Assessment of Communication Programs In Support of Polio Eradication: Global Trends and Case Studies

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Executive Summary

This document reports the findings of an assessment conducted between June 2003 and January 2004 of communication programs in support of the Polio Eradication Initiative (PEI). The United States Agency for International Development (USAID) Washington solicited the CHANGE Project to carry out an assessment of communication programs in support of polio eradication (PE).

From the late 1980s until the mid-1990s, communication largely played a secondary role in the PEI. Because many of the difficulties that PE has encountered in the past years have been defined as "communication obstacles," communication has gained more attention and recognition. However, increasing awareness about the importance of communication does not mean that the status of communication programs is comparable to other aspects of the PEI (vaccine procurement, cold chain, surveillance). Social mobilization/ communication committees (SMCCs) have been established, but staff and resources are thin (particularly at state and district levels). Most SMCCs are active only a short time before National Immunization Days (NIDs). Consequently, plans are put together haphazardly and the quality is uneven. Although there are more communication positions, polio partners (PP) need to make a stronger commitment by adding and training staff.

This report reviews the design and implementation of programs for advocacy, social mobilization (SM), and information, education, and communication (IEC) activities. Through global advocacy, the partnership has garnered a good deal of support from heads of state, international organizations, the private sector, and celebrities. Below the global level, however, advocacy activities have had mixed success.
SM has been central to NIDs by putting in action a variety of community organizations. However, PP have not taken advantage capitalized on either the social energies or the organizational capital to improve the chronic problems with routine immunization (RI) and surveillance, particularly in African countries.

IEC strategies have been used with interesting and positive results, but more systematic, evidence-based planning has been missing. Decisions have generally not been based on studies of populations' knowledge and attitudes about immunization. Had this data been strategically used IEC interventions could have been more effective in reaching zero-dose children. Data on the main sources of information on the time and place of vaccination show similarities across countries and regions. Sources are different in urban and rural settings: whereas radio, television, and religious organizations (mosques, churches) and leaders (priests, imams) are effective means of information in cities, interpersonal communication (IPC) between caretaker with local leaders and health workers is crucial in towns and villages.

One of the most important lessons about the impact of communication programs is the need for integrated media strategies. When communities hold favorable attitudes towards immunization and logistics work well, conventional communication activities can successfully promote demand and convey basic information. However, when communities are filled with negative rumors or resist polio vaccination during NIDs, other communication strategies are needed. The media are important to create awareness, but their impact is limited if IPC and SM are not conducted to guarantee that caretakers will bring children to vaccination booths or wait for vaccination teams (VTs) at home. Without IPC and community action, the media have limited impact on turnout figures and coverage rates.

This report also examines the functioning of communication programs within the institutional structure of the PEI, namely the inter-agency coordination committee (ICCs), the social mobilization/ communication committees (SMCCs), and the interaction and coordination among PP. It is concluded that an effective ICC needs to meet four conditions:

1. Regular participation of all major partners
2. A clear agenda that reflects the priorities of all partners

3. Good communication system between national ICC and state ICCs
4. Sustainable and effective leadership

Country experiences show that ICCs and the partnership function better when roles and responsibilities are clear, partners are in regular contact to build trust and facilitate coordination, and are unequivocally committed.

The performance of the SMCCs has been highly uneven. At the national level, they have been increasingly effective in recent years (although with important variations across countries), but remain relatively disempowered. At state levels, they lack sufficient human and technical capacity and leadership to carry out activities and coordinate with the national SMCC. One of the key deficits is the lack of a sufficient number of staff with the appropriate technical expertise and management skills. Generally, the Ministry of Health (MOH) has a small number of officers in communication positions that generally lack formal training in communication. PP have better capacity than governments, but their capacity is stronger in the capital city than in peripheral areas. The fact that communication staff working for PP particularly outside the main cities are typically hired on short-term contracts has resulted in constant turnover and weak ownership.

Institutional problems are also related to limitations in technical and personnel capacity in communication programs. The most important limitations have been:

- The lack of communication staff with a broad perspective of communication at all levels;
- The lack of expertise in communication planning for SM among PP, especially at MOHs at central and local level;
- The lack of expertise in operations and evaluation research and strategic orientation towards immunization as a social practice;
- The poor quality of IPC skills among HWs and VTs.

Notwithstanding these limitations, communication programs in support for polio eradication have made a number of contributions in terms of building capacity:

- Developing micro plans
- Organizing social mobilization
- Carrying out advocacy among local leaders
- Dealing successfully with rumors and resistance
- Identifying hard-to-reach populations

That capacity is not equally distributed across organizations and administrative levels, and the quality of those skills can be improved.

Recommendations for USAID Washington and Mission Programs

Support is needed in three areas: institutional management, communication programs (advocacy, SM, and IEC), and human and technical capacity. The following actions are recommended:

Institutional/Management Strengthening

- Strengthen local communication resources through funding positions in priority countries and areas. Positions could be at WHO, UNICEF and/or NGOs. Officers should be responsible for convening regular meetings of the SMCC with local communication staff (MOH health promotion/education, media, schools, private sector, etc.), elaborating action plans and goals, planning and conducting training workshops, and liaising with the SMCC.
- Offer support for communication programs that integrate NIDs and RI.
- Develop programs to strengthen supervision and monitoring of IPC communication skills of HWs and VTs in partnership with NGOs and MOH, particularly at district levels.

Communication Programs

- Support the development of advocacy indicators in countries where government commitment (at different levels) is weak. Indicators should help to guide advocacy activities, and will need to be discussed with the ICCs and SMCCs, and presented at regional ICC meetings.
- Design programs that support (both financially and technically) operations research for SM to build community action for PE and RI on a regular basis. Programs could stipulate specific conditions to ensure that applicants (such as coalitions/alliances of local communication organizations/PP) submit long-term plans and evidence-based studies.
- Support programs to develop strategic messages and materials adapted to programmatic needs and local cultures.
- Fund studies measuring impact of communication activities in support of PE and RI (e.g. branding, popular theater).
- Support communication aspects of surveillance programs through funding positions and training of communication officers in WHO or NGOs. Officers could collaborate with Surveillance Medical Officers (SMOs) in the design and implementation of communication interventions in support of surveillance activities.

Capacity Building Activities

- Develop programs that require the participation of local consortia of private and public organizations (government, universities, NGOs, private sector). Capacity should be built in MOH offices (e.g. training departments, health promotion/communication offices) and other institutions (e.g. universities, NGOs) whose steady presence is more likely to ensure sustainability.
- Offer workshops for key personnel in communication approaches (behavioral/social change, network analysis, agenda setting) to be used in the design of communication plans.
- Support communication positions at district levels in priority countries and areas.
- Develop and implement programs for media organizations to assign reporters to cover health stories, and receive training in use of small equipment (recorders and cameras) and technical assistance.
- Develop programs to monitor and improve use of communication materials.
- Fund workshops to train communication staff in operations and evaluation research.

- Develop district-based programs to train community motivators/mobilizers in priority areas.
- Offer workshops and refresher training in communication management and planning for NGOs and MOH staff.
- Develop mechanisms to ensure that training workshops for VTs and mobilizers include communication modules, that modules are interactive and allow plenty of opportunities to practice skills and tools, and that curricula take into consideration actual working conditions as the starting point.
- Provide technical assistance to minority-run media in key communities/areas.

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Acronyms

AFP	Acute Flaccid Paralysis
CDC	Centers for Disease Control and Prevention
CI	Communication Initiative
EPI	Expanded Program Immunization
HW	Health Worker
ICC	Inter-Agency Coordinating Committee
IEC	Information, Education, and Communication
IPC	Interpersonal Communication
KAP	Knowledge, attitude, and practice
LGA	Local Government Authority
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization
NID	National Immunization Day
OPV	Oral Polio Vaccine
PAHO	Pan American Health Organization
PE	Polio Eradication
PEF	Polio Eradication Facilitator
PEI	Polio Eradication Initiative
PP	Polio Partners
RI	Routine Immunization
SM	Social Mobilization
SMCC	Social Mobilization and Communication Committee
SMO	Surveillance Medical Officers
SNID	Sub-National Immunization Day
UNICEF	United Nations Children's Fund
USAID	Unites States Agency for International Development
VT	Vaccination Team
WHA	World Health Assembly
WHO	World Health Organization

Preface

The World Health Assembly (WHA) launched the PEI in 1988. Much progress has been made since 1988. Between 1990 and 2001, the PEI made dramatic progress: the number of global cases of polio fell from approximately 300,000 to 483 but rose to 1,925 in 2002. In 2001, ten countries reported transmission: Afghanistan, Angola, Egypt, Ethiopia, India, Niger, Nigeria, Pakistan, Somalia, and Sudan. Three regions (The Americas, Europe, and Western Pacific) have been declared polio-free, but despite enormous progress, PP have not been able to meet the original goal of eradicating polio by 2000. The goal has been reset for 2005.

Presently, the majority of polio cases worldwide are in three countries: India, Nigeria, and Pakistan. In the second semester of 2003, developments in Nigeria have been particularly concerning as virus transmission continued in Northern states and expanded into Southern states that had been polio-free for a few years. The identification of cases in other countries in the region (Benin, Botswana, Cameroon, Central African Republic, Ghana, Burkina Faso, and Togo) has raised the specter of a larger problem that could reverse much of the progress made in the last decade.

The majority of polio cases are found among minority populations in countries where those communities are large, alienated from both mainstream society and national politics, and are distrustful of government services.

Communities include tribal groups in Pakistan, Muslim populations in the Northern provinces of Uttar Pradesh and Bihar in India, and tribal and Muslim groups in Nigeria.

Making oral polio vaccine (OPV) available to these populations present daunting challenges that communication can help resolve.

One of the main challenges for PE is making OPV available to hard-to-reach populations with low rates of RI. These populations have little or no access to health services, and can be classified into distinct groups:

- Mobile groups such as migrants and refugees in conflict areas
- Urban poor
- Cross-border populations
- Minorities politically isolated from the mainstream

Another challenge is effectively addressing resistance to OPV among some minority communities. Recent global news has been filled with reports about the opposition among Muslim communities in India and Nigeria to the PEI. Rumors and resistance are two main obstacles to interrupt circulation in polio-endemic countries. In reaching these populations, PE confronts a series of difficulties, of which some are specifically communication issues and others are "technical" (from logistics to vaccine procurement).

This report aims to understand what and how communication has contributed to PE and to suggest ways communication could make further contributions to PE and RI.

Introduction and Methodology

This report discusses the findings of an assessment of communication programs for polio eradication. The assessment was done between June 2003 and January 2004. USAID Washington commissioned and funded the CHANGE Project to carry out the assessment. The SOW asked several questions to guide the analysis, which correspond to the sections and headings of the report.

USAID has supported the PEI and Expanded Program on Immunization (EPI) in about 40 countries with an emphasis on the remaining polio endemic countries in Africa and South Asia. Because efforts to eradicate polio in recent years have focused on both regions, this assessment pays special attention to the experiences of communication in Africa and South Asia. References are also made to experiences in Latin America, Eastern Europe and the Middle East.

Between 1987 and 2000, USAID contributed over $150 million for PEI in support of NIDs/SNIDs, mopping up, surveillance, laboratory, and communication. Between 1988 and 1996, USAID contributed approximately $50 million for PE to the Pan American Health Organization (PAHO). Contributions between 1996 and 2002 have been estimated around $260 million. Since 1996, funding for communication in support of PE has been more than $3 million per year. USAID Washington and USAID Mission Programs have supported communication programs in different ways. Funds have supported advocacy, SM, and IEC activities conducted by WHO, UNICEF, and several NGOs. Through grants, USAID has funded communication positions in WHO (Geneva, AFRO and SEARO offices) and UNICEF (New York and regional offices in Africa). In some cases, USAID mission support for communication has been done through UNICEF (for example, in India and in Bangladesh). Also, USAID has supported the work of a number of projects and organizations on PE including BASICS, the CORE Group, Johns Hopkins University (JHU), and CHANGE among others. Since the first meeting on communication for PE in Africa held in Brazzaville in 1996, USAID has supported all meetings hitherto.

Methodology

Several methodologies were used to gather information for this report. The author conducted interviews with key informants. A total of 84 interviews were conducted (the list of names is included in the appendix). Documents analyzed included reviews of PEI and EPI programs, meeting presentations and proceedings, and publications (books, articles from academic journals and bulletins, newspaper articles). Print (posters, flyers, vaccination cards, stickers) and audio-visual materials (radio and television spots, songs) used in communication for PEI were also analyzed through content analysis.

Information was also gathered through an online survey and a discussion forum. Through a contract with the Communication Initiative (CI), the CHANGE Project facilitated the survey and forum. Both designed the survey, identified forum questions, and analyzed the data. The CI was responsible for setting up the survey and the forum, contacting participants, moderating the survey and forum, and compiling the data. The CI also conducted a search of recent newspaper articles on issues relevant to the PEI.

Information included in the country profiles was gathered during visits that the author made between October and December 2003 to Nigeria, Bangladesh, and Angola. The visits included meetings with relevant local experts from different organizations (MOH, WHO, UNICEF, USAID, Rotary, NGOs), document review, and field trips. Given the limited timeframe of this study, each country visit lasted between 7 and 10 days. Because in-depth examination of each country would have required time that exceeded the deadline, this study does not intend to provide comprehensive case studies. Instead, the country profiles are intended to identify main trends, indicate comparative lessons, and illustrate and support arguments about the experiences and results of communication for PE at the global and regional level.

1. The Role of Communication in the Polio Eradication Initiative

Like all immunization programs, supply and demand factors have determined the evolution of the PEI. Supply-side factors include logistics, transportation, personnel, money, and general organization to ensure that vaccines are available at health posts and booths or delivered during house-to-house campaigns. Demand requires that caretakers know, request and use vaccination services, because they believe either it is a service given to them or it is a right they have as members of a community/country.

Both supply and demand are needed for an immunization program to function successfully. If supply-side factors falter but demand is successful, caretakers and children show up at vaccination booths (or wait at home for vaccinators) but vaccines are not available. If supply works but demand is limited, vaccines may be available, but only a percentage of the population is immunized. Recent studies have concluded that the lack of resources in communication efforts has had deleterious effects on immunization rates in developing countries because supply-sided actions alone cannot promote and sustain a culture of immunization that affect demand for services.

The PEI has had a three-pronged communication scheme: advocacy, social mobilization, and information, education and communication activities. Communication programs in support of the PEI were expected to make contributions to both supply and demand factors by:

1. Carrying out advocacy among decision-makers at different levels (global, regional, national, state, and local)
2. Mobilizing communities, leaders, and organizations to participate in vaccination days.
3. Informing caretakers about vaccination dates and places to ensure compliance.

Each communication activity has distinctive goals. Advocacy aims to obtain support from policy makers by participating in activities, providing financial support, and persuading others to rally behind the PEI. SM encourages communities to participate in vaccination activities in different capacities (e.g. mobilizers, vaccinators, transportation support, information providers). IEC targets caretakers with a variety of messages to ensure that their children will receive OPV at facilities or outreach session or at home. All strategies combined should contribute to a common goal: increase and maintain vaccination rates, both for supplementary and routine immunization. Ideally, all three communication activities should work in synergy towards a common goal, and each activity should have clear behavioral goals, audiences, and messages. However, the process hasn't always worked in a coordinated fashion. Despite the apparent success of specific activities, coordination among the three communication approaches has been rare.

Originally, communication programs were intended to support PEI's four-pronged strategy: NIDs, RI, Acute Flaccid Paralysis (AFP) surveillance, and mop-up campaigns. However, most communication activities actually were implemented to support the NIDs and SNIDs. In fact, many interviewees think that the overwhelming emphasis on campaign communication has undermined the possibilities of communicating information about RI and surveillance. There have been exceptions. In Bangladesh, for example, efforts were made to inform a large number of private medical practitioners and traditional healers to identify and report AFP cases. But on the whole, campaigns have been largely "missed opportunities" to convey information about RI and detecting and reporting AFP cases.

A combination of reasons accounts for why most communication programs have been active during NIDs in all regions. Some interviewees point out that this was direct result of an overall campaign-focus mindset among PP that only belatedly assigned more importance to RI and surveillance. Others suggest that the campaign emphasis was a strategic decision partially based on the assumption that if messages promoted NID, RI and surveillance simultaneously, they would be confusing and suppress each other. No data testing this hypothesis could be found, however.

Some studies suggest that a strong communication focus on PE has diluted or confused the messages on RI. Others observe that because campaign communication is more high-profile a few times a year (international and national media cover the event, communities are mobilized, government officials are attending), partners get more attention and reap more public-relations benefits than from low-key communication for routine and surveillance.

PEI's original strategy mainly viewed communication as having an informational role. The underlying premise was that making vaccines available would be sufficient to get children immunized. It was implicitly assumed that motivation to vaccinate children already existed. It was not deemed necessary to create demand among potential users; instead, it was believed that the demand already existed, and that knowledge to create familiarity with the service would suffice to bring about the expected practice.

Arguably, such a premise is basically correct: PE could reach the majority of the population with a simple, well-planned informational approach. This was particularly applicable in Latin America, the first region that eradicated polio: the combination of functioning health services and built-in demand necessitated a communication strategy based on a conventional informational approach. However, the limitations of such strategy became obvious when PE started in other regions of the world in the 1990s. It was not purely a matter of tapping into existing demand. The original strategy made a substantial contribution to immunizing large swaths of the population and eradicating polio from the Americas. The notion that if "vaccines are ready" and "caretakers know about when and where to get them" applied to the majority of areas around the world, but it failed to persuade all populations. It notoriously failed to reach two kinds of populations: those with scarce or no access to conventional means of information and those who refused or resisted OPV during NIDs/SNIDs for a variety of reasons.

2. The Impact of Communication Activities

The absence of evaluation research makes it difficult to assess the impact of communication activities. We have little data measuring the impact of communication activities on specific communication goals or on the overall objectives of the PEI. Given this situation, key strategic decisions have often been based on gut feelings and beliefs informed by past experiences. Those beliefs lack "scientific" basis and are not replicable. They have been giving a sense of orientation, of "do's" and "don'ts" based on years of trial-and-error experiences.

Advocacy

Advocacy is necessary because without the commitment from organizations and policy-makers at different levels, it would be impossible to mobilize financial and human resources that are needed to eradicate polio. Global partners cannot do it alone; the political will of governments (national/provincial/district) is crucial. Partners have sufficient power and clout to persuade governments to embrace the PEI, but only governments control resources and pull levers to make PE possible in a certain geographical area. National and local political authorities (presidents, first ladies, governors, mayors, and others) have the power to set domestic health priorities, assign resources, and order MOHs and other ministries to participate in the PEI in different ways (mobilizing HWs, providing transportation, procuring vaccines, etc). They also have public visibility to signal domestic support for the PEI through participating in flag-off ceremonies and other high-profile events.

It is impossible to summarize the results of advocacy carried out at global, regional, country, state, and district levels, basically because the experiences and achievements have been widely different. At the global level, the partnership has garnered a good deal of support from heads of state, international organizations, the private sector, and a wealth of media celebrities (entertainers, athletes). Consequently, the PEI has been efficiently positioned worldwide. Below the global level, however, the success of advocacy has varied.

At the regional level, many judge advocacy to have been successful in creating awareness about PEI and positioning the PEI within regional priorities. The online survey shows that 70% of respondents rated the advocacy efforts a 6 or better with 46% indicating a 7 or 8 rating on the 0-10 effectiveness scale. The lack of evaluation studies makes it difficult to assess the impact of advocacy. Interviewees have opinions about "what strategies worked" and "what actions were needed", but there are no evidence-based studies measuring commitment or drawing causal relations between advocacy and results. It is certainly not easy, for example, to measure how the participation of a First Lady in NIDs or the endorsement from regional organizations affects vaccine procurement, turnout, or vaccination rates. Developing a more methodical and strategic approach is necessary to assess the impact of advocacy efforts in different contexts and to achieve different goals.

Likewise, it is also necessary to have more rigorous measurements of government commitment. Advocacy is expected to drum up government support, but it is not obvious what kind of support is necessary. What indicators can be used to gauge the extent of government commitment? An incomplete list of indicators of government commitment would include: participation in media events, carrying out one-on-one advocacy with local leaders, procuring vaccines, funding vaccine costs, assigning HWs to work full-time on PE, earmarking resources for RI, and punctual payments to HWs. Without an index of "government commitment", it is hard to assess the impact of advocacy at different levels and to identify needs and priorities for future activities.

Social Mobilization

SM activities have been central to NIDs. Without the vast mobilization of government and community resources, it would have been difficult to run successful campaigns. Unfortunately, partners haven't capitalized on the intense SM efforts devoted to NIDs for strengthening RI and AFP surveillance. SM aims to create a festive and participatory atmosphere in which government

and civic organizations act as community mobilizers and vaccinators, and provide logistical support (transporting vaccines, VTs). It requires government offices (MOH, MOE, MOI, Armed Forces, Police, and others) as well as a variety of civic organizations (NGOs, private voluntary organizations, churches, mosques) and leaders (political, religious) to coordinate the organization of activities to ensure that OPV would be available and children brought to vaccination points or wait for VTs at their homes.

SM has symbolic and instrumental goals. SM symbolizes community participation and support for PE. It signals the commitment of political authorities particularly in countries where SM during major events is ingrained in the political culture of the country. It provides a moral booster to fatigued and underpaid HWs and VTs. It renews support for the PEI, especially after many years of campaigns.

SM also has instrumental goals, namely, to deliver OPV to hard-to-reach populations. Hard-to-reach populations are those who are not reached either by the health system or conventional communication interventions. The fact that the health infrastructure is too distant or fails to provide services partially accounts for levels of coverage lower than the national average, and large numbers of zero-dose children.

Hard-to-reach communities are characterized by:

- Irregular access to health services (due to geographical distance and ease of access to health posts, lack of information about vaccination schedules and places).
- Insufficient or no access to mass media.
- Living on the move (cross-border migrants, refugees, nomads).
- Religious/ethnic minorities excluded from the health system.

SM typically involves organizations that already play a crucial role delivering immunization services throughout the year, particularly in countries where understaffed and under-funded health systems do not reach the majority of the population. SM was necessary to overcome difficulties to access communities residing in hard-to-access geographical areas or affected by natural disasters. SM is particularly important to reach linguistic/cultural minorities that are underserved by health systems. In countries with a complex multi-linguistic, multi-ethnic demographics, SM in local languages and through IPC is important to reach communities that are either not reached by government systems (health, media, education) or are distrustful of top-down interventions in non-local languages.

Working with traditional leaders is consistently mentioned as key for successful SM. This includes partnering with religious leaders (clergy, spiritualists, healers) and political leaders (chiefs, governors, mayors) who enjoy wide respect and support in their communities. One-on-one meetings with leaders (instead of mediated, impersonal appeals) are fundamental. Getting their support facilitates the work of VTs (without it they are often not allowed to enter the communities) and increases the likelihood of higher turnouts during vaccination days. Meetings with leaders were also important to explain why VTs were coming back and to discuss why some communities were unwilling to get children vaccinated.

Although conventional wisdom is that SM is indispensable, there are not enough research data to guide decisions. In Niger, a report concluded that involving traditional leaders had been successful for changing attitudes about PE and sensitizing communities to the need to get children vaccinated. By the same token, conventional wisdom also says that insufficient engagement with local leaders accounts for high number of zero-dose children in some communities or rejection of PE. A case in point is Northern Nigeria where, according to interviewees, advocacy and SM with political and religious leaders has been sporadic and only carried out recently, as local resistance to the PEI became more visible in the national media.

Cooperation from leaders is particularly important to mobilize community institutions to provide information and bring people out during NIDs. Any SM plan needs to consider the different social capital and institutional make-up of a specific community. This includes religious, political and educational organizations, community networks, and NGOs.

A wealth of publicity materials (stickers, banners, vests, caps, flags, billboards, songs) is typically produced and distributed for SM. Some materials have mainly symbolic purposes, that is, to create an enthusiastic atmosphere during NIDs. Other materials provide essential information, namely, the location of vaccination sites. Banners help to identify booths, and t-shirts, vests and caps are helpful to locate VTs and mobilizers. Colored markers on VTs and transportation vehicles were particularly necessary in war zones to ensure the safety of the personnel.

In addition, publicity paraphernalia (including print materials) are helpful to boost morale among HWs. They are used as incentives to stimulate participation and raise spirits among fatigued HWs, especially after several rounds of NIDs. HWs are typically underpaid, and in many countries, payments have been delayed. Respondents to the online survey often mention payment delays as a key factor accounting for low morale and poor performance of HWs. One answer states: "The allowance of participants has been tampered with. Either delay in the payment, part payment or absolute lack of payment. This subsequently brings apathy."

Information, Education, and Communication (IEC)

IEC activities aim to increase and sustain demand for OPV. In order to achieve these goals, the purpose is to increase knowledge among caretakers about OPV (purpose, amount of doses, vaccination schedule, virus transmission, need for permanent campaigns), and to provide information about places and dates where OPV is administered. In doing so, IEC also aims to cultivate a favorable attitude towards OPV and immunization in general.

Studies and personal observations suggest that a mixed strategy is necessary to provide information about NIDs. The media are important to create awareness, but their impact is limited if no other actions are taken to guarantee that caretakers will bring children to vaccination booths or wait for VTs at home. Without IPC and community action, the media have limited impact on turnout figures and coverage rates. While IPC is particularly important in hard-to-reach and rural communities, an overall reinforcing communication/media environment needs to be created.

The main sources of information on time and places during NIDs are similar across countries and regions. It is not surprising that sources are different in urban and rural settings. In cities, radio, television, and religious organizations (mosques, churches) and leaders (priests, imams) are regularly mentioned as effective information disseminators. In towns and villages, instead, IPC is fundamental. Miking, town criers and religious leaders are cited as the most important sources to raise awareness about NIDs. Fixed miking in bus and train stations and mobile miking are widely considered to be indispensable and have been used extensively.

Country reports show consistent results. In Angola, a study reported that nearly all caretakers had learned through church sermons, mikers, radio and television. Research on urban Egyptian mothers shows that interviewees heard about NIDs from mobilizers with megaphones, television or radio. Television sports and spots have been particularly effective in providing information. Most stated that if a religious or community leader told them to participate they did and would. A KAP study in Ethiopia showed most interviewees became aware of NIDs from town criers and churches. Likewise, the media was effective only in urban areas in D.R.Congo in providing information about NIDs. Television and radio had limited impact in most regions. Similarly, although posters and banners were everywhere, recall was poor and populations remembered photos but not text.

In predominantly rural countries, such as Niger, town criers played a fundamental role among other channels such as television and traditional leaders. Although people had a lot of exposure to radio during the NIDs, IPC was decisive in increasing levels of knowledge and mobilizing caretakers. Interestingly, the importance of religious leaders as sources of information varied in rural and urban areas: while only 10% of rural caretakers mentioned them, 24% of urban caretakers said that they knew about NIDs from them.

The main advantage of the broadcast media is its wide reach, which often justifies expensive

production costs for materials (radio spots, television advertising). Surely, this decision depends on the intended goals. If the intention is to reach large populations with the same, basic message, then, media investments are warranted. If the goal is to reach small, specific audiences who are aware of polio vaccination and accept immunization, but do not bring their children to the booths or don't wait for VTs, then, large-scale media may not be needed. Broadcast media are favored to create an enabling and legitimating environment, that is, a context in which vaccination is presented as a desirable and accepted practice in a community. Often, however, media saturation before the NIDs responds to other considerations rather than to strategic plans. The fact that funds have been earmarked for media expenditures is often sufficient to decide to assign a determined amount of funds for media campaigning. Because communication strategies have often been made haphazardly and at the last minute, the instinctive reaction has been (particularly during the early stages of the PEI) to spend funds on the mass media without much consideration for specific needs.

Work with international news organizations has also been important. Collaboration with Voice of America (VOA), the British Broadcasting Corporation (BBC) and other global news organizations was particularly necessary in countries where civil war devastated the communications infrastructure, and consequently, domestic media had limited coverage at the national level. In post-Taliban Afghanistan and in Uzbekistan, for example, reliance of VOA, BBC, and Radio Free Europe was considered fundamental to solve problems of reach and credibility.

Although, at the beginning of the PEI, a strong emphasis was put on print media, research data show and PE staff now believe that neither print materials (posters, banners, billboards) nor newspapers are effective means to disseminate information. They could be useful for advocacy purposes with specific audiences and for political elites to show support. However, impact on actual users of immunization services is dubious, particularly in terms of changing practices among populations who are resistant to PE.

Sure, the weakness of messages is not unique to print media. Media messages, in general, often reflect a lack of strategic thinking. There have been exceptions. Among other examples, it is worth mentioning the decision of partners in Bangladesh to target middle- and upper-middle class neighborhoods with media messages emphasizing that polio was not restricted to poor districts (research showed that well-to-do residents didn't consider it necessary to get their children immunized against polio during NIDs/SNIDs because they associated it with a "disease of the poor"), and messages in the Turkish media and IPC addressing concerns among "resistant" populations who feared that OPV damages fertility.

Message design needs to start by identifying the kind of information that caretakers need to carry out the expected practice. Program staff point out that messages are rarely targeted to keep interest high or to reach zero-dose children. Nor do messages address community concerns (why vaccination/NIDs every year? How does OPV work?). Often, they simply provide basic information about dates and times, but fail to address existing concerns among users and non-users. Why are they vaccinating children again? Should sick children be taken? Is vaccination free? Nor do messages, particularly in high-risk areas, tend to incorporate findings from previous NIDs to address why caretakers fail to take their children to booths or to wait for VTs at home.

The limitations of print media highlight the importance of oral culture in communication activities. Program officers consistently mention the value of IPC to disseminate information and to persuade resisting communities and leaders about why children should take OPV. Evaluation studies unanimously conclude that IPC provides the most culturally and linguistically appropriate channels, particularly in rural areas without access to the mass media. Likewise, interviewees consider oral communication as the most effective way of reaching and mobilizing populations.

Miking and meetings led by community leaders and women's organizations have also been considered effective in mobilizing rural citizens. The use of credible local people is strongly recommended. A study in Nepal found out that female community health volunteers and health

workers were the most legitimate sources of information among mothers with low level of formal education. In Pakistan, it was reported that IPC at the community level was effective, particularly to change refusals.

Given the relevance of IPC in making people to receive OPV, it is not surprising that studies continue to emphasize the importance of strengthening the IPC skills of HWs through adequate training and monitoring. A friendly and open disposition to caretakers and a willingness to provide information reminders about vaccination schedule are seen as basic IPC skills. Besides these, other skills are necessary when VTs and HWs work among communities that question or strongly resist OPV. Required skills include the ability to negotiate and to provide positive encouragement.

Summary

One of the most important lessons about the impact of communication programs is the need to use integrated media strategies. When communities are well predisposed to immunization and the health system functions minimally well (e.g. vaccines are available, logistics are operational) the task of communication is relatively easy: to promote demand and convey basic information. Under different conditions, such as in communities rife with rumors or resistant to OPV during NIDs/SNIDs, an approach that combines different communication methodologies is needed.

The most effective strategies to disseminate information require a mix of town criers, miking, community meetings, churches/mosques, plays and cultural events, and radio. The specific mix depends on local practices. In some cases, IPC strategies are sufficient and radio is not required; in other cases, radio makes it possible to create an overall environment supplemented by different IPC actions. However, without research data, how can programs attribute impact and determine the extent to which their activities affected trends and achieved goals? How should programs decide future courses of action? How should they monitor results if baseline information is missing?

Another lesson is to identify hard-to-reach populations from the beginning. When populations are frequently reached by the health and media infrastructures, the task is less complicated. The abundance of information channels (from HWs to radio stations) facilitates the work of communication professionals. When neither the health nor the media/communication systems reach them, then, the challenges are different. A diagnosis of the reasons why specific groups of children don't get vaccinated needs to guide strategic decisions about communication plans.

The communication mix needs to be consistently used and planned sufficiently ahead of time. When messages are communicated just a few days before the NIDs, it is questionable whether they would have a big impact. Systematic planning based on a careful evaluation of previous experiences is necessary.

3. Institutional Aspects of Communication for Polio Eradication

This section examines institutional aspects of communication programs in support of PE by analyzing the planning, coordination and funding of activities by the global/regional/national ICCs and SMCCs. A review of these efforts also allows us to understand the strengths and weaknesses of the polio partnership. Experiences show that a one-size-fits-all institutional model cannot be applied to all countries with similar results. The institutional framework needs to be sufficiently flexible to take into account national and local factors. Nor have all PP been similarly present in all countries at different levels. Because institutional factors and experiences have been widely different worldwide, it is impossible to provide a quick summary of all experiences.

The Inter-Agency Coordinating Committee

The ICCs have been the institutional cornerstone of the PEI at the global, regional, and national levels. The main goal of the national ICCs has been to coordinate the participation of the PP. Issues that ICCs have dealt with include facilitating donor coordination, identifying funding gaps based on action plans, and involving partners and civil society organizations to get ownership and share tasks, make decisions on immunization policies, to provide technical assistance, to mobilize national and international support, and avoid duplication of activities. Not all ICCs have always dealt with these issues. Local and national circumstances as well as the interests of PP have determined the agenda of the ICCs.

It is also important to note that agreement on the need for the ICC has not been unanimous. In countries where MOHs were more likely to carry the bulk of the activities on their own, ICCs were not considered as necessary as in countries where MOHs were weaker and relied on local and foreign partners to deliver services, organize activities, and fund programs. In the latter cases, the presence of a higher number of partners that contribute in different capacities to the PEI made it necessary to develop and sustain the ICC as a mechanism to coordinate activities.

Top MOH officials (the Minister, Vice-Minister, or EPI Manager) have typically chaired the ICCs. Representatives from government departments, international agencies, and civil society participate at ICC meetings. The composition varies according to a number of factors: from the presence of organizations nationally and locally to the interest of MOH authorities to have a limited or broad number of associations represented. The ICCs typically divide tasks among a number of committees. Although the specific configuration varies, in general, committees deal with vaccination, logistics, and social mobilization and communication. Meeting schedules are also varied: some meet weekly, others meet monthly, and others are convened four times a year. The general impression is that regular meetings are necessary, but there is no agreement on how frequently they should meet. Some ICCs have been effective meeting quarterly, and others have accomplished many tasks in monthly meetings.

Likewise, the performance of the ICCs has been extremely varied. How one evaluates their performance depends on the expectations about the ICCs. If the expectation is that they should be able to accomplish basic tasks (e.g. coordination of activities, distribution of responsibilities), then, there have been successful cases (such as in Angola, Bangladesh, Gabon, Ghana, Liberia, Mali, Senegal, and a number of countries in Eastern Europe, just to name a few). However, if one expects ICCs to deliver high-quality technical assistance on a number of issues (cold chain, logistics, communication), then, the evidence is mixed.

An effective ICC needs to meet four conditions:

1. Regular participation of all major partners
2. A clear agenda that reflects the priorities of all partners
3. Good communication system between national ICC and state focal points
4. Sustainable and effective leadership.

1. *Regular participation of all major partners*

   First, regular participation of all major partners is indispensable. Experience shows that if partners feel disenfranchised and lack a sense of ownership, the ICC is not viewed as a representative body that coordinates the actions of all parties involved. An ICC that merely rubber-stamps decisions made elsewhere or that simply legitimizes the goals of the MOH is not an effective tool to strengthen cooperation and assign tasks.

2. *A clear agenda that reflects the priorities of all partners*

   A clear focus representing the agenda and priorities of the major partners is needed. Because ICCs bring together a number of partners with different agendas and organizational cultures, coordination has not been easy. Unless partners agree on basic programmatic goals, it is difficult, if not impossible, to have well-defined, minimal objectives. If the mandate is not clear, conflicts over priorities and strategies are inevitable. Many ICCs originally focused only on polio eradication. On the one hand, this gave a clear mandate that helped to solidify the partnership and give coherence to the work of the ICC. On the other hand, a focus on polio has been a source of tensions among partners about expectations and strategies.

3. *A good communication system between national ICC and provincial/local ICCs*

   A well-functioning communication system between national and provincial/local ICCs or, when they are absent, communication staff, is necessary. Without it, neither decisions made at the national ICC are relayed to provincial levels on a timely fashion nor sufficient information from below rises up to provide first-hand information about developments on the ground that should inform strategic decisions.

   Because the PEI has had a centralized structure, a good communication system among levels is crucial. Those who argue that the PEI needs a centralized structure mention the need for the central government (on another institution when governments are weak or absent) to make a commitment to PE, to send powerful messages throughout the country, and, in collaboration with other institutions, to elaborate and implement vaccination plans. Synchronizing NIDs and SNIDs in an entire country (and, in some instances, among various bordering countries) several times a year would have been impossible without centralized structures. Centralization is also necessary given the need to administer the concentrated flow of resources. Also, it allows the local dissemination of unified media messages through the media, miking and community leaders. A "national planning – district implementation" approach has its advantages to improve efficiency and to overcome the general lack of local capacity.

   Those who argue against centralization state that it disempowers local communities, particularly in hard-to-reach areas or communities that strongly oppose or distrust central authorities. Without local empowerment, the sustainability of immunization is questionable. Centralization reduces local participation to the use of strategies and messages that are decided elsewhere. It does not encourage adaptation to local needs and culture or, at best, adaptation is done by central offices without much input from local communities. Centralization has also been responsible for the late distribution (or no distribution) of communication messages, which more than just a logistical problem, could also be interpreted as a symptom of the lack of local involvement in the program.

4. *Sustainable and effective leadership*

   A sustainable and effective leadership is needed to facilitate communication, address interests, and create a cordial working environment. Interviewees praised specific ICC chairmen at regional and national levels who made a valuable contribution by devoting attention to several matters, assigning tasks among partners and coordinating plans, being personally involved, exercising a charismatic leadership, and signaling official support to local and foreign actors. Continuous changes in leadership, which are not unusual given that chair positions are often held by MOH official

(whose tenure is always subject to permanent in-fighting) undermine the functioning of the ICC.

In this regard, government commitment is crucial for effective leadership. Many interviewees consider that whether the government, specifically the MOH, takes ownership is decisive for the functioning of the ICC (and ultimately for the success of PE). PE can only be successful with a strong and clear mandate from the national government. In many cases, the biggest challenge has been the fact that PE has ranked low in the government's list of priorities.

Social Mobilization/ Communication Committees

As part of the ICCs, the SMCC have been responsible for communication activities. Depending on the country and circumstances, members of the SMCC have typically included representatives from Ministries of Information, Health, Religious Affairs, and others; officers from WHO, UNICEF and NGOs; donors; media personnel; and communication and journalism faculty.

The progress of SMCCs attests to the evolving perceptions and place given to communication in PEI. SMCCs were given little importance in the past, which was reflected in the limited resources allocated for personnel and programs. In recent years, however, important changes have taken place. As the coordinator of a SMCC puts it, "Everybody now knows that SM is more important." However, such realization has not always been made effective in the formation and consolidation of SMCCs. Regionally, the performance of SMCCs has been uneven. At the national level, SMCCs have been increasingly effective in recent years (although with important variations across countries), but remain relatively disempowered. Below the national, communication resources are weak. There is insufficient capacity and leadership to coordinate actions with national SMCCs. Without sufficient people in charge of planning and coordinating, the overall structure is weak. High staff turnover further deepens the difficulties of state and district communication staff to meet regularly and have a permanent agenda. Consequently, experiences and decisions may be shared at the national level, but plans were poorly consulted, adapted and coordinated at the state and district level. The weakness of communication resources reinforced a built-in tendency towards the centralization of the design and production of communication materials. Thus, messages have rarely been adapted to local strategic needs, and materials have been distributed late or not distributed at all. Without sufficient human resources or strong leadership, it is unlikely that SMCCs can be regularly active and effectively function in dealing with issues related to PE as well as communication for other immunization programs.

Communication and the Polio Partnership

The performance of the ICCs and the SMCCs throws into sharp relief the successes and the challenges of the polio partnership. The ICCs and SMCCs have been catalysts and expressions of how well the partnership has functioned at different levels. Because experiences varied at different levels, an assessment of partnerships needs to disaggregate the levels.

Interviewees often point out that coordination among partners worked well at the global level. At the global and regional levels, the relationship between UNICEF and WHO, two of the major partners, went through conflicts and frictions particularly in the early years, but their relationship eventually improved. In the 1980s, while UNICEF was heavily involved in vaccination (cold chain, vaccination management, vaccine supply), WHO had a limited presence. During PE, UNICEF assumed most communication responsibilities (as well as others in specific cases), and WHO and the Centers for Disease Control and Prevention (CDC) became responsible for technical issues. Rotary International has provided key financial support, carried out advocacy activities, and mobilized communities worldwide. It has taken some time for partners to follow the division of tasks and to respect each other's performance at different levels.

Against the backdrop of different institutional cultures, many interviewees point out difficulties in the relationship between WHO and UNICEF. These organizations have different yet complementary approaches. WHO's medical approach differs from UNICEF's social, human-

rights focus. Some interpret the fact that WHO has devoted more resources to PE than UNICEF as a signal of different institutional commitment to the PEI. On the ground level, WHO staff have been more likely than UNICEF staff to be fully funded and devoted to PE. However, it would be mistaken to draw sweeping conclusions about the interaction between WHO and UNICEF. Although in some cases there have been tensions, in other cases, largely due to good personal chemistry among country staff, there has been good cooperation and coordination.

The performance of the partnership cannot be reduced to the relations among the major partners, however. Because the commitment of the government as well as other domestic factors strongly influenced the relationship among the partners within countries, the partnership has functioned differently across countries. For example, the partnership experienced difficulties in Asia, but it functioned relatively well in some countries (e.g. Bangladesh, Indonesia, Thailand) largely thanks to good government commitment. In other countries, government policies had the opposite effect. In Turkey, for example, Rotary and UNICEF found it difficult to get full and open collaboration from MOH, particularly regarding activities for hard-to-reach, minority populations (nationalistic politics have apparently played a role in those disputes). This was further complicated by the fact that WHO didn't have full-time PE staff until 1998.

It is difficult to find financial information on communication in support of PE. At the global level, information is scattered in many organizations and is not always available. At the national level, such as in Tanzania and Zambia, the fact that funding for polio communication hasn't been separated from funding for immunization programs in general, or that no distinction is made between communication for RI and NIDs, makes it difficult to assess the exact amount of funding for PE. Also, the fact that EPI offices do not centralize financial information, and that PP do not report all expenditures (including for communication) to a central organization, makes it difficult to identify and tally expenses.

Funding limitations have hobbled the PEI but do not seem to have seriously undercut communication programs. Certainly, as long as the PEI continues to experience financial shortages, communication is negatively affected. However, most interviewees and reports seldom mention it as a major problem for communication. Some even point out that communication staff have been too timid to request funding. Some suggest that because funds have been available and donors have stipulated that funds should only be spent on PE, funds for communication for PE have often overshadowed expenditures for other immunization programs.

Here it is important to distinguish between funding for human resources in communication and communication activities. Most interviewees agree that funding shortages have particularly affected the availability of qualified staff than specific communication activities. The most serious effect of limited funding is the insufficient number of communication positions in MOH and NGOs, particularly at the state and district levels. Also, it is not unusual that those in communication positions (who are not always trained in communication) are not fully dedicated to PE, but need to juggle responsibilities for many programs.

Summary

From the review of institutional dynamics and relations in the polio partnership, the following lessons can be drawn:

1. Assign clear roles and responsibilities

When the division of labor is clear, each partner is more likely to accomplish its tasks effectively. Lack of clarity about roles and responsibilities breeds tensions and makes coordination difficult. When partners assume specific roles, then, it is possible that they complement each other and fill personnel and technical gaps. Once roles are divided, consistent leadership is necessary to facilitate the process and ensure collaboration. Because governments are expected to take leadership at the national level (and below), their participation is decisive for the functioning of the partnership.

2. Maintain continuous communication to build trust and facilitate coordination

Secrecy about plans and second-guessing the qualifications and performance of other partners are not conducive to creating an ideal climate for collaboration. Building trust is important to sort out tensions based on the distribution of technical and geographical areas and giving/taking credit for the impact of communication activities (and, more broadly, the success/failures of PE). While such tensions existed at the beginning at different levels, competition and distrust seem to have subsided in recent years. Recognizing each other's participation and maintaining open information channels are also necessary to facilitate goodwill and diffuse potential tensions.

3. *Need for unequivocal institutional commitment*

If partners are only half-heartedly committed to communication in general or specific communication tasks, the program falters. If one organization is expected to be in charge of specific aspects of communication activities, then, it is indispensable that sufficient resources are put into those programs. In some cases, personalities as much as institutional commitment have made a difference in terms of the quality of the functioning of the partnership. Regardless of how well institutions coordinate actions and are committed at the global and regional levels, personal networks and characteristics notably affect the dynamics of the partnership.

4. Strengthening Human Resources and Capacity in Communication

The purpose of this section is to discuss the limitations of capacity-building programs in communication for PE in two aspects: personnel and technical issues. The contributions to capacity building are discussed in the following section.

Personnel

The lack of a sufficient number of staff with the appropriate technical expertise and management skills has hobbled communication programs in support of PE. The problem has been twofold, insufficient staff at different levels, and staff with limited skills in various communication competencies.

At the time of the launching of PE, the presence of communication personnel was extremely limited at all levels. At the global and regional level, WHO offices have had a small number of communication staff which, mostly, performed information tasks (public relations, archival and library work). UNICEF had several communication positions in New York and in regional and country offices. The situation has improved, yet there isn't sufficient funding to support more positions. In Africa, for example, UNICEF has two USAID-funded positions for regional coordinators of communication programs. WHO/AFRO has a USAID-funded regional coordinator. Since 1996, WHO/AFRO has communication staff in Abidjan for West Africa and Yaoundé for Central Africa.

At the country level, the situation widely varied. Generally, MOHs had a very small number of communication positions, and most officials had medical training but no skills in communication. If they were qualified, it was more likely that they had training and/or experience in public relations or journalism. While personnel were typically only found in central offices, district health departments lacked communication positions and staff with adequate training. This situation has not substantially changed. In D.R. Congo, for example, the MOH has not allocated funds for communication personnel at intermediate levels, including provincial coordination of EPI sub-units; the EPI manager (a nurse by training) also coordinated communication and SM activities.

Other partners (UNICEF, WHO, NGOs) have had better capacity (as measured by the number of people exclusively working on communication issues) than governments. Their capacity has been stronger in the capital city than in peripheral areas. Moreover, the perception is that health communication officers at MOH and WHO offices lacked power within their organizations. Therefore, the scarcity and low status of in-country communication personnel presented important challenges.

Although the PEI has made important contributions to tackle these problems, the situation has not substantially changed. The lack of baseline data makes it difficult to assess precisely the number of communication positions that the PEI has created. Important efforts have been made to strengthen the number of communication staff, but the results have been mixed.

More positions have been created in different organizations, but there is not a sufficient number of communication staff within the health system to implement a variety of tasks that are needed. Also, only a few have been exclusively dedicated to PE. The total number continues to be insufficient, and most people are commonly assigned to work on polio and other immunization and health programs. In Pakistan, for example, UNICEF hired district focal persons, but their mandate was broader than polio. Likewise, WHO country offices have had a small number of communication/information staff, which was insufficient to manage activities. Also, many communication staff at both UNICEF and WHO, particularly in areas outside the main cities, have been working on short-term contracts which, not surprisingly, generated constant turnover and weak ownership.

The combination of unstable working conditions and low salary has made it difficult to maintain staff and coordinate activities through time. If staff do not hold positions for an extended period of time, then, program continuity becomes difficult. Particularly in countries experiencing

difficult situations, full-time communication personnel working on PE continue to be necessary. Unfortunately, it seems improbable that substantial resources will be assigned to increase the number of communication staff.

Technical

Equally important has been the problem of limited expertise to carry out a number of communication tasks at several levels in different agencies.

Several *deficits* need to be mentioned:

1. *The lack of communication staff with a broad perspective of communication at all levels.*

   There have been qualified professionals with expertise in specific areas, but not enough individuals with sufficient knowledge and vision to identify different communication interventions that were appropriate to address different issues. Consequently, diagnoses and recommendations often reflected the specific areas of expertise of the communication staff available, rather than a strategic assessment of needs and resources.

2. *The lack of expertise in communication planning for SM among partners, especially at MOHs.*

   Studies and interviewees observe that capacity in designing communication plans has been scarce. There has been little understanding of the needs and the requirements of communication planning, for example, the need to address regional differences and consider audiences profiles based on demographic and KAP data. The quality of micro-planning remains sub-optimal in many places.

3. *The lack of expertise in operations and evaluation research and strategic orientation towards immunization as a social practice*

   Very few communication programs have shown sufficient interest and expertise in operations research to guide strategic decisions, particularly in terms of approaching immunization as a behavioral issue that requires the acquisition and maintenance of specific practices on a regular basis. Baseline research has been sporadically conducted. Decisions have often been made on factors that had little to do with strategic needs and actual attitudes and behaviors in populations. The lack of these skills and orientation has been particularly pronounced at district levels, where capacity remains extremely weak.

4. *The poor quality of IPC among HWs and VTs.*

   The relevance of HW's IPC as well as the importance of IPC training has been demonstrated for quite some time, but it still needs to be more widely recognized. A mix of factors account for why it has taken too long for PP to realize the importance of IPC: the overall unawareness about the contributions of communication, the lack of evidence on the impact of IPC, and the programmatic focus on generic communication activities which has only occasionally taken consideration of specific circumstances and populations.

   Interviewees and reports indicate a number of problems related to the poor IPC skills of health personnel such as: giving out messages that are not targeted to the correct population, incorrect and misleading messages, and messages that have not been carefully planned; disinterest in engaging caretakers, failure to provide information about vaccination schedules and raise awareness of AFP, lack of specific directives about messages from health offices, and lack of negotiation skills and patience. These problems are rooted in a mix of poor training/expertise, and weak management. Despite repeated calls to strengthen HW's IPC, much remains to be done. In many countries (e.g. Angola, D.R.Congo, Somalia), district health personnel have not received training in several years or not at all. In other countries, HWs haven't received consistent and standardized training. There haven't been consistent efforts to train outreach staff in IPC skills for NIDs. Moreover, training workshops have assigned a limited amount of time to IPC modules. Interviewees observe that, in many cases, efforts to incorporate those modules (as well as on other communication issues) in the workshops went against the intentions of EPI managers.

No matter how much attention is paid to training HWs, a substantial improvement of HW's IPC skills seems unlikely if PP do not seriously address two problems: working conditions and weak management.

First, a critical step is to recognize that a fundamental core task of HWs is to provide key information to clients in a way that encourages them to return for services. However, as long as HWs are pressured to vaccinate rather than educate, it would be naïve to think that lessons from training seminars would be regularly put into practice. Changing the working environment (including expectations about workload, incentives, payments) is necessary to produce a situation that could be more conducive to the application of workshop lessons. Second, management remains notoriously weak in most cases as expressed in the lack of enforcement of checklists and guidelines for supervisors, falsified data, and continuous IPC deficits. Many reasons are suggested for why supervision is weak: the absence of district-level monitor systems; the lack of involvement of NGOs in supervision; the lack of clear responsibilities between MOHs and NGOs, the absence of independent supervision; insufficient training of supervisors. What is needed is to shift away from seeing training as the beginning and end of capacity building, and to make supervision a high priority. Giving feedback on performance is an important opportunity to improve the IPC skills of HWs; supervisors need to comment and train on the spot.

5. Linking Communication in Support of Polio Eradication and Routine Immunization

This section discusses the contributions of communication programs in support of PE for building and strengthening communication for RI. Communication for PE has had positive and negative contributions to RI. Substantiating those answers (no matter the conclusions) is difficult, again, given the lack of controlled studies and pre- and post-intervention data. From interviews and reports, the following contributions and limitations can be indicated.

Limitations

1. Overwhelming focus on communication for NIDs at the expense of RI

Communication officers lament the fact that communication for PE has overwhelmingly focused on NIDs, and that little has been done for RI and surveillance. In general, there has not been an integrated communication strategy to articulate communication programs for NIDs, RI and surveillance. Respondents to the online survey describe communication for PE as having "a single focus, a tunnel vision." If PE, in general, has not been properly used as a platform to strengthen immunization programs, as some observers have critically pointed out, the same conclusion applies to communication programs for PE.

The lack of flexibility and perspective has not been a mere coincidence or oversight on the part of communication staff. Because the conventional wisdom among leading partners has often been that communicating about RI would take attention away from PE, non-campaign communication has been relegated to a low priority. A communication officer points out that "it has been difficult to think outside the PE box. We could hear demands from people on the ground, but polio people didn't want to get into uncharted territory." The main issue hasn't been whether communication for NIDs could have positive effects on RI, but rather, the lack of a balanced approach that could recognize potential synergies and address them in strategic plans.

2. Poor use of social mobilization for RI

Community mobilization has become part of the vernacular of development initiatives, particularly in health and immunization programs. It has been the backbone of NIDs, absorbing large amount of resources and human energies. Overall, it has been used widely and relatively well in terms of logistics and planning (although the strategic uses of SM are more dubious).

Two limitations need to be addressed, however. First, work with communities has been irregular. Because of a campaign-centered focus, sustainable actions to engage communities on a permanent basis have been rare. Sporadic contacts, instead, have been the norm. Second, the huge mobilizing efforts put into campaigns have not been capitalized for broader immunization programs. This reflects the lack of more general, strategic perspective about how community mobilization could be channeled to strengthen RI.

3. "Opportunity costs" in assigning tasks to communication staff

Communication in support for PE has presented numerous and unique opportunities to communicate about RI. However, those opportunities have been often missed. There haven't been sufficient linkages with other programs to give information and persuade different populations (from decision-makers to caregivers) about the need and urgency of RI. Staff has been taken away from RI for PE could have also made a contribution to RI, if as part of their job descriptions, it was made explicit the need to promote OPV and RI. This was rarely the case, however, because if polio funds supported those positions, then, they were expected to concentrate on PE activities.

4. "Missed opportunities" to promote immunization programs and other health goals.

Communicating about polio campaigns also presented rare opportunities to promote other vaccines, other health information and

practices, and other development programs. Most communities have had numerous, long-standing unsatisfied needs. In some cases, NIDs have been used to promote other immunization and health services, basically to have "pull-in factors" to attract populations. However, the provision of OPV through campaigns could have been used more regularly and systematically to promote the value of vaccination in general and to raise awareness about other services and healthy practices. NIDs could have been conceived as mini-health camps to build awareness about other issues (nutrition, maternal health, etc.). Having other programs and services to attract populations and maintain participation in NIDs could have benefited PE, too. Some services have been offered such as immunization, health services (malaria prevention, ORS, vitamin A, reproductive health), birth registration, or educational programs to increase synergy among programs. However, a wide set of services has not been offered sufficiently, particularly in communities that demanded other services in addition to OPV or questioned why OPV was the only service available.

Contributions

Two kinds of contributions of communication in support for PE need to be distinguished: building communication capacity, and developing and reinforcing institutional mechanisms to implement communication programs.

1. Capacity building

PE has made important contributions to building capacity in communication. One could argue whether capacity could be built and strengthened better, but one could hardly doubt that PE has made important contributions. There are a higher number of communication staff who have participated in PE have gained valuable skills that they can apply in working on other vaccination efforts.

Many interviewees mention that through participating in NIDs, communication staff has developed a number of skills that are relevant for RI (as well as other health programs): micro planning, organizing social mobilization, carrying out advocacy among local leaders, dealing with rumors and resistance, and identifying hard-to-reach populations

2. Institutional

PE has contributed to putting in place an institutional infrastructure (ICCs, SMCCs) for organizations to exchange information, discuss plans, and design other immunization and health interventions on a regular basis. Because the functioning and sustainability of that infrastructure varies across countries and levels, it is hard to draw general conclusions. However, it is clear that even after partners move beyond PE, the experience of institutional collaboration remains in place, ready to be mobilized again for planning other immunization services and monitoring RI.

Although communication programs for PE have made important contributions to RI through building capacity and institutions, it has taken too long for PE officers to gain skills and for institutions to function effectively. Only when problems arose (rumors, difficulties in reaching populations, missed children due to poor planning), then, staff were confronted with the need to develop specific competencies.

6. Challenges and Recommendations

Challenges

Communication programs in support of PE face three kinds of challenges: institutional/management issues, implementation and effectiveness of activities, and personnel and technical capacity. To deal with some challenges (particularly management and institutional difficulties such as lack of coordinated planning between national and district levels, delayed payments to HWs), a mix of actions from PP with strong MOH leadership is required. Other challenges could be successfully addressed through targeted funding and technical support from donors.

USAID could make important contributions by developing and implementing programs to tackle the following challenges:

Institutional/Management

- Weak SMCCs at state and district levels in key areas/countries due to, among other reasons, insufficient and poorly trained communication staff.
- Synergies not fully utilized between communication for PE and other immunization programs.
- Poor supervision and monitoring of HW's IPC skills.

Communication activities

- Implementation of advocacy activities that lack systematic research, indicators, and goals.
- Poor community ownership and participation in communication programs (except for short-term SM during NIDs).
- Communication activities and messages are rarely based on strategic needs assessment and research data, and are not sufficiently sensitive to perceptions in different communities.
- Insufficient materials adapted to local needs and cultures.
- Insufficient communication activities in support of surveillance programs.

Capacity

- Weak capacity-building programs.
- Few communication staff trained in development/social change/behavior change approaches.
- Insufficient human resources/ focal points in communication below the national level.
- Lack of properly trained local personnel.
- Poor follow-up of actual uses of communication materials and training tools.
- Weak strategic thinking.
- Weak capabilities in management, fund-raising, and planning.
- Sporadic training of community mobilizers.
- Few evaluation studies measuring impact of communication on immunization behavior.

Recommendations for USAID Washington and Mission programs

Countries where support for communication for PE is needed can be classified as:

- Countries where polio virus has not been interrupted (e.g. Egypt, India, Nigeria, and Pakistan).
- Countries surrounding Nigeria where imported cases have been recently found (e.g. Niger, Togo, Cameroon).
- Countries where polio virus has been interrupted in the past years, but where low and stagnant coverage raises concerns about sustainability (e.g., Angola, Zambia).
- Countries with the largest percentage of unvaccinated children in the Africa region (the "Big 4" - Angola, D.R.Congo, Ethiopia, and Nigeria).

Institutional design of future interventions

Because no single global organization is able to take global/regional leadership and carry out multiple communication tasks in many countries simultaneously, a flexible, case-by-case institutional strategy is needed. The situation is different from the early stages of the PEI when a global institution such as UNICEF was indispensable to carry out a global effort. UNICEF still performs key functions, but lacks sufficient capacity on the ground to meet all demands.

Given the fact that the PEI currently confronts urgent challenges mainly in two geographical areas (Nigeria/West Africa, and India and Pakistan), localized support is needed. Likewise, in other countries where support for communication for PE is still needed (e.g. Angola, D.R. Congo, Egypt), future programs need to be tailored to fill specific institutional and technical gaps. Some form of institutional coordination among country and regional programs is desirable, but it should be the result of interaction and collaboration among a number of organizations rather than the primary responsibility of one organization.

USAID could commission organizations with strong local presence to implement training and supervision of HW's IPC skills. International and local NGOs could work in partnership with MOHs and maintain regular communication with UNICEF and WHO, who could contribute technical input and share materials. Because communication problems are similar across countries (e.g. weak supervision, poor communication plans, infrequent IPC training, lack of strategic thinking), an institutional mechanism to share best practices within a region and across regions is needed. UNICEF or WHO regional offices could perform theses roles.

In addition, USAID could support country-based consortia of organizations (MOH, NGOs, donors, universities, private sector) to work on a variety of communication activities. Each member of the consortia should have clear responsibilities based on their expertise and resources. An agency/organization with global reach and expertise could provide technical assistance to strengthen capacity on strategic communication planning, training, evaluation, and supervision/monitoring. That organization could also facilitate capacity-building programs through coordinating activities, streamlining content of training activities, and convening meetings. Given the political sensitivity of PE in most priority areas (Northern Nigeria, UP and Bihar in India, Pakistan), local/national organizations in partnership with non-U.S.-based agencies should be primarily responsible for conducting communication programs, particularly in districts. U.S.-based agencies with extensive expertise in communication for immunization could provide technical assistance, for example, in the design of strategic communication plans, the development of advocacy indicators, and the production and testing of communication and training materials.

Given the current challenges and institutional resources available in each country/region, working with a mix of partners that have complementary strengths at national and district levels is recommended. Although in many cases the most urgent needs are in districts, institutions with national presence (MOH, universities, research organizations, large NGOs, religious organizations) could be responsible for building management and communication capacity. They

are more likely to reach several districts and be capable of coordinating activities in a country.

Support is needed in three areas: institutional management, communication programs (advocacy, SM, and IEC), and human and technical capacity. The following actions are recommended:

Institutional/Management Strengthening

- Strengthen provincial and district SMCCs through funding communication positions in priority countries and areas. Positions could be at WHO, UNICEF and/or NGOs. Officers should be responsible for convening regular meetings of the SMCC with local communication staff (MOH health promotion/education, media, schools, private sector, etc.), elaborating action plans and goals, planning and conducting training workshops, and liaising with the national SMCC.
- Offer support for communication programs that integrate NIDs and RI.
- Develop programs to strengthen supervision and monitoring of IPC skills of HWs and VTs in partnership with NGOs and MOH, particularly at district levels.

Communication Programs

- Support the development of advocacy indicators in countries where government commitment is weak. Indicators should help to guide advocacy activities, and will need to be discussed with the ICCs and SMCCs, and presented at regional ICC meetings.
- Design programs that support both financially and technically operations research for SM to build community action for PE and RI on a regular basis. Programs could stipulate specific conditions to ensure that applicants submit long-term plans and evidence-based studies.
- Support programs to develop strategic messages and materials adapted to programmatic needs and local cultures.
- Fund studies measuring impact of communication activities in support of PE and RI (e.g. branding, popular theater).
- Support communication aspects of surveillance programs through funding positions and training of communication officers in WHO or NGOs. Officers could collaborate with SMOs in the design and implementation of communication interventions.

Capacity Building Activities

- Develop programs that require the participation of local consortia of private and public organizations (government, universities, NGOs, private sector). Capacity should be built in MOH offices (e.g. training, health promotion, EPI) and other institutions (e.g. universities, NGOs) whose steady presence is more likely to ensure sustainability.
- Offer workshops for key personnel in communication approaches (behavioral/social change, network analysis, agenda setting) to be used in the design of communication plans.
- Support communication positions at district levels in priority countries and areas.
- Develop and implement programs for media organizations to assign reporters to cover health stories, and receive technical training.
- Develop programs to monitor and improve use of communication materials.
- Fund workshops to train communication staff in operations and evaluation research.
- Develop district-based programs to train community motivators/mobilizers in priority areas.
- Offer workshops and refresher training in communication management and planning for NGOs and MOH staff.
- Develop mechanisms to ensure that training workshops for VTs and mobilizers include communication modules, that modules are interactive and allow plenty of opportunities to practice skills and tools, and that curricula take into consideration actual working conditions as the starting point.
- Provide technical assistance to minority-run media in key communities/areas.

Concluding Remarks

Future advances in PE will be dependent on the ability to effectively work in a context of:

- debate and questioning of OPV
- connections being drawn between vaccination and broader social issues including minority community rights, religious values and political processes
- rapid flow of information and ideas
- the need to address at policy and revenue allocation levels the increasing inadequacy of health systems and health infrastructure in priority countries
- government, donor and other beneficiary interest continuing to move from the comparatively small numbers of polio cases to the seemingly much larger problems of, for example, malaria, tuberculosis and HIV/AIDS

Given these conditions, then, an effective approach to PE requires much stronger, more effective and different communication programs. Such programs should:

- promote dialogue and debate on key polio issues to ensure that the voices of vested interests often missing (e.g. caretakers from poorer households) are central to that discussion
- facilitate and supporting coalitions of local and national groups, networks and organizations with an interest in and/or working on child health issues, supporting them to further engage and contribute to better and wider polio action.
- ensure the wide distribution of accurate information on polio vaccines including vaccine safety
- negotiate the way forward on the specific issues that are blocking polio progress
- advance the social norms that are necessary for sustainable long term impact on polio issues - from the central importance of child health across cultures and communities to the ways in which health workers interact with parents
- develop and support communication networks - from TV entertainment producers to leaders of local, traditional drama troupes - that provide a platform for specific communication activities.

These actions require:

- developing, adopting and implementing a clear set of impact performance indicators for assessing the communication performance on polio issues
- increasing the level of research and evaluation related to those indicators
- recruiting communicators with the appropriate communication skills for the polio communication challenges already highlighted
- upgrading and reorienting the skills of existing communication staff working on polio issues so that they can more effectively relate and respond to the challenges highlighted
- increased communication and coordination between the on-the-ground polio communication actors in different countries
- a common planning, reporting and monitoring system that is supportive of both efficient sharing of resources and excellent learning and collaboration between and amongst the polio communicators and
- learning systems that allow and support polio communicators in one context to learn from the experiences of their peers in other contexts.

APPENDIX

Case Studies: Angola, Bangladesh, and Nigeria

Summary

Angola, Bangladesh and Nigeria were selected as subjects of country studies to discuss thematic issues and illustrate global trends analyzed in the main body of this report.

Only a few years ago, polio virus transmission and cases existed in the three countries. Now, the situations are different. No cases have been detected in Bangladesh since 2000 and in Angola since 2001. Nigeria, instead, hasn't been able to interrupt circulation and recorded the highest number of polio cases in the world in 2003. The prospects in Bangladesh seem encouraging. Instead, the situation in Angola is better but doesn't allow for unbridled optimism. Low coverage rates and persistent institutional and logistical problems (particularly in the provinces that have been severely affected by the civil war) are worrisome.

The case studies suggest that institutional factors explain the different evolution of PE efforts. The existence of a well-functioning institutional structure at different levels (national, state and district) is decisive for communication programs and PE in general. Only when institutional conditions at the national and sub-national levels are conducive to good collaboration among PP and effective implementation of district activities can global support be integrated. If partners lack a well-functioning institutional network to communicate decisions, coordinate actions, and implement programs, communication suffers.

Government commitment is crucial for the institutional structure to function. It doesn't mean that governments have to carry the lion's share of PE activities through funding, staffing and training. Governments make important contributions by effectively communicating decisions to lower administrative levels, rallying and leading PP through the ICC, and letting PP carry out tasks that the government is unwilling or unable to do.

The fact that Bangladesh has an impressive array of NGOs (particularly in urban areas), good communication capacity, and a relatively stable political situation and homogeneous culture has certainly helped. Angola, despite better government commitment to PE in the past years, still suffers from a variety of war-related problems (safety, weak government structure in areas that were previously controlled by UNITA, poor infrastructure) that challenge PE and immunization in general. None of the positive factors that explain improvements in Bangladesh and Angola are found in Nigeria. In the latter, the governments, from federal to state to the local government authorities (LGAs), have not unanimously and unambiguously supported PE. Institutional resources and networks are thin, government structures have been slow-moving, and some states have actively opposed to PE. More importantly, long-standing ethnic, religious, and regional conflicts, which have long divided Nigerian politics, have overpowered the PEI.

Communication programs have suffered from poor capacity both in terms of the limited number of personnel and limited technical skills (HW's IPC, planning, management, evaluation, operations research). These problems cannot be resolved without a functional institutional network committed to PE. Such a network requires a clear division of roles: the government needs to lead and ensure that decisions are implemented everywhere; partners need to divide up responsibilities, respect roles, and secure sufficient human resources for the tasks they have committed; and the ICCs need to facilitate coordination as well as consultation and information flow upwards and downwards.

The case studies demonstrate that those institutional conditions are necessary in countries where governments cannot eradicate polio without substantial support from global partners, immunization coverage rates are low, and management and logistics problems persist.

Angola

Challenges and Recommendations

Specific challenges to communication programs are the following:

- *Continue with advocacy of government officials to ensure that logistical and management issues are properly resolved.*

  More government commitment has been positive for the PEI. Commitment needs to be made concrete in specific actions that will help to consolidate gains and ameliorate conditions, particularly outside Luanda. PP need to maintain advocating at all levels and work with authorities to find ways to resolve logistics (e.g. vaccine distribution), management (e.g. delayed payment to HWs), and personnel shortage (e.g. insufficient SM/C staff at the district level).

  Producing indicators and evaluation of government commitment could help in identifying priorities, audiences, and advocacy actions. Without indicators of government commitment in all 18 provinces, it is hard to draw solid conclusion about the achievements of advocacy, or to produce a strategic plan for future actions to promote and sustain official support.

- *Develop and implement an integrated plan to strengthen technical capacity in communication planning, IPC, and evaluation.*

  PP have carried out a number of interesting communication activities (from popular theater to branding, from community mobilization to training of journalists), which arguably have contributed to the improvement of PE activities. Some capacity has been built, but it has been done without a clear strategy and in a haphazard manner.

  An integrated strategic capacity-building plan is needed to identify the most important needs at all levels (particularly within the MOH and below national offices) and strengthen communication capacity. Interviewees suggest that, among other actions, training programs are needed to improve planning and IPC skills of HWs and operations research and evaluation competencies of PP and MOH staff.

Angola has a rich experience in communication for PE. Building evaluation capacity will be important to understand and demonstrate better how those experiences have actually made a difference and could be strategically used to contribute to solve problems in terms of coverage and demand for vaccination services. Despite the visibility of the brand of the immunization programs and other communication interventions, we still need to know better a number of questions: How it has contributed to increasing knowledge of vaccination dates and places during NIDs? How to document that impact of the popular "immunization" song on attitude and behavior? What has been the impact of drama groups on building a "culture of demand"?

The implementation of communication programs for PE doesn't seem to have expanded the communication capacity of the MOH. The MOH still lacks staff sufficiently qualified to design, plan, and implement communication activities. Its Office of Health Promotion still depends on partners' technical assistance and funding. Nor does it seem that capacity has been sufficiently built in NGOs. NGOs have limited human and technical resources to carry out a number of communication activities that are needed.

A capacity-building plan should not consist of a series of sporadic workshops, but rather, needs to present a systematic vision that integrates PP and other actors (e.g. universities, private sector). Linkages with existing but underutilized university programs in journalism and communication could be helpful. Also, future efforts should aim to build institutions and programs that build communication capacity, not just for PE but also for other immunization programs.

- *Support communication staff at provincial and municipal level*

  If the number of SM/C staff below the national level is not increased, it is unlikely that much progress can be made. Understaffed MOH offices cannot do it alone. If the MOH doesn't have funds or interest in expanding human resources and assigning SM/C personnel on a regular basis, then, PP need to take this deficit seriously, and find alternatives to ensure that SM/C are present. If this doesn't happen, it will be difficult to resolve many obstacles (e.g. on-and-off communication activities, lack of synergy between communication programs for PE and RI). It will not be a matter of just creating new positions, but rather, an issue of identifying what expertise is needed and where.

- *Consolidate the presence and activities of provincial and local SMCCs*

  Insufficient human resources partially explain why provincial and local SMCCs have functioned at a sub-optimal level. Commitment from the MOH, PP, and other organizations (e.g. media) to meet regularly and design communication activities that are not solely focused on NIDs are also needed. PP should work with members of the national SMCC to identify future courses of action to improve the workings of local SMCCs, the quality of communication plans, and coordination among levels.

- *Link communication for NIDs to RI and AFP surveillance*

  It would be important for PP to discuss ways in which communication staff and activities can be integrated into ongoing efforts to strengthen RI and surveillance. Communication for PE needs to be integrated with other programs and RI. Thanks to efforts by the MOH and WHO, the Antenna Surveillance System is on the right track, but much remains to be accomplished. Adding a communication component to the Antennas in terms of human resources and targeted community programs is necessary. Communication professionals could team up with surveillance medical officers in a few communities to identify ways and tasks for future collaboration.

Bangladesh

Challenges and Recommendations

Partners are confident about Bangladesh's chances to achieve certification-level surveillance in 2005, but as long as problems persist in India, excessive optimism is unwarranted. High awareness exists about keeping focus on internal and external challenges. Although it is too soon to call the PEI "a success," the improvement has been remarkable considering the situation a decade ago.

Despite substantial achievements, many challenges remain:

- *Risk of virus importation persists*

A 3,000-kilometer border between Bangladesh and India gives plenty of reasons to be cautious. Strengthening vaccination and surveillance is mandatory. A worsening of the situation in India might have disastrous consequences for Bangladesh, particularly given the intense cross-border traffic and the number of wild polio cases in neighboring states such as West Bengal. Despite the difficulties (coordination, funding), the planning and implementation of cross-border activities is crucial. Important decisions to deal with this situation have been already made. The distribution of information and vaccination of cross-border population, and the training of bus and truck drivers to identify AFP cases and give information to passengers are important steps.

- *Maintain broad commitment of the Ministry of Health and Family Welfare staff and the Government*

Although fatigue is not apparent yet, partners are concerned about the effects of conducting annual NIDs on the enthusiasm of health workers, and eventually, in many communities. As one interviewee puts it, "Bangladesh is the most NID'ed country in the world." Moreover, because the last polio case was recorded in 2000, many fear that PE may be losing steam as partners and staff assume that polio has been de facto eradicated.

Keeping the sustainability of the PEI and keeping it a priority in the agenda of the partners remains an important task. If support at all levels declines, this could turn into a severe problem given the birth rate and the potential number of missed children. Attention to urban areas, where approximately 20 percent of Bangladeshi children live, is crucial considering that regular access to poor and wealthy children has not been easy. Partners are well aware of the communication difficulties to reach those populations, and have implemented targeted strategies. Strengthening communication for RI and surveillance, particularly the IPC of health workers, is necessary.

- *Stagnant coverage rates*

Data on zero-dose children is inadequate, but available information suggests a possible downward trend. Needless to say, this would have negative consequences for PEI. To buck the trend, it is necessary to continue communication activities to address the lack of information about OPV (and other vaccines), particularly among high-risk, hard-to-reach groups, and increase awareness to shorten delays in reporting AFP cases. This should include strengthening family support and communication between HWs and caretakers. Attention should also be put on logistics and management issues that have not been satisfactorily resolved: staff shortage and retention, training and supervision of HWs, shortage of supplies, limited access to vaccination sites, and long delays during vaccination sessions.

Nigeria

Challenges and Recommendations

Given the enormous difficulties for PE in Nigeria, progress in all communication programs is necessary. It is clear that, besides communication solutions, the program needs important changes in management, logistics, and surveillance. If they are not addressed, it is difficult to envision a fast and substantial turnaround. Because one the main problems is access, improving advocacy efforts at all levels to maximize continuous access is crucial. Advocacy should not consist of one-shot actions or random action devoid of a master plan that indicates courses of actions and tracks progress. Continuous, sustainable advocacy at the local level, with both leaders and communities, is needed. Advocacy should follow a detailed plan of responsibilities and goals among partners in local SMCCs. It should be based on detailed, state-by-state diagnoses of the situation. PP should increase activities to mobilize support from community leaders and local opinion makers.

Support/commitment to PE should be approached as a behavior change issue, discriminating between "doers/supporters" and "non-doers/non-supporters" to understand motivations and incentives explaining why specific leaders support, undermine, or shift their positions about PE. This perspective offers a way to understand whether resistance is based on misinformation/lack of information, religious, and/or political reasons. Once a comprehensive behavioral diagnosis is produced, advocacy should be strategically planned, identifying actors and expected actions. Monitoring of advocacy is needed, too. However, monitoring should not stop at tracking appearances in flag-off events or media space; it needs to follow how the (in)action of decision-makers affect PE at district levels. Who should take leadership isn't clear as PP are short-staffed and are already spread too thin in various states. An advocacy task-force integrated by a number of partners seems necessary, not only to bring together resources and technical expertise, but also to send a message about the significance of political commitment for all actors.

Even if such advocacy actions, plans and approach are put in action, it is unlikely that they would be effectively used as long as SMCCs in states and LGAs meet sporadically, lack sufficient human resources, aren't fully integrated, and design micro-plans haphazardly.

Recommendations

- Strengthen training of HWs and VTs with well-planned communication and negotiation modules (that are not hastily put together at the last minute).
- Ensure the recruitment of local and gender-equitable VTs who are local residents and aren't simply political appointees.
- Improve monitoring and supervision of HW's IPC.
- Find solutions to money management deficits by negotiating changes with federal/state/local policymakers towards building a more decentralized system of financing and payment delivery.
- Find ways to increase the sustainability of SMCCs at state and LGAs, and ensure fluid communication with the federal SMCC, and planning communication activities ahead of time. Without a substantial and targeted increase in the number of communication staff, improvements seem difficult.
- Build capacity in micro-planning, operations research and program strategic design in ways that are directly connected to actual interventions.

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