new tasks, etc
- Programme communication
  - Formative research required to develop strategies
  - Operational research is needed
  - Efforts made to minimise use of easily available materials e.g. posters, pamphlets and focus on essentials, e.g. tin plates nailed to posts within the area
  - Emphasis on inter-personal communication, the greatest block to sustainability
  - Materials can also be used to support inter-personal communication
  - Radio
  - Careful use of traditional or folk media (e.g. theatre, song) is recommended
  - Messages are designed to target various segments of the population

- Special events, or 'pulsing'  
The national immunization weeks held in Bangladesh are a good example, and involve
  - identification of regular venues and time,
  - health service sites and the same outreach sites (i.e. schools) are used over a two to five year period,
  - home visits are avoided,
  - activities focussed in areas where outbreaks have occurred,
  - micro-planning,
  - mini-training on specific issues
- NIWs should be considered for communication and promotion of programme activities since, in other regions they have proved more appropriate and more flexible. Furthermore
  - NIDs already take longer than a day, usually a week,
  - NIWs can be used to incorporate surveillance messages,
  - each country can plan for the most appropriate strategy,
  - NIWs offer better possibilities for communication and help reinforce routine immunisation activities

#### *Discussion*

- NIWs are primarily for communication, so how could they link to NIDs? Perhaps a single annual NIW can be held to promote routine immunization
- Namibia already holds NIWs. There is still a need to hold events during the year to promote routine immunization, which may culminate in an NID
- Recording system initiated during NIDs would enable follow up between rounds, but would be impractical
- NIWs held without providing vaccines might damage the credibility of the programme
- Social mobilisation campaigns have led to higher coverage rates (e.g. in Kinshasa)  
However
  - these campaigns are different from the vaccine administration in NIDs,
  - they focus more on promoting the use of services for all antigens,
  - case detection needs to be all-the-year-round so continuous promotion is needed
- Health promotion weeks are not a viable option since previous experience of WHAs was poor, and the activities were not sufficiently focussed
- Another option is to link the NIWs one month after the second NID round, providing an opportunity to announce the results of the NIW and promote routine immunisation at the same time. However, it may be tiring to organise another national event a month after the NIDs
- Countries should be encouraged to try the various options. Some countries have already tried mixing NIDs promotion with routine immunization promotion (e.g. Ghana)
- Alternatively, NIWs can be organised for EPI communication before the first round NID, or the strategy may involve NIW mobilisation between NIDs rounds followed by EPI promotion
- The 'low period' of the NID year can be used for routine promotion during NIWs and the rest of year used to intensively promote NIDs

- Another option is to replace NIDs with NIWs for second round. This may be more affordable.
- Routine immunization promotion during the weeks between the NIDs can be mixed with NID-Polio mobilisation.

### **Innovative approaches and tools**

#### ***6.11 Use of puppetry Georges Collinet BASICS representative***

##### ***Presentation***

- The programme aims to promote interest and motivation through the use of puppet/ muppet characters. The programme is low-cost, multi-lingual and effective. It provides a good opportunity for the promotion of health issues.
- The script is prepared by a panel and recorded on video. Portable video playback machines (priced at \$US 300) are used. The programme has proved successful in Madagascar, where local songs were used. The video recordings have also been broadcast on RFI and CFI.
- Entries are received from all African countries for a competition for local polio songs. The winning entry is featured on CNN and during a fund-raising concert.
- There is need to identify a female African spokesperson, an apolitical celebrity known for strong family values. National first ladies may be suitable where they are considered to be 'first mothers'.
- Follow-up of organised events is important to ensure that people do not feel abandoned thereafter.

##### ***Discussion***

- Previous experiences with the concept of cartoon characters in Africa
  - UNICEF's "Sara" has worked in 10 countries. During a Sara festival in Uganda, children composed songs and presented plays and artwork (multi-lingual).
  - Puppets /toys of Sara can also be distributed as incentives.
  - The adolescent girl embodies empowerment of women.
  - The character conveys gender-sensitive issues (e.g. for teachers) and serves as a focus for family discussions.
- Potential exists for using puppetry in hard-to-reach areas.
- Official ambassadors should be used more often in promoting activities. Based on UNICEF's experience it is advisable to have more than one ambassador since different characters can be targeted at different sectors of society. It is important to utilise these characters effectively once they are identified.
- Previous experience with selecting ambassadors
  - Miss Angola less controversial than the first ladies.
  - Apollinaire important because he is well known, apolitical and articulate.
  - Musicians are very important because they are usually apolitical, but it is difficult to access celebrities and sportsmen for participation in events.
  - Ambassadors have the potential to attract sponsors.

- Importance of retaining the big picture, the overall plan and strategy There is no harm in including many components if they are integrated in a plan
- Communicators need tools and not just technical facts Comic books and cartoon characters are useful and such tools also help to motivate the communicators

## 6 12 *SARA the film UNICEF, ESARO*

This film addresses the general problem of school attrition which is particularly high for girls (as revealed by a year long research study that involved 573 focus group discussions in many southern and eastern countries) In Uganda, 50% of adolescent girls are already out of school

Other films are planned for AIDS, female circumcision, sexual abuse and other gender and development-related issues The organisation is also considering developing one on nutrition The World Bank is paying for four language versions and UNICEF welcomes other sponsors to facilitate development of other applications of Sara

An evaluation exercise showed that Sara was accepted and understood well in Ethiopia, proof that the character is cross cultural within Africa

### *Discussion*

- The video is used to train teachers and NGO groups in facilitation methods that lead events and discussions based on the film BBC radio programmes (multi-lingual) are produced for a single BBC broadcast then as raw material in other countries
  - The video stimulates production of other materials, including strip cartoons, serials in newspapers, caps, posters, etc
  - Plays written locally on based on the character and therefore the story and video serve as springboards for other forms of communication
  - Not stand alone, integrated into programmes
- There is a need to produce more materials that provoke discussion

## **Plan of Action: January to June 1998**

### **Sub Group 1**

#### **1 Research and evaluation**

Types of research

- formative/KAP,
- impact,
- operations

Areas of research

- resistance to immunization
- channels,

- low-performing districts,
- impact of NIDs on routine EPI,
- participation of partners,
- information needs of communicators,
- training needs of communicators,
- materials distribution,
- messages,
- collaboration beyond NIDs

#### Research methods

- Through collaborative institutions
- Questionnaires or materials
- Review to include social mobilisation

#### Monitoring (e.g. media reach)

- Use NIDs monitoring system
- Shared use of monitoring tools
- Guideline on monitoring

## 2 **Communication Planning**

- Social mobilisation plan to be based on research
- Communication personnel to be involved in the planning at all levels
- Plans should incorporate the needs of specific groups and areas
- Participatory planning, involving partners and allies
- Consider elements of Development Communication Model, Advocacy, Social Mobilisation and Programme Communications
- Strengthen skills of communication personnel
- Upgrade confidence and profile of communicators
- Build communication monitoring into plans, develop qualitative indicators

#### Activities

- Training to increase manpower
- Bi-annual meetings (regional and national)
- Development of guidelines

## 3 **Co-ordination**

Strengthen co-ordination mechanisms to strengthen health delivery through the following

- Ensuring that donors are informed and agree on the timing of major events
- Ensure that EPI personnel responsible for routine immunization at the national level plan together with those responsible for NIDs
- Countries should empower themselves to follow their own plans, rather than be subjected to external pressures to receive visitors at inconvenient times or to change programme priorities
- The Inter Agency Coordinating Committee (ICC) is an indispensable tool for participatory planning and members should meet monthly

- The written work plans of different organisations involved in routine EPI or NIDs should be shared
- Each UN organisation should operate within its own mandate
- Terms of reference should be drawn up for the ICC in each country and shared among all the partners in immunisation, both routine and NIDs

## Sub Group 2

### 1 Resistance to immunization: interventions & tools

- 1 Deliberate misinformation and rumour-mongering (e.g. vaccines kill, transmit disease, sterilize etc.)

#### *Target group Opinion leaders and "intelligencia"*

- TV talk show with experts and rumour-mongers, scripted and including information video
- Radio phone-in with experts and rumour mongers
- National Vaccine Control Authority to run a vaccine safety & efficacy "Hot-line"
- Meet with national or international organisations controlling rumour-mongers
- Private meetings between MOH, external experts and rumour mongers

#### *The people*

- Radio programmes in local languages
  - Organise "chat" sessions with opinion leaders and public in problem districts
  - Use celebrities to refute allegations
  - Demonstrate vaccination of children of celebrities
  - Puppetry and video cartoon shown on handheld battery driven video device (\$300)
  - Questions and Answer sheets for communicators
  - Radio programmes in local languages
  - Organise "chat" sessions with opinion leaders and public in problem districts
- 1 Use parables to explain complex ideas of vaccine protection and efficacy

#### *Health professionals*

- Prepare and disseminate annotated bibliography on vaccine safety
- Meet with professional associations
- Sensitize health workers through training and empower them to communicate correctly to public
- Inform health workers and doctors comprehensively on the vaccine/drug trials in their region
- Use immunization Taskforce to correct health professionals who pass the wrong messages

- ii Mis-conception or ignorance (vaccines not effective - disease in immunized children)

#### *Opinion leaders and 'intelligencia'*

- TV talk show with experts and rumour-mongers, scripted and including information video
- Radio phone-in with experts and rumour mongers

- University seminars and info packages for schools
- National Vaccine Control Authority to run a vaccine safety & efficacy “Hot-line”

*Health professionals*

- Provide vaccine efficacy literature and bibliography

iii Disagreement with or misunderstanding of the strategy of polio NIDs

*Opinion leaders and 'intelligencia'*

- Prepare and broadcast a video on the aim and effectiveness of NID strategy
- Radio programme on polio eradication in which the NID strategy is explained

*Health professionals*

- Sensitisation workshops for health workers
- Ministerial directives

**2 Maintaining credibility in the face of adverse events**

- In cases of coincidental death, complications and death/disease, investigation and media FAQ should be applied for opinion leaders, intelligencia and other community members, whereas training is more appropriate for health professionals
- In cases of unsafe injection and cross infection health professionals should be provided with training For opinion leaders and other community members, the following activities are recommended
  - Use safe injection equipment and practices
  - Create demand for safe injections
  - Warn against injections received outside the formal health sector
- For ineffective vaccine (i.e. cases in immunised children), cold chain investigation and improvement is recommended to address the concerns of health professionals Opinion leaders should be provided with appropriate audio-visual and written materials

**Sub-Group 3**

**1 Promoting routine EPI with NIDs**

The main issues are as follows

- i It is important that NIDs are not regarded as a substitute for routine immunisation
- ii There is a lot of rhetoric on the integration of NIDs with routine immunisation but the reverse is the norm
- iii There is need to explain NIDs in relation to EPI to the local communities

These issues present the following problems

- Concentration of NIDs still diverting all available energy and resources
- Health workers and community members think that NIDs might replace routine EPI Where the state of the routine service was poor before NIDs, this belief is reinforced
- Decentralisation may also reinforce the notion that NIDs replace routine EPI
- Where the percentage of immunizations given at temporary posts is high and the place of the post is varied, there is confusion and low coverage

- There is not enough effort to identify districts with low immunization coverage and to investigate why coverage is low

#### Recommendations

- Use second round of polio NIDs for communication on routine EPI over longer period (say 1-2 weeks)
- Countries to adapt the policies as they see necessary
- Clearer messages for community members and health workers on NIDs vs routine EPI to answer the questions why? when? and where?
- More consistency in selecting and using outreach sites in successive NIDs to avoid confusing the public

## 2 Community surveillance

The issues to be addressed are as follows

- Need to define benefits to the community of reporting
- Incentives to reward disease reporting
- To whom does the community report?
- Need for lay case definitions
- Just a few diseases in the community surveillance package - which ones?

The problems

- Community members are not reporting cases of AFP
- Health workers are not reporting, or not reporting promptly
- First contact - misinformation or not reported
- Polio/AFP usually not seen as a priority in the community (not in top 5) but is a priority for the affected family

Recommendations

- Develop appropriate communications strategies to strengthen surveillance systems targeted at
  - medical professionals,
  - other health staff,
  - traditional healers,
  - communities,
  - families

### Prioritising Activities

- **Sub-Group 1 Research, evaluation, communication and co-ordination**
  - I Develop communication research guidelines
  - II Enhance exchange of experience through
    - sharing of materials,
    - providing opportunities for meetings between countries
  - III Capacity building for communications through
    - training,
    - technical assistance,
    - exchange visits

- **Sub-Group 2 Interventions and tools to address resistance to immunization and maintaining credibility**

- 1 Design TV and radio talk-show for Uganda and Kenya, main activities including
  - obtaining the video on vaccine safety,
  - identifying a producer and preparing a video to address adverse rumours in Uganda,
  - preparing a script for MC
- 11 Hold a private meeting with the MOH, external experts and the rumour mongers (either Nick Ward or Peter Ndumbe can assist)
- 111 Create a cartoon/puppet character and produce a video based on this character This will entail
  - definition of priority messages,
  - a meeting in April 1998 to agree on an appropriate character,
  - planning, budgeting and fund-raising

- **Sub-group 3 Promoting routine EPI with NIDs and community surveillance**

- 1 Hold a workshop to review the status of the communication and commission guidelines, with participants drawn from most of the partners in immunisation activities
  - SM materials from each country should be submitted before the workshop
  - The outline will be created during the workshop
  - Preferably, the workshop should be held for three to four days during April, with 10 to 15 participants
- 11 Prepare a communication guide focussing on surveillance, routine immunisation and NIDs
  - The consultant should prepare a draft guide by 1 May, 1998 and circulate it
  - Funding should be raised from the participating organisations

- 111 Capacity building for communications through
  - training,
  - technical assistance,
  - exchange visits
  
- **Sub-Group 2 Interventions and tools to address resistance to immunization and maintaining credibility**
  - 1 Design TV and radio talk-show for Uganda and Kenya, main activities including
    - obtaining the video on vaccine safety,
    - identifying a producer and preparing a video to address adverse rumours in Uganda,
    - preparing a script for MC
  - 11 Hold a private meeting with the MOH, external experts and the rumour mongers (either Nick Ward or Peter Ndumbe can assist)
  - 111 Create a cartoon/puppet character and produce a video based on this character This will entail
    - definition of priority messages,
    - a meeting in April 1998 to agree on an appropriate character,
    - planning, budgeting and fund-raising
  
- **Sub-group 3 Promoting routine EPI with NIDs and community surveillance**
  - 1 Hold a workshop to review the status of the communication and commission guidelines, with participants drawn from most of the partners in immunisation activities
    - SM materials from each country should be submitted before the workshop
    - The outline will be created during the workshop
    - Preferably, the workshop should be held for three to four days during April, with 10 to 15 participants
  - 11 Prepare a communication guide focussing on surveillance, routine immunisation and NIDs
    - The consultant should prepare a draft guide by 1 May, 1998 and circulate it
    - Funding should be raised from the participating organisations

## SOCIAL MOBILISATION WORKPLAN: JANUARY - DECEMBER 1998

Activity	Timing	Responsible	Collaborators	Funds needed US\$	Funds Available	Remarks
<b>1 MEDIA ADVOCACY</b>						
<b>Key Messages for 1998</b>						
Emerging polio free zones Success of NIDs in 1997 NIDs Africa wide in 1998 - All time of football and polio Reaching the targets - active surveillance Routine immunisation is just as important						
<i>1.1 Organise press briefings</i>						
press conference for sporting journalists at CAN 98	Feb					completed Report to come
press conference for international press at the World Health Assembly	WHA May					
press conference during the Regional Committee	sept					
briefing at workshop of WHO HHPs	July					
				5 000		

Activity	Timing	Responsible	Collaborators	Funds needed US\$	Funds Available	Remarks
<i>1.2 Radio</i>						
Develop and disseminate regional radio programme design production distribution and evaluation consultancy	March to June			to be determined		To establish roles of the different players and sources of funding
radio spots production and timing	Oct - Nov			15 000		to coincide with NIDs in West & Central Africa
<i>1.3 Media Advocacy through major events</i>						
CAN 98						completed Report to come
follow up activities from CAN 98						
Launching of NIDs in DRC	Aug					
consultancy to coordinate 3 months				20 000		
				approx 100 000		to develop proposal and budget
<i>1.4 Develop and distribute materials to support regional advocacy</i>						
press kits	June/Nov					
video of African countries experience broadcast copies from countries production and distribution	Nov			7 000		
radio programmes	July			5 000		
brochure PFI achievement in the region design layout and production	May			5 000		To have a statement from Mandela

Activity	Timing	Responsible	Collaborators	Funds needed US\$	Funds Available	Remarks
promotion of materials (T-shirts, badges etc)						proposal for sponsorship to European & global football organisations
Distribution distribution list						
<i>1.5 Advocacy with ambassadors and spokespersons</i>						
Gahungu to attend 2 events				10 000		
<b>2 ADVOCACY WITH REGIONAL BODIES</b>						
<i>2.1 OAU and Committee for a polio-free Africa</i>						
statement of polio eradication progress to OAU and Committee	June					
statement by Mndel						
				5 000		
<b>3 STRENGTHEN NATIONAL SOCIAL MOBILISATION</b>						
<i>3.1 Skills/capacity building</i>						
3.1.1 develop updated communication guide on IPI polio and surveillance consultant translation production	March - May			25 000		
consultative workshop	April 6-9			25 000		
3.1.2 Organise review and skills building meeting of national social mobilisation focal points West Africa	to be decided			30 000		

Activity	Timing	Responsible	Collaborators	Funds needed US\$	Funds Available	Remarks
Follow up in countries with difficulties Nigeria DRC Ethiopia	on going		All partners	18 000		Prepare plan and schedule of follow up by partners
3.1.5 Meeting of social mobilisation focal points at LPI managers meetings for exchange and training Southern Africa Eastern Africa Central Africa	Feb 11-17 March 18-20 Feb 16-20			25 000		
3.1.4 Information exchange administrative support of regional office				5 000		
<b>3.2 Addressing resistances to PFI and maintaining credibility</b>						
distribute questions and answers sheet for communicators	April					
prepare and disseminate bibliography on vaccine safety to health workers	April					
meeting of MOH external expert and difficult groups Uganda/Kenya				5 000		
study to determine resistances to polio eradication initiative Uganda/Kenya	by June			15 000		technical support needed
<b>3.3 Surveillance</b>						
develop communication strategy guide						to be incorporated into communication guide

Activity	Timing	Responsible	Collaborators	Funds needed US\$	Funds Available	Remarks
support community surveillance pilot project in Uganda Document	by Nov					technical support needed
<i>3.4 Research and evaluation</i>						
prepare research guidelines	by May					to be incorporated into communication guide
compile and share simple research tools	by May					continuous exchange
support national research studies	ongoing	All partners				technical support is needed
<i>3.5 Documentation of lessons learned</i>						
<b>4 REGIONAL COORDINATION</b>						
review meeting of partners NY	June 1st week			5 000		to confirm dates
review meeting of partners and national social mobilisation focal points Victoria Zimbabwe	Nov 25-27			25 000		

pt

**APPENDIX D**  
**Implementation of EPI in**  
**African Region in 1997**



**WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR AFRICA**

# **IMPLEMENTATION OF EPI IN AFRICAN REGION IN 1997**

**Progress Report - 1997**

**EPI/AFRO  
10/12/97 - Rev.1**

---

## Table of contents

### Highlights of major achievements

#### Introduction

- 1 Development of surveillance of AFP and other EPI priority diseases
  - Development of AFP/Wild poliovirus surveillance system in 1997
  - 01 AFP/EPI data management
  - 02 Wild poliovirus epidemiology
  - 03 AFP reporting and stool specimen collection
  - 04 Using AFP/viral surveillance to evaluate NIDs
  - 05 Regional Polio Laboratory Network
  - 06 Integration of AFP surveillance with surveillance for other EPI and non EPI target diseases
  - 07 Summary
- 2 Implementation of the 2<sup>nd</sup> series of National Immunization Days
  - Progress made
  - 21 Multi-interventions NIDs
  - 22 Major constraints and Lessons learnt
  - 23 Plans for 1998 NIDs
- 3 Status of the routine immunization activities
  - Reported coverage achieved in the Region
  - 31 Review of main issues with the routine delivery of immunization services
  - 32 Status of the cold chain and EPI logistic
- 4 Progress with specific disease control/eradication initiatives
  - 4 1 Polio eradication
  - 4 2 Measles control
  - 4 3 NT elimination
- 5 Social mobilisation and advocacy
  - Regional level
  - 51 Country level
- 6 Vaccine supply and Introduction of new vaccines
  - Forecasting of vaccine needs
  - 61 Vaccine financing
  - 62 Vaccine procurement
  - 63 Introduction of new vaccines
  - 64 Regional production of vaccines
- 7 Management of the regional programme
  - EPI planning and budgets
  - 71 Staffing and Technical cooperation with Member States
  - 72 Financial status of the regional programme

47

---

## Highlights of major achievements during 1997

One of the major achievements is the effective expansion of wild poliovirus surveillance in most countries in the Region. During 1997, 31 countries (out of 46) submitted stool specimens to a WHO network polio laboratory. Surveillance has thus become a very high priority for AFRO and all WHO EPI staff have been fully briefed on activities that need to be conducted in the countries in this area.

Fourteen out of fifteen laboratories comprised in the WHO/AFRO Network of Polio Reference Laboratories were operational in 1997. However, of the five laboratories submitted to yearly accreditation (according to standards set by the Global Commission on Polio Eradication), all attained only provisional accreditation because they have not met the criterion for testing at least 150 stool specimens per year. This indicates the need for further boosting AFP case detection and investigation.

The 2nd series of Polio NIDs will involve 36 countries between March 1997 and March 1998 (compared to 30 countries during the 1996-1997 first series and about 100 million children below 5 years of age are expected to be immunized with two supplemental doses of OPV). Due to political instability and/or civil war, SNIDs are to be implemented in the cities of the Democratic Republic of Congo (DRC) and NIDs planned in the Republic of Congo, Sierra Leone and Liberia will not be implemented. By end of November 1997, NIDs were implemented in 25 countries. Overall, NIDs were successful with preliminary results well above the 80% targets.

As of October 1997, no wild poliovirus was isolated in East Africa, and throughout southern Africa. In continental southern Africa, no wild poliovirus has been isolated since 1993 and just over 200 stool specimens have been negative for wild poliovirus in the last three years.

In collaboration with its partners, the Regional Office initiated a series of activities for advocacy and social mobilisation to increase political commitment, public awareness and community participation for immunisation, with focus on social mobilisation for the PEI and the promotion of routine immunization.

The EPI reviews carried out in six countries revealed that the immunization coverage has been static or on a decline in most countries since the early 1990s. Deficient quality of immunization in some areas due to or associated with poorly motivated or untrained staff, unsuitable and even dangerous injection and sterilisation practices, inadequate supportive supervision at district and health centre levels and poor communication between health workers and mothers are most of the reasons identified.

In addition, inventories of the cold chain equipment and the logistics systems have been conducted in seven countries, resulting in the estimates of the funds needed for cold chain replacement and strengthening of the EPI logistics.

Support for improving the Region's abilities for vaccine production was provided with follow up visits in the four vaccine producing countries (Cameroon, Nigeria, Senegal and South Africa). The follow up visits have made it possible for South Africa to advance discussions for instituting an autonomy management structure and for Senegal to finalize the agreement on an independent control authority. Nigeria and Cameroon need their Government's important decisions to enable viable production capacities.

## Introduction

The Regional EPI has continued to work within the context of the framework defined in the Regional EPI 5-year plan of action, adopted by the TFI/ICC in 1994. All major components of the EPI have been addressed. Expanding AFP/EPI surveillance, implementing National Immunization Days (NIDs), and strengthening the delivery of routine immunization activities have been looked at while striving to achieve the EPI disease control goals set for the 1990s and the improvement of routine immunization coverage.

Substantial difficulties were observed with the functioning of the Regional Office during the second half of the year, due to the civil war in Congo and the subsequent re-location of the Office. Inter-country meetings and workshops had to be cancelled. Nevertheless and more importantly, nearly all activities planned at country level including NIDs, were carried out without disruptions. This was made possible with the temporary re-location of the EPI/AFRO at HQ and the excellent coordination provided at the level of Inter-country EPI Epidemiologists and Logisticians.

The Regional EPI continues to benefit from the strong support of the Division of Integrated Disease Prevention and Control, as well as from the Regional Director and the supportive Units of the Regional Office and HQ. On the other hand, the cooperation with the partners has been improved during the year, with frequent exchange of information, joint field visits and improved collaboration between the respective Representatives based at country level.

## 1 Development of surveillance of AFP and other EPI diseases in 1997

### 1.1 Development of AFP/Wild Poliovirus Surveillance System in 1997

In contrast to 1996 and before, wild poliovirus surveillance became operational in most countries in Africa by October 1997. During January to October 1997, Mozambique, Angola, Chad, Mali, Rwanda, Burundi, Liberia, Sierra Leone, and Eritrea were the only countries with >3 million population which had not submitted stool specimens to a WHO polio network laboratory.

By March 1998, almost all countries will have conducted one NIDs and many countries will have conducted two series of NIDs. Surveillance becomes therefore a very high priority. In this context, a full-time Medical Officer responsible for AFP/EPI surveillance was appointed in the Regional Office at the beginning of 1997. Previously, in 1996 and much of 1997, most WHO EPI staff had concentrated on NIDs. However, a WHO EPI staff meeting was held in October 1997 to stress the importance of surveillance. This meeting was to take place in June 1997 but was postponed due to the civil war in Brazzaville that affected some inter-country activities.

Countries were advised to prepare national surveillance budgets which include the following key items:

- Active surveillance from national to provincial and from provincial to district levels, including

transport for all provinces

- Sensitizing clinicians at one or half-day meetings
- Two- to three-day training of AFP case investigators in completing forms for AFP cases and stool specimen collection and transport
- Stool specimen containers and reverse cold chain
- Transport of specimens to the national level or national laboratory
- Transport of stool specimens from the national level to WHO inter-country laboratories
- Use of mass media, including radio, to sensitize communities and clinicians

About \$250,000 were spent on surveillance from January to September in 1997. Most of the 1997 surveillance funds (approximately \$3 million) became available in July 1997. During September and November 1997, approximately half of the surveillance money was distributed to countries according to surveillance budget plans submitted.

In order to effectively monitor the geographic distribution and frequency of active surveillance and the effective use of active surveillance funds, the Regional Office has introduced Active Surveillance Management Tool Forms. These forms indicate facilities visited and should be submitted to WHO Block epidemiologists and AFRO each month.

## 1.2 AFP/EPI Data Management

Starting in May 1997, efforts were made to have all countries report AFP case-based data to WHO on a monthly basis. AFP/EPI data management was decentralized to the level of the Inter-country Epidemiologists. By the 7th of each month, countries are to report AFP case-based data and EPI information to WHO country offices. By the 30th of each month, block Epidemiologists should consolidate and send to the Regional Office a database of AFP case-based data, summary data of measles, NNT, and yellow fever, and timeliness of monthly reporting using data from the countries of their respective blocks.

National EPI and epidemiology units have been requested to start reporting monthly to WHO a database with timeliness of district level surveillance reports. For certification of polio eradication, each country needs to demonstrate that all districts have been submitting 80% of all expected reports in a timely manner.

On the other hand, all Polio Reference Laboratories of the African Region network are using a standard database structure to send data on a monthly basis to WHO. The three Regional Reference Laboratories have started to notify the AFRO virologist, the Block Epidemiologists and the country surveillance officers by email immediately on identification of a wild poliovirus. Two days of the annual laboratory meeting were spent exclusively on data management.

An All-Africa Wild Poliovirus Sequence Database and Tree has been developed thanks to an extraordinary cooperation between the Pasteur Institute (Central African Republic), the Noguchi Institute for Medical Research (Ghana), the National Institutes of Virology (South Africa) and the Centers for Disease Control and Prevention (USA). This sequence database and tree is a powerful epidemiological tool to assist in the eradication of wild poliovirus in Africa. For this task which is near completion, the cooperating laboratories are sequencing several representative viruses from all known foci from which wild polioviruses were isolated.

A map of Africa by health district has been made in order to map reported AFP cases, stool specimens collected, NIDs coverage, and routine coverage by district. A separate map by province was also made to show non-polio AFP rates by province. Population density by district was added. In addition, a

unique district code for every health district in Africa was made. This code is to be used in the EPIINFO data entry programme for AFP, neonatal tetanus, and yellow fever cases. This map, population data and coding scheme is another example of AFP surveillance funds benefiting other EPI and non-EPI programmes.

### 1.3 Wild Poliovirus Epidemiology, 1997

As of October 1997, no wild poliovirus was isolated in East Africa from southern Uganda through Kenya, Tanzania, Zambia, throughout southern Africa around to Namibia. In continental southern Africa, no wild poliovirus has been isolated since 1993 and just over 200 stool specimens have been negative for wild poliovirus in the last three years.

From January to October 1997, wild poliovirus was isolated from 20 AFP cases region-wide. Wild poliovirus was extensively isolated from the Democratic Republic of Congo and countries of central and west Africa, except Ghana. Of great concern was that wild poliovirus was isolated in CAR and Cote d'Ivoire more than 30 days after the second round of the first NIDs.

### 1.4 AFP Reporting and Stool Specimen Collection

Zimbabwe was the only country with >3 million population with a high annualized non-polio AFP rate of 0.8 per 100,000 children <15 years. Although several countries had non-polio AFP rates of 0.4 or better (Botswana, Ghana, Namibia, Swaziland, Uganda, Zimbabwe), only Swaziland had a percentage of AFP cases with 2 stools within 14 days >50%. Two large countries with medium non-polio AFP rates (Ghana and Uganda) have similar problems in that viral surveillance is present in only half of the country and half of the stool specimens are being collected more than 30 days after the onset of paralysis.

No stool specimens were collected in Angola. Stool specimens have been taken from 3 AFP cases in Ethiopia but the specimens have not yet been processed. Stool specimens were collected from only 2 AFP cases in Nigeria.

### 1.5 Using AFP/Viral Surveillance to Evaluate NIDs

Virologic evaluation of NIDs in four countries with sufficient virologic data indicated that NIDs were extraordinarily effective in those four countries. Prior to the NIDs in Ghana, Zambia, Uganda, and Tanzania, wild poliovirus was isolated from between 19% and 59% of all AFP cases with stool specimens taken. After the NIDs, wild poliovirus has not been isolated from any of the 61 cases of AFP with stool specimens taken as of October 1997. Although indigenous wild poliovirus may still be uncovered in these countries, these data clearly shows that a single NID in those countries was able to reduce the magnitude of wild poliovirus to very low levels.

### 1.6 Regional Polio Laboratory Network

Fourteen of the 15 laboratories comprising the WHO-AFRO Network were fully functional during the year. With additional 8 countries commencing AFP surveillance with stool sample collection in 1997, the network laboratories are currently providing polio diagnostics services for 31 countries. The countries that commenced using the services of the network in 1997 are Benin, Chad, Ethiopia, Guinea, Guinea-Bissau, Mali, Niger and RD Congo.

**Training** The annual training course for the polio diagnosis was carried out at the Regional Laboratory in Ghana. This was the first in the new series of training courses jointly supported by WHO, JICA and the Government of Ghana. Although emphasis was on Yellow Fever (YF) diagnostic, considerable

time was devoted to polio diagnostic procedures during the course. Other laboratories of 9 countries in the YF epidemic zone attended the training.

**Accreditation of polio laboratories** It is required by the Global Commission on Polio Eradication that the Network Laboratories are accredited every year. Using the set guidelines provided by the Commission, the laboratories are assessed on 6 criteria. For full accreditation, they are expected to meet set standards for all 6 criteria. Of the 5 laboratories, the criterion for testing at least 150 stool samples per year has not been met. Additional time has been given to these laboratories to meet this criterion. Consultants are being recruited to carry out the exercise for the remaining 5 national laboratories early in 1998. Arrangements are also being finalized by WHO/HQ to carry out the exercise for the 3 Regional Reference Laboratories.

#### 1.7 Integration of AFP Surveillance with Surveillance for Other EPI and Non-EPI diseases

During active surveillance visits, it has been suggested to personnel to also look for neonatal tetanus, yellow fever, measles, cholera, meningitis and other cases of diseases that are of national importance. During meetings to sensitize clinicians on AFP reporting, clinicians are also reminded to report neonatal tetanus, yellow fever, measles, cholera and meningitis cases as well. In some countries, district level epidemiology training integrating EPI and emerging infections surveillance has already taken place.

#### 1.8 Summary

In 1997, the progress made in AFP/viral surveillance was lower than expected. There was a 6-month window of surveillance opportunity from January-March 1997, when all epidemiologic blocks had finished NIDs, to May-September 1997, when surveillance would have been pushed to higher levels. However, several factors prevented achievement of higher levels. First, significant funds which could be utilized by countries for surveillance, were not available until July 1997. Second, the civil war that erupted in Brazzaville delayed a staff meeting to orient the WHO/EPI staff towards surveillance and also prevented surveillance workshops in East and West Africa. Third, it was found that field staff were insufficient to adequately accomplish high quality NIDs and high quality surveillance at the same time.

Despite the constraints, considerable progress in surveillance has been made in 1997. AFP/viral surveillance spread to almost every country. Almost every country in AFRO has reported an AFP case and had stool specimens processed in the Laboratory Network. The AFP case-lab network has shown that stool specimens can be collected and transported internationally for isolation, transported internationally for intratypic differentiation, and in most cases, transported internationally again for genomic sequencing.

Although the reporting of AFP case-based information from countries to WHO/AFRO has been inadequate, the data management in the laboratory network has been excellent at this stage in the development of the surveillance system, and in many ways has made up for the deficiencies of reporting from EPI units in the Ministries of Health.

A map of all AFRO countries by health district and province has been linked to the AFP case-based and laboratory data systems, which will allow rapid identification of surveillance gaps, potential wild poliovirus reservoirs, and routes of transmission.

Instituting a surveillance system for AFP cases in Africa is developing a strong surveillance foundation for other EPI and non-EPI diseases. AFP surveillance is strengthening surveillance strategies (case-based surveillance), active surveillance, data management skills, data management hardware (computers and email), data analysis (EPIINFO skills mapping) laboratory networks and laboratory data management,

and district-level routine surveillance reporting

In 1998, the Regional Office expects to utilize the financial and human resources made available to begin to reinforce active surveillance from the national to provincial level and from provincial to the district level in all countries. It is projected to increase the field staff by about 17 more positions and all country-based epidemiologists will have to spend approximately 30-40% of the 1998 polio eradication money on surveillance. In this way, AFP reporting and stool specimen collection will spread to all provinces, and by encouraging the reporting of all paralyzed children, including GBS, the Region will achieve significant progress towards the goal of a non-polio AFP surveillance rate of 1.0 per 100,000 children <15 years as well as other AFP surveillance targets in almost all countries.

## 2. Implementation of the 2<sup>nd</sup> series of National Immunization Days (NIDs)

### 2.1 Progress made

The second series of NIDs with OPV have been planned in 36 countries between March 1997 and March 1998, compared to 30 countries during the 1996-1997 first series of NIDs. About 100 million children below 5 years of age are expected to be immunized with two supplemental doses of oral polio vaccine (OPV) in 1997-1998. This number was estimated at 74 million children for the first series of NIDs.

Sub-National Immunization Days (SNIDs) were implemented in the Democratic Republic of Congo (DRC) due to political instability and civil war early this year. NIDs planned in the Republic of Congo and Sierra Leone will not be implemented because of the civil war. The effects of the devastating war that just ended in Liberia have left the country with no adequate infrastructure and manpower to prepare and implement NIDs, which have been postponed till November 1998.

By the end of November 1997, NIDs had been implemented in 25 countries, and preliminary results are yet to be received from some countries. Overall NIDs were successful with reported coverage well above the 80% target.

In West Africa, eight countries have so far implemented NIDs, with two of them (Guinea and Niger) conducting NIDs for the 1<sup>st</sup> time.

Preliminary reports received from Guinea indicate very good achievements with NIDs. The national average is over 100% and this is consistently seen in the reports from all 38 districts but 7. Although the population figures may not be accurate, the consistent district achievement indicates good NIDs planning and high level social mobilisation.

Niger reported 88% coverage of the under-five for the 1<sup>st</sup> round of NIDs conducted in mid-November 1997. For this 1<sup>st</sup> round of NIDs, 13 out of 40 districts reported coverage below 80%.

With another successful NIDs this year (90% and 95% coverage for 1<sup>st</sup> and 2<sup>nd</sup> round respectively), Mauritania further demonstrated the potential that exist even in countries with weak health infrastructure, in successfully reaching children with supplementary immunization activities, when national planning and micro-planning exercises are carried out on time and adequate resources are committed. The administration of Measles vaccine, Vit A and Mebendazole (an anti-parasitic drug) was successfully combined with one round of OPV.

Ghana conducted this year's NIDs during one single day. The most fascinating features reported are related to social mobilisation with live reports on the national radio station throughout the day, and very outstanding participation of the local Rotarians. Results are yet to be received.

Togo, Benin, Algeria and Burkina Faso also conducted one round of their 1997 NIDs and results have not yet been received.

Delays in the acquisition of cold chain materials and vaccines have constrained several countries in this block to postpone their NIDs till later after the observed month of the Ramadan (January). The period for when NIDs implementation are now planned (February and March) is however not epidemiologically suitable, given the high temperatures.

In Central Africa, Cameroon is the only country that has conducted one round of NIDs so far this year. This country has used lessons learnt from its unsuccessful first NIDs (NIDs coverage was 20%) for the smooth preparations and organisation of this year's NIDs. District micro-planning was carried out three to four months prior to the launching of NIDs, additional cold chain equipment was distributed to provinces/districts most in need and unlike last year's centralized organisation, the Provincial Health Managers took over the responsibility for the organisation of the campaigns. Preliminary results from 3 provinces indicate achievements of 80-85%, whereas the central province with the capital city has reported 95% coverage. NIDs have been postponed till early next year for the remaining countries.

In East Africa, NIDs performance has been as good as during last year's series. Kenya reported 80% for the 2<sup>nd</sup> round (a slight improvement from 76% for the 1<sup>st</sup> round), Uganda reported 92 and 95% respectively for 1<sup>st</sup> and 2<sup>nd</sup> rounds, Zambia reported 97% for the 1<sup>st</sup> round and 91% for the 2<sup>nd</sup> round (results of the second round are yet incomplete and expected to be higher when data are received from all districts) and Tanzania reported equally very good performance with the attainment of nearly all under-five children during both rounds (97% and 95%).

The coverage data from Uganda indicate, however, that 5 low performing districts, comprising 200,000 children were below 60% in each round during the 1996 and the 1997 series of NIDs. (These districts also reported lower OPV-3 coverage for their routine EPI).

Results achieved in Tanzania and Zambia also show that the variation of coverage among districts is very narrow, confirming the countries' managerial capacities and the strength of the decentralized health infrastructure in coping with the organisation of major initiatives such as Polio NIDs.

In Southern Africa, five mainland countries plus Madagascar carried out NIDs during the 1997 winter season whereas Zimbabwe and Botswana conducted limited campaigns in identified high risk districts during the same period. For 1996 and 1997, South Africa consistently reported a decline of its 2<sup>nd</sup> round coverage rates (77% and 76% respectively) compared to the 1<sup>st</sup> round results (90% and 81%). It should be mentioned that this apparent "NIDs fatigue" is seen in a country that started implementation of NIDs in 1995.

Despite some improvement in its 1997 NIDs, Lesotho has not yet reached adequate OPV coverage rates during NIDs (below 70% for the 2 years). Several factors, including severe winter, were mentioned. However, a recent evaluation has indicated that preparations of NIDs at district level were not adequately addressed.

Malawi substantially improved its performance in both rounds this year, and achieved practically 100% coverage (compared to 74% and 86% last year). Namibia achieved excellent results with 105%

54

children immunized with OPV in the first round and 95% in the second round (a much better performance compared to 1996, especially for the 1<sup>st</sup> round)

Botswana implemented SNIDs with OPV in four districts bordering Namibia and Zimbabwe implemented SNIDs in areas bordering Zambia. Children under 5 years old in these districts received supplemental OPV doses in 1995, 1996 and 1997. In 1997, 97% of the target children were immunized in Botswana during the first round and 81% in the second round.

Mozambique implemented sub-national immunization days in 1996 and the first country-wide NIDs in 1997. Although results of the second round indicate noticeable improvement, the coverage rates remained inadequate. Even in urban areas involved in the 1996 SNIDs, OPV coverage in the two 1997 rounds were lower than those in 1996 (respectively 73% and 68% in 1997 and 81% in both 1996 rounds). The main reasons are the inadequate preparations, including poor planning/micro-planning, inadequate coordination at central level and conflicting priorities.

Madagascar reported remarkable success with the implementation of its first NIDs in 1997. This country reported OPV coverage of over 100% for both rounds. Preparations for NIDs in this large island were initiated at least 6 months in advance and involved from its start all agencies under the coordination of the MoH.

#### **NIDs in the countries classified as being in "difficult circumstances"**

Angola successfully implemented NIDs in all 18 provinces, including districts which were under-served during the 1996 NIDs, and immunized 83% of children in the first round and 90% in the second round. This is a remarkable improvement compared to the 71% and 80% coverage in the respective rounds of their 1996 NIDs.

In 1997 the Democratic Republic of Congo continued implementation of their urban SNIDs initiated in 1996 with over 2 million children targeted. By mid-November 1997, results of the first round were available for 22 urban centers in 6 provinces of the country. OPV rates varied between 80% and 135%. Excellent results were reported in Kinshasa where 97% of children received OPV, during the 1<sup>st</sup> round.

Ethiopia's launching of the 1<sup>st</sup> nation-wide NIDs coincided with the Annual Conference of the Rotary Foundation on 14 November 1997 and was attended by the Head of State, the WHO/AFRO Regional Director and the Rotary Foundation President. The impressive series of social mobilisation activities as well as careful planning of the NIDs logistics, facilitated the implementation of NIDs. However, unforeseen rains hampered the operations in some areas. Results are still pending.

Nigeria also took all the necessary steps for the smooth implementation of NIDs in a timely manner this year. Unlike last year's NIDs whose preparations were followed up adequately only in 15 States, this year's micro-planning involved all 37 States and all 779 LGAs. The First Lady launched the 1<sup>st</sup> round that was implemented from 5-6 November 1997 and preliminary results from a few States indicate average coverage levels of about 80%.

## **2.2 Multi-interventions NIDs**

In 1997, the following countries included measles vaccine in their NIDs

- Botswana children 9 months - 14 years in nearly half of its districts, and reports indicate average coverage of nearly 100%

55

- DR Congo included measles vaccination during 2<sup>nd</sup> round of NIDs carried out in selected districts and reported coverage ranged from 83%-120%
- Mauritania immunized all children 9 months - 4 years and achieved 88% coverage
- Mozambique included measles vaccine targeting under-five children in selected cities and reported coverage of 75%
- Namibia immunized all children 9 months - 14 years and reached 97%
- South Africa continued with the staggered administration of measles vaccines in selected provinces, some of them targeting the under-fifteen and others the under-ten

It is important that these information are properly recorded at national level in order to facilitate the assessment of the impact of the measles campaigns on disease control

#### Other interventions

Vitamin A was administered during the Polio NIDs in several countries including the DR Congo Ethiopia, Mauritania and Zambia Also, Mebendazole was administered during NIDs in Mauritania, with coverage of 82%

### 2.3 Major constraints and Lessons learnt

#### **Planning**

- With the number of competing priorities at the Health Ministries, preparations of NIDs should be initiated at the central level at least 6 month in advance, and district micro-planning exercises conducted at least three months before the launching of NIDs
- Poorly conducted district micro-planning exercises, in some cases, with insufficient operational details, resulted in unexpected problems and constraints during the implementation phase
- Shortage of reliable population data and undefined catchment areas observed in some countries resulted in insufficient analysis and use of data from evaluation of previous NIDs

#### **Funding and resource mobilization**

- Funds for NIDs were received in WHO much later this year (in July for Rotary and August for USAID) This has hampered smooth preparation of activities, mainly the micro-planning and the acquisition of cold chain and other needed equipment
- The lack of adequate planning and micro-planning led to the revision of NIDs budgets from several countries This has been particularly difficult for WHO when countries started requesting more funding than the amount allocated for them
- At country level, slow release of funds by the WHO Representatives has been reported

This was due in some cases in the late submission of financial reports of previous EPI related activities

### Advocacy and social mobilization

- There seems to be a reduced interest and involvement by top-level political figures and opinion makers in the 1997 NIDs compared to the previous year. This includes fewer addresses and statements by Heads of State and First Ladies at launching ceremonies and through the mass media
- Difficulties in obtaining support from certain religious, political and ethnic groups were observed in both 1996 and 1997 NIDs
- Resistance by part of the medical practitioners to cooperate in NIDs has also been observed particularly in some countries of East Africa
- Wrong messages and rumours about safety of OPV were disseminated in some countries. On the other hand, the importance of polio eradication and the inadequate understanding of the role of supplemental immunization hampered the mobilisation of the public and the health professionals, especially in the capital cities

### Logistics

- Countries conducting NIDs for the 1<sup>st</sup> time always order cold chain equipment, including vaccine carriers. It has been difficult to have the equipment on time given short period between ordering equipment and launching NIDs
- Several countries conducting NIDs for the 2<sup>nd</sup> time still ordered cold chain equipment (refrigerators and durable vaccine carriers). This certainly indicates the scarcity of other sources of funds to address the replacement or the extension of the cold chain equipment

### Other

- Lower coverage in the 2<sup>nd</sup> round was observed in some countries due to "anti-climax effect" after the intensive planning phase and implementation of the first round, and inadequate social mobilization before the second round,
- The lack of a standard, simple and effective method for validating reported results of NIDs makes it difficult to assess reported figures, especially where population figures do not appear to reflect the realities

2 4

### Plans for 1998 NIDs

- West Africa Epidemiological Block NIDs to be carried out in all countries of West Africa and in Nigeria, preferably in November / December 1998. Algeria will coordinate its NIDs with the other Northern African countries (EMRO)
- Central Africa Epidemiological Block NIDs to be implemented in all countries in November / December 1998

51

- East Africa Epidemiological Block The period proposed is July / August 1998 NIDs to be conducted in Burundi, Rwanda, the DR Congo, Kenya, Zambia and Uganda, coordinated with SNIDs in border areas and low-performing districts of Tanzania Coordination with EMRO is sought as NIDs will be implemented in Somalia, Southern Sudan and Djibouti For Ethiopia, NIDs will be conducted in November / December 1998

- Southern Africa Epidemiological Block July / August 1998 is the proposed period NIDs should be conducted in Lesotho, Madagascar, Malawi and Mozambique SNIDs in Northern Namibia coordinated with NIDs in Angola

### 3 Status of routine immunization activities

#### 3.1 Reported coverage achieved in the Region

Immunization coverage rates reported in the Region for 1996 are similar to coverage data reported for 1995 (figure 1) A slight decline in measles coverage is however noticed (from 60% in 1995 to 56% in 1996) Other reported coverage rates are 69% for BCG, 54% for OPV-3, 53% for DPT-3, 56% and 34% for TT-2+

Figure 2 indicates DPT-3 coverage figures by epidemiological block, comparing the two last years A substantial decline in DPT-3 coverage (from 80% to 66%) is observed in Southern Africa The low coverage reported from Kenya (a decrease of 38 points reaching 46% in 1996) has heavily contributed to this block's reduced performance The four large countries in "difficult situation" have also reported a lower DPT-3 coverage rate (from 48% in 1995 to 37% in 1996) In this category of countries, Ethiopia has continued to show a steady increase in its reported immunization coverage, which for DPT-3 has attained 67% in 1996 (compared to 57% in 1995) Coverage figures for Angola and the Democratic Republic of Congo (formerly Zaire) have remained stagnant but at levels lower than 45%, Nigeria's reported DPT-3 coverage has decreased by 10 points, to a low 24%

Although the reported TT-2+ coverage seems low, an unpublished sero-survey carried out in Central African Republic indicates much higher protection of women (72%), compared to the 17% coverage reported with the routine data of 1996 (M Deming and J B Roungou, personal communication) If this information can be verified in other settings, then the protection against neonatal tetanus and maternal tetanus is much better than estimated through routine TT coverage

#### 3.2 Review of main issues with the routine delivery of immunization services

In 1997, programme reviews were carried out in Guinea, Mali, Tanzania, Uganda, Mauritania and Zambia In the first four countries, the reviews were jointly undertaken by USAID and UNICEF to examine national strategies to sustain effective implementation of EPI within the context of national health system reforms and the polio eradication initiative, to identify current factors related to progress, constraints and gaps in immunization, and to propose strategies and activities for future donor support to other countries in Africa, taking into account the most effective means of sustaining and strengthening immunization services within national contexts The reviews involved a desktop component and country visits by inter-agency teams All four reviews took place between May and October 1997

The EPI reviews in Mauritania and Zambia were requested by the respective governments, and followed pre-planning visits made to those countries to identify the specific components of the EPI programme warranting review Both countries evaluated the following components of their programmes cold

chain and logistics, cost management, immunization service delivery and surveillance, while Mauritania added a review of vaccination coverage, and Zambia added programme management and immunization activities in relation to the health sector reform. In Mauritania, the schedule for reviewing the different components was staggered, taking place between July and November, while in Zambia all the components were reviewed in one session between September and October 1997. The reviews were carried out by mixed teams of nationals and international/inter-agency experts on the various components for review. Generic WHO questionnaires were adapted by each country for use, and in Zambia, more appropriate instruments for evaluating service delivery at health centre and community levels were developed and used.

### **Main findings of the 1997 EPI reviews**

- Since the early 1990's immunization coverage has been static (with a substantial decline noticed in Mauritania and Guinea in 1996). The possible reasons include deficient quality of immunization in some areas, poorly or untrained staff, unsuitable and even dangerous injection and sterilisation practices, inadequate supportive supervision at district and health centre levels, and poor communication between health workers and mothers. This has also contributed to high drop out rate among target groups.
- Except in Uganda, the cold chain equipment in most of the countries visited is aged and/or poorly maintained, and needs replacement. National policies for maintenance and replacement of the cold chain equipment and injection safety are not available.
- In many centres, service is delivered by untrained and unmotivated staff, with very little supportive supervision, resulting in sub-standard injection, sterilization and communication practices.
- Governments in some of these countries are contributing to vaccine procurement. The government of Uganda has increased its vaccine budget lines by 100% (to \$640,000) and the Mauritanian Government will finance Hepatitis B vaccination (at a cost of US\$160,000). In addition, districts are relying more on themselves to finance some operational costs for immunization.
- Vaccines and supplies stock forecasting is deficient and vaccine and supplies stock-outs are frequent.
- In Mauritania and Zambia, the surveillance system does not provide enough information for the detection, investigation and control of EPI priority diseases, especially for AFP surveillance which is not even understood at district, health centre and community levels.

**Health sector reform and immunization services (studied during the EPI review in Zambia)**  
Immunization is delivered as part of the essential package of health services at health centres, and districts are in charge of managing their quota of funds. This decentralization has greatly increased local interest in the planning, monitoring and implementation of health activities in the community, thus increasing accountability. However, decentralization has laid emphasis on the management of service delivery, but has paid less attention to the quality of service and the technical support of the peripheral staff. It is still unclear how immunization activities will be affected by the de-linking of health personnel from the Ministry of Health from 1 January 1998, after which they are to re-apply to the various district and hospital boards for jobs.

Status of the cold chain and EPI logistics  
(presented under a separate report)

## 4 Progress with specific disease control/eradication initiatives

### 4.1 Polio eradication

In 1996, 1949 clinical polio cases were reported throughout the Region, which is a 10% decrease compared to the 1995 reported cases. Ethiopia, DR Congo and Nigeria reported 1425 cases, which is nearly 75% of the total cases reported in the Region. Uganda, Angola and Cameroon are the next important contributors to the regional cases, that is 13% of the total cases.

During the year, wild poliovirus was extensively isolated from the Democratic Republic of Congo and countries of central and west Africa, except Ghana. Wild poliovirus was isolated in CAR and Cote d'Ivoire more than 30 days after the second round of the first NIDs. So far in 1997, no wild poliovirus has been isolated in East Africa, including Southern Uganda, Kenya, Tanzania and Zambia as well as throughout Southern Africa (where no wild poliovirus has been isolated since 1993). Although more surveillance data are needed for assessing the situation in East Africa, preliminary analysis indicate that two series of NIDs have been effective in reducing substantially the levels of poliovirus transmission in that part of the continent. It should be noted that most of these countries (e.g. Tanzania) have sustained high levels of routine OPV-3 coverage (78-82%) since 1989.

Sixteen countries in Africa, including four of the largest and epidemiologically most important countries (Nigeria, Zaire, Angola, and Ethiopia), reported that the percentage of children below 1 year of age routinely immunized with three doses of oral poliovirus vaccine was less than 50%. NIDs will continue to be implemented focusing on the countries that constitute the "major reservoirs" of polioviruses (see also sections 2.4 above).

### 4.2 Measles control and elimination

During the period 1980-1996, there has been inversely correlated trends of declining reported measles cases and increasing reported measles vaccination coverage (figure 3), that is about 60% decline in reported measles morbidity. The Western epidemiological block has reported most of the measles morbidity (145 cases per 100,000 pop). The reported rates are 120/100,000 for Central Africa, 60/100,000 for Eastern Africa and 74/100,000 for Southern Africa.

Measles mortality is much higher in West Africa and in the large countries in difficult situation (Angola, DRC, Ethiopia and Nigeria). However estimates of the measles deaths are not simple, given the wide ranges of reported community-based and hospital-based Case Fatality Rates (CFR), that is from 3-22% in the same country.

In Southern Africa, measles elimination strategies, mainly supplementary measles mortality targeting the under-fifteen, were carried out in several countries as one time NIDs (Namibia) or several years campaigns (South Africa, Botswana). Case-based surveillance of rash and fever should be instituted in these countries with laboratory confirmation where feasible as the reported cases have dramatically decreased or are expected to decrease in the near future following the mass vaccination campaigns. The decision to launch these campaigns was taken by the respective Governments in their efforts to reduce or stop the occurrence of measles outbreaks which involve school children. It should be mentioned that these Government contributed the total or part of the costs of the measles immunization campaigns.

In the rest of the continent where measles mortality is high, accelerated implementation of strategies to reduce the measles burden is needed. With high levels of measles transmission, targeting the under-five children in densely populated areas, commencing with cities, will certainly lead to lower measles mortality. Nevertheless, while these efforts are expected to be initiated during the course of 1998, surveillance must be introduced so that the impact of these measures can be monitored/evaluated.

An AFRO position paper for accelerated reduction of measles mortality and elimination is being finalized and will be presented at TFI for discussions.

#### 4.3 NT elimination

The current situation concerning the reduction of the mortality and morbidity due to neonatal tetanus is not well known. In addition to the difficulties in estimating the real coverage achieved with TT vaccination a review conducted earlier this year at the regional level revealed insufficient information on the disease and on the control actions being carried out in the countries.

The 1996 reported NT incidence (3122 cases) shows a 50% increase compared to the previous year. The recorded incidence of the last two years is however lower than the reported incidence in 1982. The reported cases have been on a decrease each year since 1990. Whether these data do reflect the true situation in the countries is not known, given the under-reporting associated with the disease especially in rural Africa.

The reported annual TT-2+ coverage remains low (nearly 35% over the past four years) but this is not the accurate estimate of TT coverage because these data are the result of the count of TT doses administered to mothers in a given year, excluding those who are protected that year from previous immunizations. Although limited to 180 mothers, a recent non-published study carried out in Central African Republic indicates the following discrepancies in estimating TT coverage:

- Estimated protection of children protected at birth through mothers' TT-2+ coverage - 78%
- Proportion of mothers with valid TT serology - 88%
- Proportion of mothers with adequate number of TT doses by interview - 78%
- TT-2+ coverage using doses administered - 15%
- DTC-3 coverage of infants in same area - 53%

Despite the apparent decline in immunization coverage (as suggested by DTC-3 coverage) in the area survey, these data suggest a high level of protection of mothers against tetanus due to vaccinations accumulated over the years.

For Member States to move forward in the elimination of NT, district-based strategies have been formulated, that include the following:

- Improve routine TT vaccination (Pregnant and/or CBA women according to national policies)
- Assess NT incidence with available information or through active search at health facility & community levels
- Implement specific interventions in districts reporting cases
  - Two rounds of supplementary TT vaccination
  - Training and supervision of TBAs
- Investigate reported NT cases
- Monitor trends in NT incidence

At district level, preparation of EPI micro-plans should include NT elimination activities, with budget estimates and indication of shortfalls. At national level, resources should be secured to meet shortfalls and collaboration should be sought between the EPI, MCH and Epidemiology Divisions of the MoH.

## 5. Advocacy and social mobilisation

The purpose of the series of activities for advocacy and social mobilisation is to increase political commitment, public awareness and community participation for immunization so as to contribute to the achievement of the immunization programme goals.

During 1997, activities focused on social mobilisation for the PEI and included messages for promoting routine immunization. Community reporting of AFP cases during NIDs was also encouraged.

### 5.1 Regional level activities

A regional social mobilisation advisory group composed of the main partners in EPI and polio eradication was convened by the Regional Office in February 1997. The group developed a plan of activities to be implemented during the year 1997. While the main focus of the activities was on polio eradication, it was stressed that the opportunity must be utilised to promote routine immunization. The activities covered the main areas of media advocacy, regional advocacy for high level political commitment and activities to support national plans in strengthening stakeholder's and community communication and participation. In line with the 'Kick Polio Out of Africa' campaign for polio eradication, football-related activities were included.

The Media advocacy activities were done with development of sample messages for the 1997 NIDs/routine EPI activities. They were disseminated through press briefings, radio and television. A press kit assembled in April and updated in November 1997, with full support of the AFRO and HQ Information Units, was distributed to journalists and to the countries.

Generally, the media were very supportive in most countries. However in some cases they have helped to fuel negative publicity. A more aggressive regional and global media advocacy is still needed.

The Committee for Polio-free Africa's Prestigious Members assisted in the efforts for resources mobilisation, advocacy and social mobilisation especially in their countries and in launching NIDs. President Mandela sent important letters for resource mobilisation to the European Union and to the Prime Minister of Malaysia. The former resulted in the adoption of a resolution on the EU's support to the PEI. The former First Lady of Congo played a leading role in chairing meetings for preparing NIDs and in obtaining US\$150,000 to fill in the financial gaps for NIDs. The First Ladies of Nigeria and Ghana continued to be very active in resource mobilisation and community social mobilisation. General Toure of Mali is leading the national ICC for the preparation of NIDs in Mali.

Elements of the progress report on the PEI for the next Summit of the OAU were at the last session of the Regional Committee held in September 1997 in South Africa. Also, the PEI was formally presented by the Regional Office Representative attending the African First Ladies' Peace Summit organised in Abuja, in May 1997. Some decline in getting the commitment of Heads of State was noticed this year, especially in countries launching NIDs for the second consecutive year. There is need to explore ways to sustain interest and commitment and to better involve the First Ladies more and better.

**The PEI Ambassadors**, Abedi Pele, a Ghanaian football player and Appollinaire Gahungu, a Burundian journalist based in South Africa and also a victim of poliomyelitis sequelae, contributed to the preparation for "Kick polio out of Africa" TV spots and press briefings on the occasion of the launching event of the alliance between football and the PEI in Burkina Faso in April 1997. The TV spots with recorded messages of the Ambassadors were sent to the countries for their use. On the other hand, Fatuma Roba, an Olympic Gold Medalist from Ethiopia, receives the symbolic cheque of US\$75,000 from Martina Hingis, the Swiss tennis player, for support to Polio NIDs in Ethiopia.

Several **regional activities** were conducted for **strengthening country social mobilisation** for the NIDs and EPI. These included the dissemination of guidelines, dissemination of information kit (containing sample of produced social mobilisation materials), discussions with social mobilisation focal points invited to EPI managers meetings and consultancy visits to participate in the elaboration and implementation of social mobilisation plans.

## 5.2 Country level activities

**Social mobilisation activities for NIDs** have been very successful, as indicated by the excellent public participation in all countries. The activities carried out have led to strong inter-sectoral collaboration, especially between the MoH, the media and other groups such as the women's organisations and religious groups. (It should be mentioned that religious Leaders played a very important role in mobilising communities in most countries). On the other hand, district capacity for planning and implementing social mobilisation has been strengthened. Nevertheless, there is a need to evaluate effective channels so as to reduce over reliance on expensive mass media and production of excessive promotional materials.

The experience with **social mobilisation efforts for Polio surveillance** has been reported from a few countries (Namibia, Tanzania and Kenya), where the opportunity of NIDs was used to involve the community in reporting AFP cases. In this area, more attention is needed to determine the health workers' attitudes and the best methods of involving community groups and sensitization of the public through the mass media.

Concerning the expansion of **social mobilisation efforts for the promotion of routine immunization** during NIDs, only limited experience has been reported from Ghana.

## 6. Vaccine supply and Introduction of new vaccines

### 6.1 Forecasting of Vaccine Needs

Vaccine forecasting in most countries is still through a top-down planning approach. This was observed in Congo, Cote d'Ivoire, Burkina Faso, Kenya and Mali. While The Gambia has commenced the use of the WHO/UNICEF recommended method based on infrastructure, peripheral inputs are very minimal. Thus, the old assumption of wastage rates is still used for all the countries without consideration for the real wastage rates. Efforts are needed in the Region so that priority is placed on the monitoring and availability of the essential parameters (target populations, realistic wastage rate/factor, the session size, proposed presentation of the antigen) for viable vaccine forecasting.

### 6.2 Vaccine Financing.

The Regional Inventory of the Member States' contribution to vaccine financing is still incomplete for 1997. The available data indicate that overall the Region Member States contributed an average of 28%

(compared to 25 % of 1996) of the total financing needs for vaccines. Out of 46 countries, 17 countries contribute part of their national budgets to procurement of vaccines (compared to 21 countries of 1996)

Using the "WHO/UNICEF targeting grid" and an assumption that lack of data means zero financing by the respective government, the following were observed for the different bands of the global targeting grid

**Band A** (countries in greatest need for financial support) Of the 30 countries of this band, only 5 (Benin, Burkina Faso, Mali, The Gambia, and Uganda) were reported to have met the requirement of the band for financing 10 to 25 % of vaccine needs. The total number of countries contributing to their needs dropped from 10 countries in 1996, to 7 countries in 1997. The three countries that dropped from last year's performance are Sierra Leone, Niger and Tanzania. The financing average of the band improved from 8% of 1996 to 19% in 1997 of the total vaccine needs. This improvement in the band average is mainly a result of the established lines in Benin, Burkina Faso, and Mali through the Vaccine Independence Initiative supported by the European Union.

**Band B** The number of countries contributing to their vaccine needs dropped from 7 countries in 1996 to 5 countries in 1997. The 2 countries that dropped are Cameroon and Namibia. Only 4 countries out of 10 (Cote d'Ivoire, Nigeria, Swaziland and Zimbabwe) met the band's financing requirement of 80 to 100% of their vaccine needs. The financing average of band B remains almost at the same level (41% in 1996 and 43% in 1997).

**Band C** All countries classified in this band are supposed to be fully responsible for their needs. Three countries (Botswana, Mauritius, and South Africa) out of five in this band showed full independence in the financing of their vaccines and Algeria met 89% of its financial needs. There was no indication of the level of financing for Gabon.

**Band D** Seychelles, the only band D country within the Region is fully responsible for its needs and had also introduced HBV into its programme.

### 6.3 Vaccine Procurement

Owing to the donor dependence of most programmes within the Region, vaccine procurement is still largely through UNICEF supply channels. While the 30 countries in band A receive almost all their needs through donor support, countries in bands B, C, and D have established varying degrees of independence in their procurement capabilities. A number of countries in these bands still preferred the UNICEF channels for their procurement because of the assured known good quality status of its vaccines. However, the ongoing decentralization of Health Services, the numerous donations of vaccine within the Region to countries in need and the introduction of new antigens (that are yet to be included in the UNICEF supply channels) had called for Regional Guidelines for vaccine donation and procurement. Draft Regional Guidelines for vaccine donation have been developed for possible National adaptation by Regional Members. The Regional Guidelines on vaccine procurement is being finalized.

### 6.4 Introduction Of New Antigens

**Yellow Fever vaccine** While 17 of the 31 at risk countries to yellow fever (YF) are still fully donor dependent, 14 had introduced it into their routine immunization programme. However, sustainable introduction had been hampered by the financing constraints over the years in the respective countries. A Global meeting (Geneva) has been planned for March 1998 to review the current strategies for yellow fever control. The issue of sustainable financing and supply of the vaccine would be critical to the adopted strategy.

**Hepatitis B vaccine.** Regional reports indicated the sustainability of Hepatitis B vaccine (HBV) in the programmes of Botswana, The Gambia, Seychelles, South Africa, and Swaziland. Pilot introduction was commenced in Algeria and Mauritius. Cote d'Ivoire, Kenya and Gabon have planned for pilot introduction in selected district in 1998. Zimbabwe planned to stage a come back in 1998 after 2 years break in the financing of HBV. Finance has been identified as a major constraint. Despite the high priority placed on the introduction of HBV in Burkina Faso, Mali, Nigeria and Senegal, sustainable financing has been the major constraint in these countries. Thus, its use in these countries has been limited to selected Medical corps of the Ministry of Health.

**Others.** The Gambia has introduced Hib conjugate vaccine after its successful evaluation. This was achieved through the general agreement with the manufacturers (from the conception of the trials) for the supply of the required vaccine in the next five years. The Gambia programme had also planned for the beginning of evaluation of pneumococcal vaccine in 1998. While all this progress is being recorded in The Gambia, the issue of supply of the new antigens remains a priority of the National Programme. Since the introduction of these antigens had been (in most cases) with DTP vaccine, appropriate supply of the latter also remains a critical consideration for the achievement of the objectives.

#### 6.5 Regional Vaccine Production

There are four major potential vaccine producers within the Region. These are the South African Vaccine Producers, the Institut Pasteur in Senegal, the Federal Vaccine Production Laboratory in Nigeria and The Laboratoire National Veterinaire in Cameroon. These producers are at varying degrees of viability. However the common constraints to all is the delay in taking some major crucial decisions by their respective Governments to ensure their viability. The donor dependence status of the Regional Programme has also created an unpredictable demand pattern of the different vaccines. Thus, strategic production plans would not be predictable. The improvement of the demand and an independent management are the first set of priorities in ensuring the viability of these facilities.

**South African Vaccine Producers.** The potential annual output of SAVP is 11 million doses of BCG, 2.6 million doses of DTP, 1.9 million doses of DT, and 3.8 million doses of TT. In 1996, it produced 6.7 million doses of DTP, 3.3 million doses of TT and 3.5 million doses of DT. While negotiation is still ongoing for full autonomy of the facility, the Government had given approval for the establishment of a R 3.6 million National Control Laboratory. A positive response by the Government to the need of the facility for structured autonomy in management, would enhance a multiplier effect (access to new technology, injection of new funds etc) on the overall viability of the facility. In response to the follow up by the Regional Office, the Government is currently examining the various options open to within the context of its National Policy.

**The Federal Vaccine Production Laboratory.** The production of Yellow Fever vaccine in Nigeria, was followed up with the Ministry of Health, and it is believed that the Government of Nigeria is currently considering the restructuring of the Federal Vaccine Production laboratory for long term viability. Some of the current considerations include the conduct of a viability study on the facility, the empowerment of the facility as an autonomous parastatal, and consideration of partnership with other private parties. A committee had been constituted by the Ministry of Health to guide its decisions.

**The Institute Pasteur Senegal.** A follow up of Yellow Fever vaccine production by the Institut Pasteur of Senegal was carried out. The initial constraint of the institute was the lack of independent control of its product by the National Control Authority. However, after several efforts of the Regional Programme and the Global Programme on Vaccination, to ensure the development of the relevant capabilities for independent control, the Government of Senegal has agreed to support the NCA through a special agreement.

with the Agence Française du Medicament. This implies that the approval of the institute as one of the suppliers to UN Agencies (hitherto withdrawn within the year) could be reinstated.

**The Laboratoire National Veterinaire "Lanavet"**, the veterinary institute for vaccine production in Cameroon, had stopped the production of tetanus toxoid (TT) vaccines. It has offered for sale the bulk of 300 000 doses produced after several appeal for support from the Government of Cameroon. Indeed its current managerial and financial constraints, have reduced its human vaccine production to a secondary priority. It would require legislative support for autonomy from its government and financial support to the tune of US\$ 500, 000. The latter is meant for the procurement of a 250 litre fermenter to increase production capacity to 20 million doses and reduce the unit cost per dose to a competitive level (from US \$ 0.133 to 0.04 per dose). It is equally faced with a constraint of lack of independent control by the NCA in Cameroon in line with the recommendations of the Regional Programme. However 2 candidates of the National Control Authority in Cameroon has been proposed for training on quality control and Good Manufacturing Practice at the Global Training Network. The future of human vaccine production in LANAVET depends to a large extent on the provision of the required support by the Government of Cameroon.

## 7 Programme management

### 7.1 EPI planning

A recommendation of the 1996 TFI meeting stated that "micro-planning exercises be held in all regions/districts to provide accurate information needed to preparing national EPI action plans". Furthermore the TFI recommended that process indicators be developed to monitor the sustainability of EPI.

Early in 1997, draft guides were developed for use by countries in developing district micro-plans, 1-year plans of action, and 5-year strategic plans. These drafts were reviewed by partners and by some country/inter-country staff. Valuable comments made were used in producing the second draft of the guides which were then sent to all inter-country epidemiologists for use by countries in each block for preparation of their different plans.

#### Major issues and constraints

- A few countries (Cameroon, Madagascar, Nigeria) have adapted the draft district micro-planning guide for use in developing their district micro-plans. Several other countries, especially those repeating NIDs this year, did not do any micro-planning for estimating logistic and resource needs, but used the NIDs micro-plans of 1996. The information obtained from these countries indicate that those micro-plans were not developed at district level but at central level.
- With regards to annual or biennial plans of action received in 1997 from member countries, it was observed that some countries used the draft guides to prepare them. However, some plans received were not developed in accordance to the guidelines proposed and the EPI needs described in most were still not derived from district micro-plans.
- For 1998, the final version of the planning guides will be discussed with the national EPI Managers meetings of all epidemiologic blocks during the first quarter of 1998. Then, selected countries (mainly those of Central and West African blocks and those in difficult circumstances) will be actively supported in carrying out micro-planning workshops and in developing plans of action. In addition, all country plans received thereafter will be reviewed and feedback sent to the countries.

---

## 7.2 Staffing and Technical cooperation with Member States

To enhance its technical assistance to Member States and its coordination role at the regional level, AFRO/EPI has finalized a plan for the deployment of its EPI staff at the Regional Office as well as at inter-country and country levels. The regional unit has been reinforced with the recruitment of an Administrative Officer who will deal with financial, personnel and supply matters. This will make it possible for the Operations Officer to assist the Regional Adviser with the preparation of project grants proposals and follow up of expenditures related to the various grants.

As of November 1997, the total number of EPI "professional" staff is 57, including 30 international staff (of which 17 are African cadres) and 18 national staff. In addition, 9 secretaries are at post. The male/female ratio is 2,4/1. The staff distribution by epidemiological block shows an equal number of staff (9) in Southern and Western Africa and an equal number in Eastern and Central Africa (6). 13 staff have been recruited to work in the 4 large countries in "difficult situation". For the latter, AFRO has recruited and trained four National EPI Officers for Nigeria's four zones. Their role will be particularly crucial in expanding AFP/EPI surveillance activities in this country. Similar developments are expected for the DR Congo and Ethiopia.

It is projected that by the end of this biennium, the total number of the EPI staff will be 85, including 29 national Officers, 10 logisticians, 3 Operations' Officers and 26 Epidemiologists (international). The related salary, duty travel and their operational costs will increase from US\$4,9 million to 6,0 million.

The first meeting of the AFRO/EPI Regional and field staff took place in Akosombo, Ghana, from 20-24 October 1997. This has been very useful in bringing together all the staff (national, short-term professionals, international fixed term staff and CDC-detailed staff) involved in the support of EPI in the Region. In addition, the training needs of these staff have been expressed, with most staff requesting further training in the management of surveillance data. Efforts will be made to fill in the gaps that have been identified, through special training activities and field supervision.

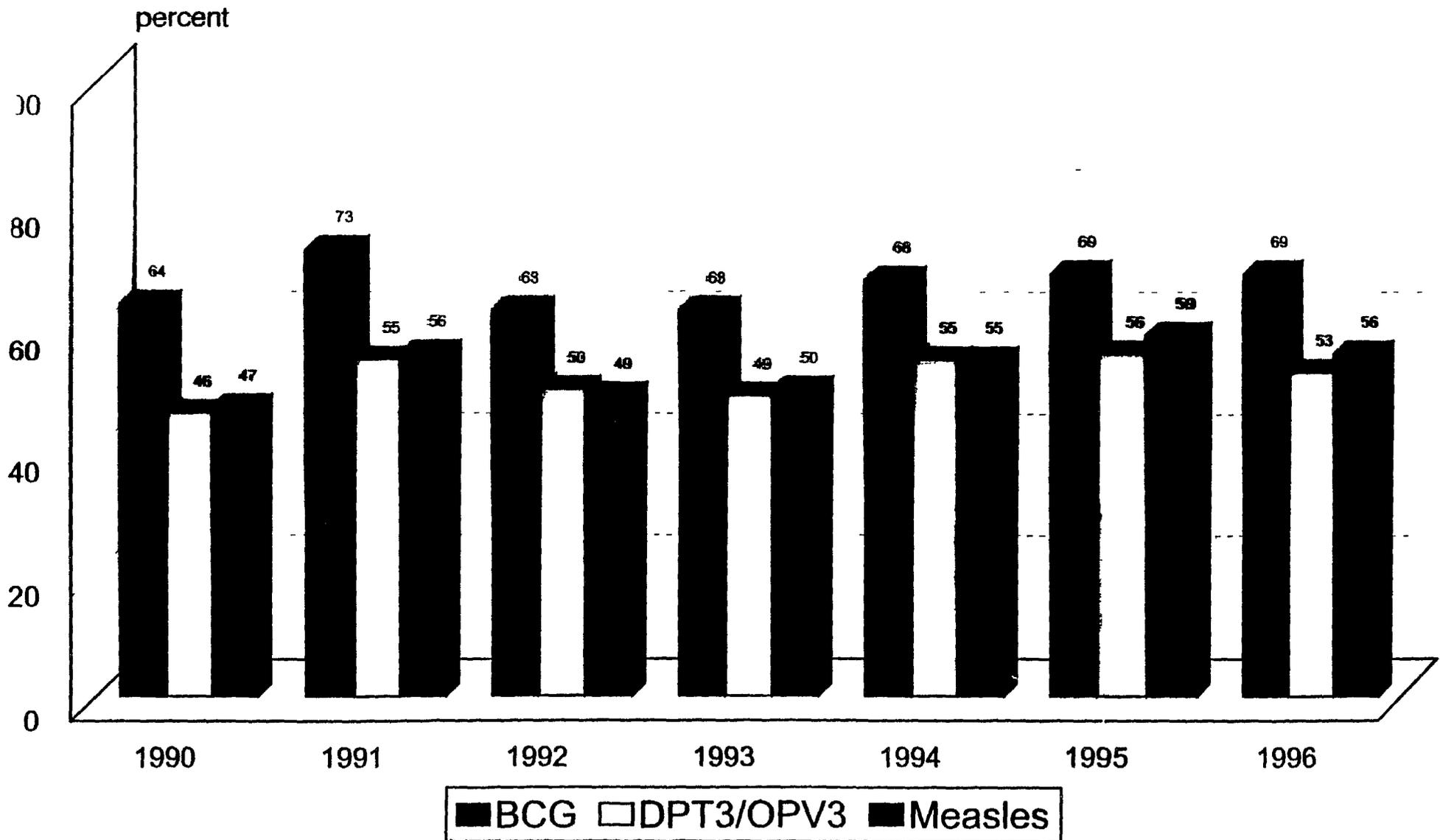
## 7.3 Financial status of the regional programme

(Presented under a separate report)

Immunization Coverage with EPI vaccines  
WHO/AFRO 1996

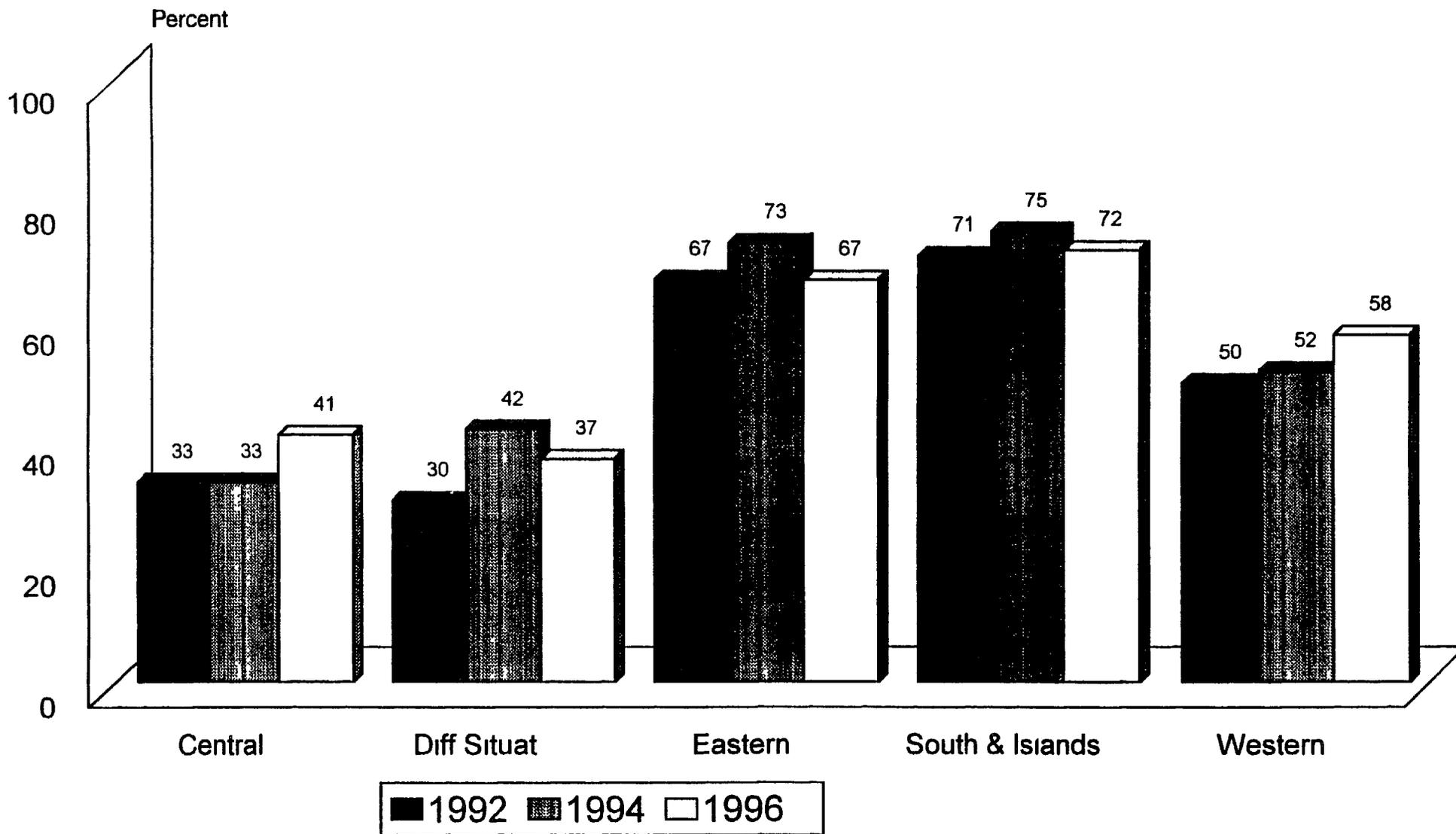
Location	BCG	DTP3	OPV3	Measles	TT2+	
1 CAE	Cameroon (95)	54%	46%	46%	46%	12%
2 CAF	Sen Afr Rep	94%	53%	53%	46%	15%
3 CHA	Chad	40%	19%	20%	28%	19%
4 CNG	Congo	50%	47%	47%	42%	55%
5 EQG	Equat Guinea	62%	43%	43%	37%	63%
6 GAB	Gabon	54%	41%	41%	38%	4%
<hr/>						
CEN	CENTRAL Block	56%	41%	41%	42%	19%
<hr/>						
1 ANG	Angola	50%	28%	26%	41%	9%
2 ETH	Ethiopia	87%	67%	67%	54%	36%
3 NIE	Nigeria	43%	24%	26%	38%	34%
4 DRC	DR. Congo	51%	36%	36%	41%	20%
<hr/>						
DIF	DIFF SITUATION Block	57%	38%	39%	44%	31%
<hr/>						
1 BUU	Burundi	77%	63%	63%	50%	33%
2 ERI	Eritrea	52%	46%	46%	38%	23%
3 KEN	Kenya	52%	46%	43%	38%	21%
4 RWA	Rwanda	93%	95%	99%	36%	43%
5 TAN	Tanzania	84%	72%	73%	70%	26%
6 UGA	Uganda	99%	70%	69%	68%	56%
7 ZAM	Zambia	100%	83%	85%	93%	85%
<hr/>						
EAS	EASTERN Block	79%	66%	66%	63%	38%
<hr/>						
1 BOT	Botswana	67%	83%	81%	82%	61%
2 CAV	Cape Verde(95)	80%	73%	73%	66%	4%
3 COM	Comoros	55%	60%	60%	43%	25%
4 LES	Lesotho (95)	55%	58%	58%	82%	10%
5 MAD	Madagascar	87%	73%	73%	68%	17%
6 MAL	Malawi	95%	90%	82%	89%	56%
7 MAS	Mauritius (95)	86%	89%	89%	85%	78%
8 MOZ	Mozambique	83%	60%	60%	67%	
9 NAM	Namibia	79%	70%	71%	61%	75%
10 REU	Reunion (95)	82%	68%	68%	59%	
11 SAH	St Helena (95)	100%	100%	100%	100%	100%
12 SEY	Seychelles	100%	100%	100%	98%	100%
13 SOA	South Africa	95%	73%	73%	76%	26%
14 STP	Sao Tome & Prrn.	85%	68%	68%	57%	49%
15 SWZ	Swaziland	68%	70%	71%	59%	65%
16.ZIM	Zimbabwe	79%	76%	76%	77%	65%
<hr/>						
SOU	SOUTH & ISLANDS Block	88%	73%	72%	75%	30%
<hr/>						
1 ALG	Algeria	94%	77%	77%	75%	36%
2 BEN	Benin	90%	80%	80%	74%	75%
3 BFA	Burkina Faso	61%	48%	48%	54%	27%
4 GAM	Gambia (95)	99%	97%	97%	89%	92%
5 GHA	Ghana	65%	51%	52%	53%	14%
6 GUB	Guinea-Bissau	68%	53%	54%	49%	20%
7 GUI	Guinea	66%	53%	53%	55%	45%
8 CIV	Cote d Ivoire	68%	55%	55%	65%	22%
9 LIB	Liberia (95)	84%	45%	45%	44%	35%
10 MAI	Mali	79%	53%	53%	57%	20%
11.MAU	Mauritania	93%	50%	50%	53%	28%
12 NIG	Niger (95)	50%	23%	23%	43%	36%
13 SEN	Senegal (95)	80%	61%	62%	60%	34%
14 SIL	Sierra Leone	77%	65%	65%	79%	70%
15 TOG	Togo	63%	82%	82%	39%	43%
<hr/>						
WES	WESTERN Block	74%	60%	60%	62%	33%
<hr/>						
AFRO REGION	1996	69%	53%	53%	56%	32%
"	1995	69%	56%	56%	59%	35%
"	1994	68%	55%	55%	55%	37%
"	1993	63%	49%	49%	50%	37%
"	1992	63%	50%	48%	49%	32%
"	1991	73%	55%	55%	56%	41%
"	1990	64%	46%	49%	47%	39%

# Immunization Coverage with EP' vaccines in the African Region, 1990-1996



69

# DPT3/OPV3 coverage by Epidemiological block 1992-1996



5

21

(rev.21/11/97)	Performance of AFP Surveillance , 1997							Confirmed polio cases		
Country	1995 estimated population (million)	1995 estimated <15 population (million)	Expected Non polio AFP cases annually	Expected surveillance reports received	AFP cases reported	Non polio AFP rate	AFP cases with adequate specimens (%)	Total 1996	Total 1997	Wild 1997
Algeria	28.9	12.9	129	29%	36	0.37	0%	7	0	0
Angola	11.5	5.2	52	14%	7	0.18	0%	81	7	0
Benin	5.4	2.4	24	43%	0	0.00		6		0
Botswana	1.5	0.7	7	43%	4	0.76	25%	0	0	0
Burkina Faso	10.4	4.7	47	29%	3	0.06	33%	0	1	1
Burundi	6.4	2.9	29	0%		0.00		27		
Cameroon	14	6.3	63	43%	6	0.13	50%	51	0	0
Cape Verde	0.4	0.2	2	14%	1	0.67	0%	0	0	0
Central Africa Rep	3.5	1.6	16	57%	5	0.00	0%	3	8	5
Chad	6.4	2.9	29	43%	0	0.00		93		
Comoros	0.7	0.3	3	0%		0.00		0		
Congo	2.7	1.2	12	0%		0.00		0		
Cote d'Ivoire	14.5	6.5	65	29%	4	0.06	25%	3	1	1
Congo Dem Rep	41.8	18.8	188	29%	8	0.04	38%	219	3	3
Equatorial Guinea	0.4	0.2	2	0%	0	0.00		0	0	
Eritrea	3.5	1.6	16	0%	0	0.00		0	0	
Ethiopia	57.1	25.7	257	43%	11	0.06	27%	264		
Gabon	1.4	0.6	6	0%		0.00		28		
Gambia	0.9	0.4	4	14%	1	0.33	0%	0		
Ghana	17.6	7.9	79	71%	23	0.35	35%	8	4	2
Guinea-Bissau	1.1	0.5	5	14%	1	0.27	100%	0	0	0
Guinea	6.7	3	30	57%	1	0.04	100%	17	0	
Kenya	27.8	13.9	139	43%	18	0.17	17%	0	0	
Lesotho	2.1	0.9	9	29%	2	0.30	0%	0	0	
Liberia	3	1.4	14	0%		0.00		2		
Madagascar	14.1	6.3	63	57%	4	0.08	25%	1	0	
Malawi	11.1	5	50	57%	6	0.16	50%	0	0	
Mali	10.8	4.9	49	14%	3	0.08	0%	15		
Mauritania	2.3	1	10	14%		0.00				
Mauritius	1.1	0.5	5	14%	0	0.00		0	0	
Mozambique	16	7.2	72	14%	0	0.00		0	0	
Namibia	2.1	0.9	9	43%	5	0.74	60%	8	2	
Niger	9.1	4.1	41	43%	5	0.10	80%	40	2	2
Nigeria	127.7	57.5	575	14%	1	0.00	100%	942	1	
Reunion	0.7	0.3	3	0%		0.00				
Rwanda	8	3.6	36	14%	1	0.04	0%	0	0	
Saint Helena	0.1	0	0	0%						
Sao Tome & Principe	1	0	0	14%	0			0	0	
Senegal	8.4	3.8	38	43%	8	0.25	38%	1	2	1
Seychelles	0.1	0	0	14%	0			0	0	0
Sierra Leone	4.7	2.1	21	0%		0.00				
South Africa	41.5	18.7	187	57%	25	0.18	64%	0	0	
Swaziland	0.9	0.4	4	29%	3	1.00	100%	0	0	
Togo	4.1	1.8	18	43%	1	0.00	100%	2	1	1
Uganda	22.7	10.2	102	43%	33	0.43	30%	121	3	
United Rep Tanzania	33	14.9	149	57%	13	0.12	46%	9		
Zambia	10.2	4.6	46	14%	5	0.14	80%	0	0	
Zimbabwe	11.3	5.1	51	71%	30	0.78	17%	1	0	
Regional total	610.7	275.6	2756	27%	274	0.12	31%	1949	35	16

**APPENDIX E**  
**Polio Eradication in Africa**  
**Questions and Answers**

# POLIO ERADICATION IN AFRICA

## Questions and Answers

National Immunization Days (NIDs) for poliomyelitis (polio) eradication are a new activity in Africa and many people have asked questions about what NIDs are, why we are doing them and how the NIDs relate to routine immunizations. The following answers are provided to the questions that have been asked most frequently, to help clarify why so much time, money and effort are being invested in this activity.

### ***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 wild polio virus, and that there will be no wild polio virus circulating anywhere in the world. When this is achieved we may 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, 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 OAU Summit committed themselves to this goal.

In 1988 it was estimated that 350,000 children became permanently paralyzed 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 the NIDs.

### ***2 What are National Immunization Days (NIDs)?***

NIDs are part of supplemental immunization activities, one of the 3 strategies being used to make the world free of polio. The other 2 strategies are routine immunization and disease surveillance.

Achieving and maintaining high levels of immunization coverage (over 80% of all infants), through **routine immunization**, makes the NIDs more effective. This means immunizing as many infants under 1 year of age as possible, with at least 3 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 re-introduction of wild polio virus into areas that have become polio-free. The proportion of infants in Africa immunized each year with at least 3 doses of OPV is approximately 80%.

Supplementing routine immunization with additional immunization activities, such as **National Immunization Days (NIDs)**, is done to interrupt the transmission of wild polio virus. Even with high routine coverage, there are still enough unimmunized children to

support the continued circulation of polio virus. NIDs are special days when extra doses of oral polio vaccine (OPV) are given to all children under 5 years of age. Two rounds yearly, 4-6 weeks apart, for 3 consecutive years are generally needed to interrupt the transmission of polio virus.

National Immunization Days (NIDs) are for all children under 5 years of age, regardless of their immunization status. Even fully immunized children should receive a supplemental dose of oral polio vaccine 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 acute flaccid paralysis (AFP), is essential to identify areas where 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 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 isn't there. You can help by ensuring that every child, aged below 15 years and with sudden onset of weakness or paralysis of one or more limbs, be seen at a health centre or hospital within 14 days of onset, so that 2 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 occur 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 wild polio virus in the Americas since 1991.

### **3 Why NIDs?**

As the level of routine immunization coverage increases, the circulation of wild poliovirus 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 National Immunization Days (NIDs) to supplement routine immunisation 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 will be conducting NIDs between January 1997 and early March 1998, including many countries in difficult circumstances, such as Angola and the Democratic Republic of Congo. Blocks of countries such as Tanzania, Uganda, and Kenya are cooperating to conduct NIDs within 1 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 wild poliovirus

#### **4 Why do fully-immunised 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

1 To induce immunity in unprotected children. About <sup>58</sup>80% of all children aged under 1 receive all their OPV doses during routine immunization. After 4 doses of OPV, about 10% of children (about 15% after 3 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 susceptibles (non-protected) children comprising those who either did not receive any or their full routine polio immunization, and those 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 susceptibles in the community become protected.

2 To boost intestinal immunity in all children, even those previously vaccinated, so that the transmission of wild poliovirus is interrupted. Polio virus is shed from stools. By using oral polio vaccine 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?**

Young children under five are the ones who are most vulnerable, most likely to catch and also spread any diseases, including polio, because of their under-developed immune systems and their inability to practise good hygiene.

#### **6 Why so many doses? Will they not be harmful?**

The doses of OPV are administered repeatedly because the more the 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 being used for routine polio immunization. The vaccine is safe and it is effective. The vaccine manufacturers are all licensed and approved and monitored by WHO and UNICEF, to ensure that the vaccine is both safe and effective.

Vaccine for NIDs is being manufactured by 3 different manufacturers in France, Belgium and Germany. Each of these countries has a National Control Authority to also 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 do NIDs?***

NIDs are carried out as long as a country has 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 3 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 for a longer period. The disease surveillance systems needed to determine whether or not 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 3 doses of OPV through routine immunization. This will ensure that if polio is imported from outside the country, there will not be enough susceptibles available to sustain its transmission.

### ***9 Why is so much effort and so many resources being put into fighting polio when other diseases such as 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 paralyzes but rarely kills and which we rarely see in many countries nowadays?

The reason is that polio is one of the few diseases which can not 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 re-introduced 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 man for centuries. Now we have the same opportunity with polio. We can make the world free of polio virus so that no one will ever again become paralyzed 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 the following

- it boosts the immunization of the other childhood diseases by raising community awareness and reaching children never immunised before
- the war against polio provides valuable experience and builds infrastructure (such as laboratory networks and logistics) 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 re-directed 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 partnership. 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 which has been accorded 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. Experts from the U.S. Centres for Disease Control and Prevention give laboratory and technical support. Grass-roots support comes from Rotary International. The 1.2 million Rotarians world-wide have committed nearly \$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 mobilisation of the communities. Parents provide valued support in turning up with the children for the NIDs, and mobilising other parents. Community support is also provided in the form of volunteers for the vaccination posts, and in community mobilisation.

#### ***11. How shall we know that polio has been eradicated?***

When there will be no more cases of polio reported in any country in Africa

## ***12 After polio, what?***

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

**APPENDIX F**  
**Social Mobilization for Immunization**  
**Progress Report 1997**

# SOCIAL MOBILISATION FOR IMMUNIZATION PROGRESS REPORT 1997



December, 1997

---

The objective of social mobilisation is to achieve a high level of political commitment, public awareness and community participation for polio eradication and for the EPI in general

## 1 Activities

### 1.1 *The plan*

A regional social mobilisation advisory group composed of the main partners<sup>1</sup> in EPI and polio eradication was convened in February. The group developed a plan of activities to be implemented during 1997 (See summary table in folder). The main focus of the plan was on advocacy for polio eradication and on social mobilisation for National Immunization Days (NIDs). The activities were categorised as follows:

- Media advocacy for general public awareness
- Regional advocacy for high level political commitment
- National social mobilisation to strengthen stakeholders, community communication and participation

Community reporting of AFP cases during NIDs was encouraged. It was stressed to the countries, that the NIDs should be utilised to promote routine immunization.

### 1.2 *Media advocacy*

Messages for 1997 were developed and disseminated through press briefings, radio and television. A press kit, which was prepared in April and updated in November, was distributed to journalists and to the countries.

---

<sup>1</sup> WHO, Rotary International, UNICEF, USAID-Basics

### 1 2 1 Football and sports

One major media event was organised at the occasion of the World Cup Qualifier football match between Nigeria and Burkina Faso in April. An alliance between football and polio eradication was proclaimed and the campaign to "KICK POLIO OUT OF AFRICA" was broadcast on television in 22 countries and on radio throughout Africa.

Mr Abedi Pele and Mr Apolinaire Gahungu were appointed ambassadors for "Kick polio out of Africa" and participated in TV spots and public service announcements. Mr Gahungu also promoted polio eradication during press conferences at the Burkina Faso event. These media materials have been distributed to all countries and the video spots have been used in several countries including Nigeria and Chad.

Finally, Ms Fatuma Roba, the Olympic Gold Medallist received a personal cheque for \$US 75,000 in favour of polio eradication in Ethiopia from Ms Martina Hingis, European tennis champion at the occasion of Ms Hingis' investiture as WHO's global ambassador for immunization.

### 1 3 *Regional advocacy*

Following the declaration on polio eradication in Africa at the OAU summit in July 1996, a progress report was presented to Regional Committee of WHO and was sent to the members of the Committee for a polio-free Africa. A report was also made on the progress of polio eradication at the Peace Summit for African First Ladies organised in Abuja, Nigeria.

#### 1 3 1 Committee for a Polio-free Africa

The members of the Committee for a polio-free Africa helped to mobilise resources and they participated in social mobilisation in their own countries in the following ways:

- Many heads of state launched NIDs and, in some cases, participated in social mobilisation throughout the immunization days.
- President Mandela sent letters for resource mobilisation to the Secretary General of the European Union (EU) and to the Malaysian Government. The EU has now passed a resolution in support of polio eradication in Africa.
- The First Lady of Congo played a leading role by chairing meetings and mobilising resources.
- The First Lady of Nigeria was very active in resource mobilisation and community social mobilisation.
- The First Lady of Ghana played an important role in resource mobilisation and grassroots community mobilisation.
- General Toure is leading the national Inter-agency Co-ordinating Committee (ICC) in Mali for the preparation of 1997 NIDs.

The committee did not meet again in 1997.

## **1 4 National social mobilisation**

The February plan called for a number of activities in support of national social mobilisation including

- Preparation and testing of a discussion guide
- Collection and dissemination of a 'kit' of sample materials
- Appointment of national focal points for social mobilisation
- Community involvement in surveillance

### **1 4 1 Discussion guide**

The discussion guide has been developed and is in the final draft form. Comments have been received from some of the partners and national social mobilisation focal points. The draft has been shared with some countries conducting NIDs during 1997.

The guide will be finalised, translated into French and disseminated to the countries

### **1 4 2 Kit of sample materials**

A kit of social mobilisation materials has been collected and edited into a kit giving examples of fourteen categories of communication, including presidential speeches, ministerial letters, flyers, posters, banners and T-shirt designs. The kit has been presented to the second meeting on social mobilisation for polio eradication in Uganda 11-13 December.

The kit will now be disseminated to those responsible for social mobilisation in all countries.

### **1 4 3 National focal points**

Where national Inter-agency Coordinating Committees are being used as a mechanism to plan NIDs, social mobilisation sub-committees have been proposed. These sub-committees were to be chaired by the national focal point for social mobilisation and these focal points have been appointed in several countries.

Since February, these focal points have been invited to attend meetings of EPI managers held for Eastern Africa in Addis Ababa, for Southern Africa in Lilongwe, for Francophone West Africa in Cotonou and for anglophone West African countries, coincidental with a national coup, in Freetown. A core group of national expertise has thus begun to be formed and the experience which they have gained this year will no doubt improve the effectiveness of social mobilisation in their countries next year.

#### 1 4 4 Community involvement in surveillance

Some countries, including Namibia, Tanzania, Kenya, used the opportunity of NIDs to involve the community in reporting cases of acute flaccid paralysis (AFP)

## **2. Constraints and major issues**

A number of constraints and major issues relating to social mobilisation for NIDs were identified during the year and need to be addressed including

- Late starting of social mobilisation
- Resistance from religious, cultural groups and sections of the media
- Excessive emphasis on mass media rather than more effective interpersonal methods

### **2 1 *Late starting of social mobilisation***

Many countries have been observed to start planning and implementation of social mobilisation very near NIDs so that there is not sufficient time for thoroughness and for dealing with any problem groups

### **2 2 *Resistance from some groups***

Several countries, including Botswana, Kenya, Namibia, Uganda and Zimbabwe reported difficulties in convincing certain religious, ethnic and medical groups to have their children immunized during NIDs. In addition, wrong messages and rumours adversely affected NIDs results in some countries, administrative zones and communities. In Malawi, Togo and other countries misconceptions about the validity of the campaign prevented higher coverage rates in some areas. Rumors that OPV was a contraceptive, contained HIV or was intended to kill the children were reported. This resistance persisted during 1997 especially in sections of Uganda and Kenya, where coverage dropped in places to as little as 20%.

Although the media were generally very supportive in most countries such as Ghana and Kenya, in some cases they helped to fuel negative publicity and where there was weak communication on polio eradication to mothers, this was particularly damaging. Most of these problems require adequate implementation of a sound social mobilisation plan of activities to address, not only the polio NIDs, but also its linkage with the whole EPI as well.

## **3. Impact of 1997 activities**

Although some impact of regional advocacy and support to national social mobilisation has been seen, a more aggressive and a more productive implementation is needed next year. This is particularly challenging because there are some indications that the momentum and enthusiasm for polio eradication activities in the region is waning.

### **3 1    *Media advocacy for general public awareness***

The football theme kicked-off to a good start with the Burkina event. Twenty two out of a possible forty three African countries were confirmed by survey to have re-broadcast the match together with the video material on polio eradication, glimpses of the billboards, declarations by Dr Barakamfitye and Mr Souley and the display of a huge banner at the centre of the pitch (provided by Rotary International)

An in-depth survey of the audiences in Abidjan indicated that nearly 40% of the potential television audience watched the match and that 32% of this audience were able to spontaneously recall the message of polio eradication after the match. TV and radio exposure in Burkina Faso and Nigeria was intense and clearly the impact was strong.

A total of 56 African sports journalists plus TV media from Europe attended the press briefings and returned to their countries with media kits on polio eradication. Press coverage was particularly strong in Nigeria and Burkina Faso.

However, no football event has followed the Burkina match in 1997. Arrangements are being made for media coverage of polio eradication advocacy at the opening ceremony of the African Cup of Nations, Burkina Faso, February 1998.

Messages targeting specific audiences need to be developed and more widely disseminated through channels that are suitable to the specific groups. For example radio is acknowledged to reach many people in Africa and should be utilized more for wider dissemination.

### **3 2    *Regional advocacy for high level political commitment***

Although Heads of State participated in the launch of many NIDs in 1996, fewer participated in 1997, a year in which the number of countries conducting NIDs has doubled. First ladies too were more active in 1996 than in 1997 in spite of efforts to convene them for briefing in Abuja under the enthusiastic leadership of Mme Abacha.

First ladies play a vital dual role in helping to ensure the participation of their husbands in the launching of NIDs and also to involve the women's movements in their countries. Further efforts are needed to attract the interest of these important ladies and obtain a minimum commitment to action from them.

Hilary Clinton announced, during her visit to South Africa this year, that the United States was expanding their contribution to the campaign to "KICK POLIO OUT OF AFRICA" declaring that the campaign "is a partnership in the truest sense, involving national and local governments, nongovernmental organisations, businesses and bi-lateral donors. It is led by your President"

84

### **3 3 National social mobilisation**

National social mobilisation has been generally very successful in 1997, as indicated by the excellent results obtained from NIDs. Strong intersectoral collaboration has strengthened national and district capacities for planning and implementing social mobilisation activities and religious leaders played a very important role in mobilising communities in most countries.

Further strengthening of district micro-planning will enhance district capabilities and ownership in developing and implementation of timely and effective social mobilisation activities. In the rush to organise NIDs, the causes of resistance often remain insufficiently defined and the problem is not therefore effectively addressed. When this happens, the same risk groups remain un-immunized in each successive NID round. Timely and careful analysis of the problems well in advance and changes in strategy must be planned to effectively solve these problems.

There is an urgent need to evaluate the effectiveness of alternative channels of communication so as to reduce over reliance on expensive mass media and production of numerous promotional materials.

Social mobilisation for surveillance will need more attention including formative research to determine health workers' attitudes and best methods of involving community groups and sensitisation of the public through the mass media.

A few countries, including Ghana, made great efforts to promote routine immunisation during 1997 NIDs. Many more countries, however, need to orientate their promotion of polio eradication in this direction and more attention is needed generally to social mobilisation for routine and the control of other diseases, such as Tetanus and Measles.

### **3 4 Capacity building for social mobilisation in the region**

Implementation of such a varied plan of activities as proposed requires a pool of resources both human and financial at the regional and national levels. Indeed the lack of such a pool of expertise was a constraint during 1997.

At regional level there will be need to engage the services of different consultants for the various activities such as media advocacy. At the national level, there will be need build capacity of national social mobilisation focal persons through training and exchange of experience.

### **3.5 Documentation of lessons learned**

Lessons learned in social mobilisation for NIDs have so far not been adequately documented. This needs to be done so that these lessons may be applied to other disease control initiatives and to other areas of health.

## 4 Outline plan for 1998

The following are proposed social mobilisation activities to be implemented during 1998. The proposal outlines the broad areas to be addressed. Details of activities to be undertaken under each area are to be included. The activities will address the 3 main components of Polio eradication and NIDs, strengthening of routine immunisation and surveillance and will cover the following areas

- Media advocacy
- Regional advocacy
- Support to country activities

The principle target groups are as follows

- **Decision and policy makers** including government leaders, religious leaders, community leaders and opinion makers
- **Donors/partners** external and local
- service providers health personnel and medical practitioners
- **Community groups/general public** including community groups, individuals, teachers etc
- **Special groups** certain social groups which are hard to reach and hard to convince including religious, ethnic, medical etc

### 4.1 Media Advocacy

- Messages for 1998
- media materials
- Dissemination
- Radio programmes
- Distribution of media materials
- Press Briefings
- Ambassadors
- Advocacy countries by Apolinaire Gahungu
- Develop and disseminate publicity materials with ambassadors
- Football and other sports
- CAN 98
- Female sports stars - Fatuma Roba
- Internet
- "Kick polio out of Africa" on the Internet

## **4 2 2 Regional Organisations**

### **4 2 1 OAU**

- Progress report
- New resolution?

### **4 2 2 Committee for a Polio Free Africa**

- Progress report to members
- Participation of members in events such as launching of synchronised NIDs

### **4 2 3 First Ladies**

- Meeting at OAU
- Propose annual health summit

## **4 3 Country support**

- Update social mobilisation guide more details on routine immunisation and surveillance components
- Meetings of the national social mobilisation focal persons to review lessons learned, document and brainstorm on priorities for social mobilisation
- Technical support to 10 countries To decide on criteria for support
- Develop questions and answers leaflet on polio eradication
- Discuss social mobilisation at EPI Managers' meetings
- Surveillance guidelines including messages, community networks and incentives

## **4 4 Research and Evaluation**

- Study to determine and document effective channels
- Formative research for developing community case reporting/surveillance
- Study to help analysis of deeper understanding of the resistances to polio eradication

**APPENDIX G**  
**National Perspectives Uganda**  
**Addressing Rumors**

## ***Addressing rumours and wrong messages about National Immunization Days (NIDs) in Uganda.***

### **Rumours**

#### **Definition.**

- A current but unverified statement or assertion
- General talk or hearsay of doubtful accuracy

#### **What were the rumours/wrong messages?**

- Polio vaccine was contaminated with HIV
- Attributed NIDs to UPE programme
- Related NIDs to BCG vaccine which caused swellings in 1989
- Associated the origin of HIV to massive small pox vaccination
- The fear of unforeseen consequences
- Fear of overdose effects
- Death of children coinciding with polio immunisation
- Loss of confidence in the immunisation due to immunised children getting polio, measles etc
- The fear of eliminating the black race
- Polio is not a priority health problem
- Why immunise those who completed
- Religious beliefs which bar followers from taking any form of medicine
- Visions of God hence stopping them from taking their Children for immunisation (Maddu Born again)
- Why immunise after elections

#### **Who was responsible for these rumours?**

- Health Workers,
- Opposition from Political circles,

- Conservative traditional groups,
- Religious fundamentalists like Tabliques, some christians - Born again
- People who claim to cure AIDs e g Prof Ssali
- Elites e g Afunaadula
- Some media institutions e g CBS, Monitor, Crusader
- Some community leaders e g Katabi-Mpigi district
- Traditional Healers

#### **Why they spread these rumours**

- Limited involvement of Health Workers
- Ignorance
- Disgruntled politicians
- Financial greed e g THs
- Inadequate funding e g mobilisers in Lira
- Inadequate knowledge among mobilisers
- Inadequate training of mobilisers
- The concept of booster was not understood by the community and not supported by some health workers
- Wrong timing - NIDs with HIV vaccine trial and UPE

#### **Interventions to overcome the rumours**

##### **o Advocacy**

Intensive sensitisation meetings with Parliamentarians, Top religious leaders, Traditional leaders, Civic leaders of Private practitioners and opinion leaders at National, District, sub-county and community level

- o National and District launching programmes using top government officials e.g Vice President, Ministers, Parliamentarians and District officials**

o **Strengthened Alliance**

- Multi-sectoral social mobilisation co-ordination committee
- Sensitisation of line departments, Ministries, NGOs and CBOs

o **Training**

Training of mobilisers to handle rumours and misconceptions Provision of information guide including Question and Answer booklets

o **Community mobilisation**

- Use of film van operations to boost mobilisation and demystify rumours in the most affected areas (Areas with low coverage - central districts)
- Use of traditional leaders like the Kabaka of Buganda, Kyabazinga of Busoga and the Omukama of Bunyoro
- Use of Religious leaders

o **Involvement of Health Workers**

Health workers in hospitals and in private practice were called upon to participate in the sensitisation of the community to demystify rumours and misconceptions

o **Intensive mass media programmes**

Radio and TV programmes addressing rumours were organised and conducted Live phone-in programmes on both radio and TV were held These helped to clear rumours and wrong information among the population

- o Sensitization meetings with community leaders in the districts with low coverage (Mpigi-Kampala etc.)

- o Community seminars especially in the affected areas

These also emphasised that a malaria and other priority health problems campaigns were in the pipeline

- o Use of Radio stations that mis-informed the public

e g CBS the same man was used to correct his wrong messages

- o Involved the Ministry of Health in Buganda government because most rumours affected this region

- o Health workers and politicians offered their children for immunisation For example the Vice President, Minister of Health and other health workers

- o Translation of materials in 11 (eleven) local languages

- o Provision of increased allowances for mobilisers

- o Print media.

- Question and Answer
- Articles addressing misconceptions
- Interviews

**APPENDIX H**  
**National Perspectives Ethiopia**

# **1. MAGNITUDE OF POLIOMYELITIS**

<b>In Ethiopia</b>	<b>2,000 per year</b>
<b>In Africa</b>	<b>12,000 cases per year</b>
<b>Globally</b>	<b>60,000 cases per year</b>

**In the number of victims of polio in the world**

**1<sup>st</sup> India**

**2<sup>nd</sup> Ethiopia**

**In Africa Ethiopia is the 1<sup>st</sup> in victims.**

**2. NIDS SOCIAL MOBILISATION  
STRATEGY**

**NATIONAL LEVEL**

***A. ADVOCACY:***

- 1. Letter of support to partners.**
- 2. Intersectoral collaboration.**
- 3. Press conference by Health Ministers.**
- 4. Statement by Prime Minister.**
- 5. Statement by WHO.**
- 6. Message by President.**
- 7. Day off for the nation.**

## **B. MASS MEDIA**

### ***RADIO/TELEVISION***

- 1. Round table talks (Radio/TV)**
- 2. Quiz programme Radio/TV**
- 3. A 5 minute Programme and a radio play  
on OPV<sup>+</sup>**
- 4. Radio and TV spots**
- 5. 15 Minutes TV documentary**

### ***PRINT MEDIA***

- Newspapers supplements on OPV<sup>+</sup>**
- Newspaper feature and articles.**
- Weekly countdown press release.**

**4.            *C. IEC MATERIALS***

**Posters**

**Calendars**

**Leaflets**

**Booklets**

**Vaccination guide.**

## **5. *D. PROMOTIONAL MATERIALS***

- **Buners**
- **Billboards**
- **T- Shirts and Caps**

# **Stamped messages on letters.**

## **7. F. ORIENTATION PROGRAMMES**

**1. Ethiopian Orthodox Tewahido Church.**

**2. Ethiopian Islamic Affairs Supreme Council.**

**3. Ethiopian Catholic Church.**

**4. Ethiopian Evangelical Churches Fellowship.**

**5. Orientation for Media Professionals.**

**6. Orientation for Ministry of Defence.**

8.

***LAUNCHING CEREMONY (UN – ECA  
CONFERENCE CENTER)***

1. 20 Polio victim children present flowers to the President
2. 50 Children's songs on OPV
3. Welcome statement by MOH
4. Statement by Regional Director, WHO
5. Statement by President of Rotary International
6. Statement by H E President
7. Launching NID
8. Rotarians participants in vaccination activities
9. Air drop flyers.
10. Three hundred children's and major partners  
Candle Vigil Procession.
11. Rotarians football match at National Stadium

9.

***H. NID's SOCIAL MOBILISATION  
STRATEGY***

1. National level – MOH

2. Regional level – HB

3. Region 14 – Addis Ababa – HB

4. Zonal HP

5. Wereda HC

## ***I. ACHIEVEMENTS***

1. Over 88.7% OPV Coverage
2. Brought together all countries for  
a better health for our children.
3. Partners are identified till the year  
2000.

11.

***J. RECOMMENDATIONS***

1. Attention to regions

~ 2. Solve transport problems

3. Manpower shortage needs to be undertaken.

4. In the NIDs National Committee

■ The Prime Minister Office

■ Social Committee must be represented

12.

***K. CONCLUSIONS***

1. The National Committee must have a clear term of reference.
2. NIDs Social Mobilisation must start 6 months early.
3. EPI should take advantage of NIDs.

**APPENDIX I**  
**National Perspectives Angola**

**REPÚBLICA DE ANGOLA**  
**PROGRAMA ALARGADO DE VACINAÇÃO**  
**JORNADAS NACIONAIS DE VACINAÇÃO**  
**CONTRA A POLIOMIELITE/97**

**RELATÓRIO DAS ACTIVIDADES DE**  
**MOBILIZAÇÃO SOCIAL**

*BEST AVAILABLE COPY*

# **ANGOLA 1997**

## **DEMOGRAPHIC DATA**

TOTAL POPULATION: **13 270 088**

TARGET POPULATION FOR POLIO NIDs:

**2 627 416** children under 5

PROVINCES: **18**

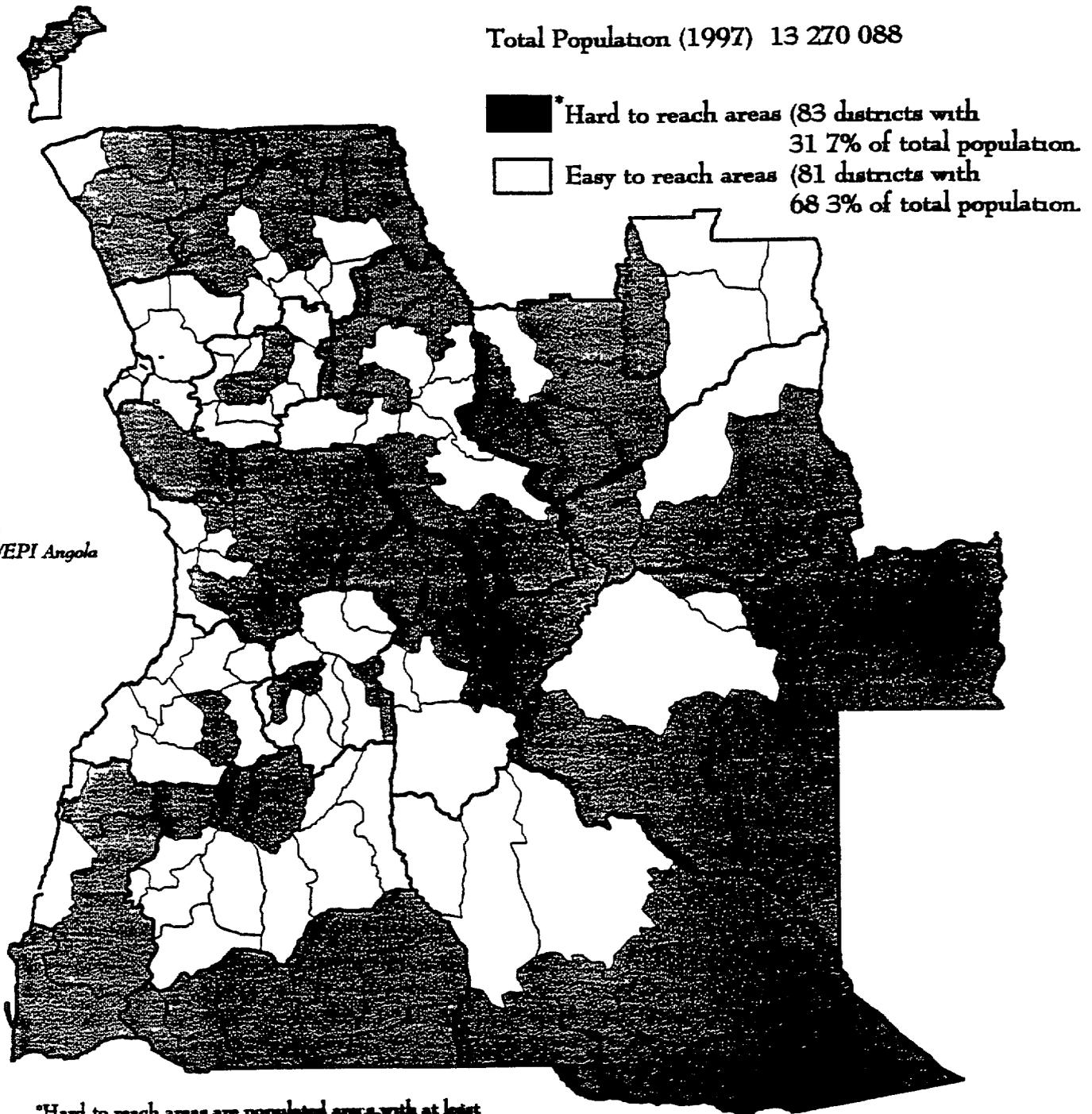
DISTRICTS: **164**

**81** DISTRICTS WITH **69%** OF TOTAL  
POPULATION ARE IN  
**EASY TO REACH AREAS.**

**83** DISTRICTS WITH **31%** OF TOTAL  
POPULATION ARE IN  
**HARD TO REACH AREAS.**

# Republic of Angola

Total Population (1997) 13 270 088



Source  
WHO/EPI Angola  
1997

\*Hard to reach areas are populated areas, with at least one of the following a) blocked or destroyed roads; b) broken bridges, c) mines, d) disperse population/long distances between small population groups; and/or e) political-military instability/insecurity

BEST AVAILABLE COPY

# **ANGOLA 1997**

## **SOCIAL MOBILIZATION STRATEGY**

### **FOR**

### **EASY TO REACH AREAS**

- PLANNING WELL AHEAD OF TIME (AND PURCHASING OF SOCIAL MOBILIZATION MATERIALS FOR USE IN THE WHOLE COUNTRY, THANKS TO GOVERNMENT AND OUR GENEROUS DONORS)
- TRAINING WORK-SHOPS INCLUDED SOCIAL MOBILIZATION ESSENTIAL ASPECTS
- PREVIOUS CONTACTS WITH TOP LEVEL POLITICAL LEADERS AND OTHER AUTHORITIES AND AGENCIES
- TIMELY DISTRIBUTION OF SOCIAL MOBILIZATION MATERIALS, INCLUDING CAPS, T-SHIRTS, APRONS, BANNERS, ETC , FOR VACCINATION TEAMS
- PRE-LAUNCHING CEREMONY RADIO AND TELEVISION
- PREVIOUS SOCIAL MOBILIZATION ACTIVITIES POSTERS, PAMPHLETS, RIBBONS, RADIO MESSAGES, TELEVISION SPOTS, AIR DISTRIBUTION OF LEAFLETS
- INTENSIFICATION OF SOCIAL MOBILIZATION ACTIVITIES DURING DAYS PRECEDING NIDs
- SOCIAL MOBILIZATION DURING NIDs EXTENSIVE USE OF MEGAPHONES BY VACCINATION TEAMS

# **ANGOLA 1997 SOCIAL MOBILIZATION STRATEGY FOR HARD TO REACH AREAS**

- TIMELY COMMUNICATION FOR HARD TO REACH POPULATIONS OF CAMPAIGN WHICH IS ABOUT TO COME
- PREVIOUSLY DEFINED PLACES FOR VACCINATION WHERE NEEDED
- INVOLVEMENT OF CHURCH LEADERS AND TRADITIONAL COMMUNITY LEADERS AS AN ESSENTIAL ELEMENT FOR SUCCESS
- COMMUNITY THEATER MORE EFFECTIVE THAN USUAL MEANS FOR MOBILIZATION
- USE OF NATIONAL LANGUAGES FOR COMMUNICATING CAMPAIGN MESSAGES (9 MAIN ETHNO-LINGUISTIC GROUPS ALL OVER THE COUNTRY)
- **AND NEVER POSTPONE WHAT WE HAVE ANNOUNCED BEFORE!!**

**REPUBLICA DE ANGOLA**  
**PROGRAMA ALARGADO DE VACINAÇÃO**  
**JORNADAS NACIONAIS DE VACINAÇÃO CONTRA A POLIOMIELITE/97**

**RELATORIO DAS ACTIVIDADES DE MOBILIZAÇÃO SOCIAL**

A Republica de Angola , constituída por 164 municipios tem uma população estimada para o ano de 1997, em 13 270 088 habitantes sendo o grupo alvo definido pelo Programa Alargado de Vacinação, de 2 627 416 crianças menores de 5 anos de idade

Segundo o acesso a essas populações 69% encontra-se em areas de fácil acesso, constituído por 81 municipios e 31% em areas de difícil acesso, num total de 83 municipios

Tal divisão permitiu a definição de estrategias específicas de sensibilização da população, e mobilização de meios e apoios para as jornadas

Integrando a estrutura para a planificação e coordenação das JNVs, foi criada a subcomissão de Mobilização Social que tinha como tarefa a coordenação de todas as actividades que visavam a sensibilização das autoridades e da sociedade

Na pratica as actividades de mobilização social tiveram inicio a 14 de Agosto, com o lançamento oficial das Jornadas , num acto coordenado pelo Rotary Club de Luanda ao qual estiveram presentes Sua Excia o Senhor ministro da Saude dr Anastacio Ruben Sicato e foi presidido pelo malogrado Dr Pedro de Castro van-Dunem ,Loy em representação do Primeiro Ministro angolano A Vice-Ministra da Saude, Dra. Tereza Cohen, Coordenadora da Comissão Executiva Nacional para as Jornadas, ao lado de membros do governo de Angola e dos Representantes dos organismos das Nações Unidas, nomeadamente a OMS e Unicef , assegurou o bom andamento da cerimonia Estiveram tambem presentes representantes do corpo diplomatico acreditado no nosso pais, num gesto de solidariedade

Posteriormente ao lançamento nacional seguiram-se as actividades de sensibilização da população e divulgação de mensagens atraves da radio, televisão e jornal, sobre a importância das Jornadas e da necessidade da cooperação da sociedade para se atingir a meta mundial da erradicação da doença

Registaram-se contactos com os governadores provinciais e administradores municipais para a planificação e implementação das JNVs , tendo sempre presente a mobilização social como o factor decisivo, para o sucesso das jornadas O Programa Alargado de Vacinação promoveu a distribuição de 15 000 cartazes , 100 000 panfletos que obedeceram a ilustração de características específicas de cada região do pais, faixas com mensagens educativas sobre a vacinação e especificamente sobre a poliomielite , em português e em 4 linguas nacionais camisolas e bones, balões, para alem de brindes promocionais como autocolantes, lapiseiras , bem como materiais didacticos como sendo capas e blocos de apontamentos todos imprimidos com o logotipo da Organização Mundial de Saúde. A utilização de aventais e de banderolas pelas equipas facilitou a identificação dos postos de vacinação

Um esforço deve ser direccionado no sentido de se disponibilizar megafones para todas as actividades de vacinação, o que segundo experiências serviu de forma extraordinaria para despertar

A liderança das entidades tradicionais, nas actividades de transmissão de mensagens educativas, mostrou ser ainda e principalmente nos países com dificuldades de acesso e de extensão da rede de comunicação, a forma mais directa, barata e segura de se atingir a população o que permitiu a implementação e o sucesso das jornadas , mesmo em areas sem rede sanitaria funcional

Uma atenção especial foi dada aos grupos teatrais comunitarios que exibiram peças educativas sobre a poliomielite nas cerimonias oficiais de abertura em todas as capitais provinciais e em alguns municipios do pais A estas cerimonias estiveram presentes os governantes locais, bem como convidados de honra entre os quais se destaca a presença do Senhor Embaixador dos Estados Unidos e do Ministro da Saude de Cabo Verde, no Huambo e Cuito respectivamente

O compromisso do engajamento do Governo Angolano nesta luta mundial de controlo e da poliomielite, ficou demonstrado pelas autoridades do Ministerio da Saude ao assumir a responsabilidade de anualmente, fazer erguer uma estatua num largo publico, como simbolo do êxito e do progresso Efectivamente, a estrategia de mobilização social adotada durante as Jornadas figuram como factores cruciais para assegurar coberturas vacinais satisfatorias para se atingir a meta de erradicação da doença ate ao ano 2000

Luanda, 2 de Dezembro de 1997

**APPENDIX J**  
**Meeting Notes and Overheads**

## Strategies for Sustaining EPI

- 1 Self sufficiency in procuring vaccines and cold chain equipment
- 2 Health Education/Information and Communication
- 3 Adequate manpower
- 4 Training of Health workers
- 5 Infrastructure
  - I) static health services
  - ii) mobile health services
  - iii) private health services
- 6 Policy guidelines
  - Guide practitioners
- 7 Political commitment
  - facilitate funding
  - provide a favorable environment
  - stability
- 8 Participatory planning
  - promote ownership
  - tap on local resources
  - reduces duplication
- 9 Monitoring & Evaluation
  - build-in the programme to keep close eye on what is going on
  - use it to strengthen the programme
  - identify new needs

## Constraints

- 1 Discrepancy in immunization policy
- 2 Non-adherence to schedule
- 3 False contradictions
- 4 Religious beliefs
  - not allowed to use any form of modern treatment believing only in the power of God

## 5 Strong cultural beliefs

- belief that injections cause diseases
- belief that certain diseases are due the witchcraft or bad omen

## 6 Poor planning

- rushed planning
- telling people what to do

### Using NIDs social mobilization mechanisms to strengthen immunizations

- use the existing structures to maintain momentum
- regularly produce press briefs on immunization status
- evaluate the impact of NIDs on immunization coverage
- continue to solicit for political support

### Effects of NIDs on Routine Immunization

Encourage intersectoral consultation and participation

Place health high in other sector's agenda

Revitalize village Health Committees and community participation

Ensure sharing of scarce resources in the country

### EPI Communications

Lessons learned

Three prong strategy

- advocacy
- social mobilization
- programme communication

Advocacy

- must change with maturity of programme
- political/social leadership support important to begin with—difficult to sustain in visible manner—necessary?
- use news—newspapers & tv to support

### Social Mobilization (partnerships & community mobilization)

Participatory planning of activities important at all levels

decentralized decision making

partners & allies must be rewarded & given new tasks as programme matures

Programme Communication (targeted behavior change)

- Formative research
- operative research
- reduce “easy to do” items e g Posters, pamphlets, do essentials
- more emphasis on Inter Personal Communication (IPC)- greatest block to sustainability
- materials to support IPC–well researched
- use mass media to support IPC–coordinated
- use of traditional or folk media
  - Theatre/drama
  - Song
  - Etc
  - But research and monitor carefully
- segmentation & targeting of audience

Special Events or “Pulsing”

NIWs–National Immunization Weeks–2 per year?

- Support routine immunization–communicate regular place & time (no change in service delivery)
- Health service sites plus fixed outreach sites (e g schools, community centers, chief’s house)
- special strategies for polio or measles, etc can be built into NIWs
- Micro-planning at district level using participatory methods
- Target health workers, not just care takers & communities on
  - Benefits
  - Side effects
  - Surveillance

Would NIWs be more appropriate & flexible?

- Allow each country to plan appropriate strategies within
- Incorporate NIDs where needed
- Incorporate communication on surveillance
- Eventually NIWs for communication push only

**APPENDIX K**  
**Presentation Georges Collinet**

## SOCIAL MOBILIZATION PROGRAM Proposal

I have worked for several NGO on problems ranging from population problems and development programs, birth limitation programs, onchocerciasis awareness programs, AIDS, etc , for NGOs ranging from Population Reference Bureau, Futures, MSH, University Research etc I participated on most of these programs as a media consultant, trying to find out ways to better involve journalists, musicians, politicians and leaders, to promote and implement the programs that we were presenting I also worked extensively on experimental program that will help people better understand the problems at hand and change mentalities

My work with United States Information Agency, National Public Radio and commercial entities had prepared me for this At the VOA, the successes of my radio shows proved that it was possible to not only please but also motivate people around the world while sitting in your studio in Washington DC All that is needed is to relate to your fellow human being and speak to him in a simple manner, that will not offend him and that would drive the point home

Having listened to you yesterday and today, I came to the realization that new ways have to be found to enhance information reliability and help social mobilization This program has to be exciting enough to create motivate, simple enough to reach all segments of the population rich and poor, city dwellers and country people It has to carry a message in a effective and proven fashion and in several languages, and it has to be cheap I have been toying with the idea of an African Sesame Street Puppets play an important part in several cultures in Africa It is attractive, it can be educational and fun at the same time and it can be dubbed in any language

without fearing lip synch

The program would be put together by a panel made up of several of you, shot on video and could be presented in different parts of any country, on portable playback tape deck costing roughly \$350, by either the vaccinator or an animateur who would get the community involved by discussing the issue presented by the program. It would achieve the success of roving theatrical groups, in a controlled presentation, without having to deal with unpredictable and expensive artists

Song creation contest is another ways of creating social mobilization. This contest will be organized by you and radio stations like Africa #1, RFI, VOA, Channel Africa, etc. The winner will eventually appear on CNN, Mnet and other major TV stations in Africa. The purpose would be to create an event that would help promote the importance of NIDs and would lure the leaders with the eventualty of appearing on a major international TV station (they love that). This will make them work harder to make the program a success. The winning song will be video taped in a clip form to be broadcast on radio and TV and through careful planning reinforcing the message of the puppet show. A international fundraising concert to be broadcast internationally could culminate the event

Besides the first ladies of a country, which was called here the first mother, it would be advisable to find a spokesperson to represent the mobilization program on a continental basis, somewhat like Liz Taylor for AIDS in the U S. That person should be highly visible, non political (even Mandela creates some jealousy among African leaders), and that represents good family values

no, not Michael Jackson

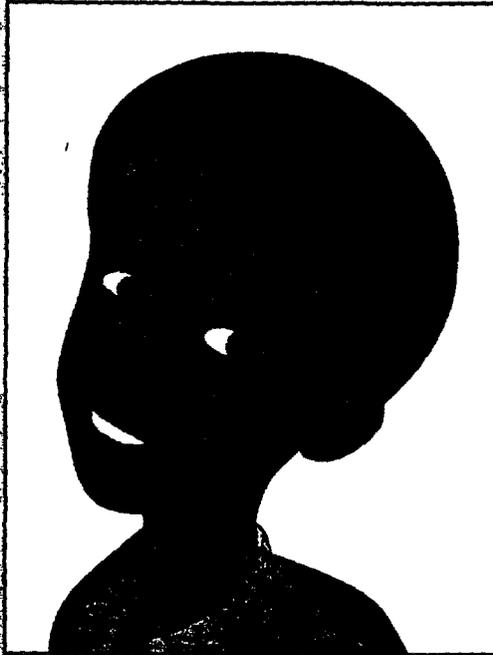
After having worked on several such programs, I have always been amazed by the lack of follow up. This is an essential element of continued success and the best way to prevent that fatigue that we've talked about, from the resource people and therefore the public. We are able to provide all the tools that are needed to successfully accomplish the task at hand. Most of the time when we leave, the people that have worked so hard with us feel abandoned because it is so much more difficult for them to make it happen. The follow up should be extended to 2 years until our partners feel secure enough to handle the program alone.

**APPENDIX L**  
**UNICEF'S Sara Communication Initiative**

# Sara

Communication Initiative

The Adolescent Girl in Africa



1996 **unicef**   
United Nations Children's Fund



# Sara

"We can only afford to keep one child in school and of course that will be your brother!" For many girls in the Eastern and Southern Africa Region (ESAR), as in much of Africa, this is the chilling death knell to a dream of education, and of everything they ever aspired to "It's the nature of things" is the damning excuse for this most obvious discrimination against girls



This and other issues affecting girls is the focus of the exciting multi-media Sara Communication Initiative (SCI), being developed by UNICEF in ESAR, in collaboration with partners and allies in the region

Sara, the charismatic heroine of the series, is an adolescent girl living in peri-urban Africa

Like many girls of her age, Sara faces nearly insurmountable socio-cultural as well as economic obstacles in her desire to reach her goals in life. But her desire to improve herself and her community, her quest for alternative solutions to problems, will be an inspiration to anyone who encounters her. Sara has valuable support in her relationship with her friends Amuna and Juma,



two peers who join her adventures and struggles. Zingo, her pet monkey, acts as her "alter ego". Zingo's antics are humorous expressions of Sara's inner feelings, feelings she could not express and remain respectful and acceptable to her elders. She often confides in a little lizard when she is most sad.

Stories about Sara are full of fun and adventure that appeal to a cross-section of society. But at the bottom of it all lie serious real life issues affecting girls and boys in Africa. They offer insight into the intricate web of factors that ensure the girl does not have a chance to improve her status in life. At the same time, they show how girls and their families can transform their lives from what is, to what should be.

## THE SCI OBJECTIVES

UNICEF and its counterparts in governments and non-governmental organizations in Africa have come together to



address the extreme discrimination that exists against girls and to highlight their needs through the SCI. Sara's ability to negotiate and persuade, and her determination never to give up even in desperate situations, makes her a dynamic role model for girls, a model who



inspires self esteem and from whom they can learn critical life skills essential for empowerment Sara is a powerful advocate for the reduction of existing disparities in the status and treatment of girls She represents a new approach in communicating issues pertinent

Through a multi-media package that includes animated films, a radio series and audio tapes, comic books, posters, manuals, and novelettes, the Sara stories communicate specific messages on education, health, and development with gender equity, and other issues relevant to the survival, protection and development of children throughout Sub-Saharan Africa The HIV/AIDS pandemic, which is a particular threat to the adolescent girl, is one of the major themes of the SCI

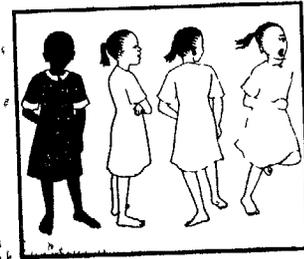


to girls Rather than being presented as a victim, steeped in self pity and in dire need of sympathy, she emphasizes girls' potential while exposing the problems that hinder their development.



### THE BIRTH OF SARA

Sara was conceived by UNICEF - ESARO's Communication Section and has involved over a hundred gender specialists, researchers, educational media producers and artists from 11 participating countries They arrived at core regional themes, research methods and operational modalities through participatory consultations Members of a sister project in South Asia, the Meena Communication Initiative, have also contributed to the development of Sara



### THE DEVELOPMENT OF SARA

The Sara project is based on an elaborate programme of qualitative research In a region of diverse socio-cultural contexts, reaching consensus on storylines that cut across all borders is a challenging task One of the major challenges was to find an identity for the model girl What would she look like? In answer to this, artists from different countries drew their concepts of an adolescent girl These



were later synthesized into a few portraits, incorporating common features of adolescent girls from each country.

The first storylines, together with designs of characters and back-grounds, were extensively field-tested in over 570 focus group sessions throughout the region

Surprisingly strong commonalities emerged. The result of the process is an inspiring sense of



ownership in the stories from Eritrea and Ethiopia in the Horn of Africa, right through Eastern and Southern Africa to the Cape of Good Hope. Throughout the region people have declared "This is our story!" and "Sara is our girl!"



### THE SEARCH FOR A NAME

Over 100 names from all participating countries were field-tested to arrive at a common name of an African girl. The exercise was perhaps one of the most exciting, if sometimes controversial, parts of the research process. No name with pure African roots was found to be acceptable throughout the region. "Sara" emerged as the name most acceptable to all faiths and cultures.

### INITIAL EPISODES An Overview

In the pilot episode, "The Special Gift", Sara is told she can no longer continue her education. Her uncle doesn't believe in education for girls and would rather support her younger brother, Tsumi, to stay in school when there is a shortage of



money. Determined not to let her dream of higher education fade into oblivion, Sara discovers a model for a fuel-saving stove from a book and builds one with the help of her friends, Amuna and Juma. Her uncle is delighted with the innovation, seeing in it a



chance to boost his popularity and further his political ambitions in the community which is facing a firewood crisis. He quickly informs the chief and the villagers about "his" ingenious solution to the community's problem. He wins instant stardom and is on his way to becoming a councillor. Challenged to explain how he made the stove, he mutters that it was so easy even a small girl was able to make it and calls Sara to explain. In the process he publicly declares he will keep Sara in school. He is later unmasked as a fraud in an ironic turn of events.





In "Sara Saves her friend", Sara's friend Amina is despondent over her future. She is tricked into drinking beer and lured to go to the city by truck drivers. She is in great danger of being abused and of contracting an STD, even HIV/AIDS. Sara discovers this in time and launches a rescue mission. With the help of her friends, and Zingo, they manage to outwit the truck drivers just in time to save Amina from being sexually assaulted.

In another episode, Sara faces female genital mutilation (FGM). Her teacher has told her of all the risks involved and she is determined not to be circumcised. But she finds herself against a solid wall of opposition from powerful forces, including her grandmother, uncle and some members of her community. She is



captured by some village women to be forcefully prepared for the ceremony. While in captivity, she devises an escape plan based on a science lesson. With the help of Juma and Amina, together with Zingo, she manages to escape and brings the community to reflect on the practice of FGM, persuading a great number to her side and winning her case.



## SCI MATERIALS

The SCI is a multi-media project with animated film as its flagship. Animated film has elements of both reality and fantasy and when this is blended with serious messages, the result is a unique fusion of fun and adventure, the recipe for irresistible entertainment for all. Sara leaves a lasting impression on people due



episodes in animated film/video, each focusing on a priority theme. The films will initially be produced in English, Portuguese, French and Swahili and then will be versioned into



to this unique combination, thereby increasing awareness of the needs of the African girl.

In phases 1-2, the project aims to produce seven

other African and international languages. African artists are undergoing on-the-job training in animation during the production of the first episode.

In collaboration with BBC, the project has produced a 13-part radio series for broadcast throughout Africa in English, French, Portuguese, Swahili and Hausa. Versioning and broadcasting in national languages will follow.





Other elements of the communication package include comic books, posters, short stories, facilitators' guides, manuals and other promotional materials. The package will be distributed through formal and non-formal channels including TV and radio mobile cinema and video vans, video clubs, schools, colleges, religious groups, non-governmental organizations and associations.

Comprehensive national plans are being developed in each country. These will include "grass-roots" media such as community drama, music and puppetry. In addition, a pan-African music festival and CD is planned.

### SUSTAINABILITY

The first phase of Sara's development has been generously supported by the Government of Norway and by Committees for UNICEF in the United States, The Netherlands, Germany and the UK. Other countries and UNICEF Committees are also considering contributions.

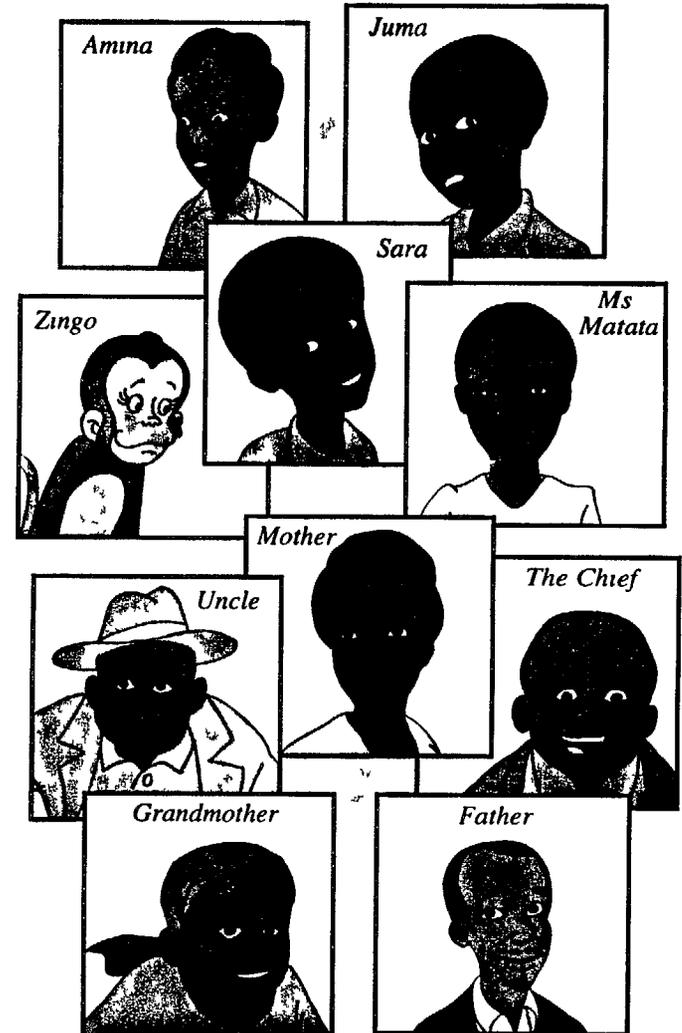
It is also envisaged that corporate and broadcast partners will join in the movement, providing assistance and expertise.



Co-production, co-publications and the commercial packaging of Sara materials will be a major focus in the months to come. An international business plan, also involving Sara products

such as games, textiles and ceramics, is also being planned. The "Sara Movement" is very promising and must be sustained for some years to achieve its full potential.

### THE MAIN CHARACTERS





**For further details contact**  
**Communication Section, UNICEF ESARO**  
**P.O. Box 44145, Nairobi, Kenya**  
**Tel 254-2 622220/622140**  
**Fax 254-2 622008/521913**  
**E-mail sara.esaro@unicef.unon.org**