

Strengthening Immunization Programs

The Communication Component



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Lora Shimp

 **BASICS II**



Abstract

Advocacy, social mobilization, and program communication should be an inherent part of immunization programs. Communication activities complement other immunization technical components, such as quality of service; cold chain and logistics; surveillance, reporting, and data management; and training, supervision, and monitoring. This report provides an overview of immunization communication and describes how to maximize its contribution to immunization programs in developing countries. The discussion and examples focus on communication's place within immunization planning, activities, and partnerships, based on lessons learned from behavior-centered analyses and programming. A detailed case study of Madagascar's immunization communication activities is provided as an example of country implementation.

Recommended Citation

Lora Shimp. *Strengthening Immunization Programs: The Communication Component*. Published by the Basic Support for Institutionalizing Child Survival Project (BASICS II) for the United States Agency for International Development, Arlington, Virginia, May 2004.

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BASICS II is a global child survival project funded by the Office of Health and Nutrition of the Bureau for Global Health of the U.S. Agency for International Development (USAID). BASICS II is conducted by the Partnership for Child Health Care, Inc., under contract no. HRN-C-00-99-00007-00. Partners are the Academy for Educational Development, John Snow, Inc., and Management Sciences for Health. Subcontractors include Emory University, The Johns Hopkins University, The Manoff Group, Inc., the Program for Appropriate Technology in Health, Save the Children Federation, Inc., and TSL.



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Acknowledgments

Many colleagues contributed to this document. Special appreciation and recognition go to immunization and communication representatives from the United States Agency for International Development (USAID), the Basic Support for Institutionalizing Child Survival Project (BASICS II), the CHANGE Project, the United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), the Children’s Vaccine Program (CVP), and the various participants and organizations in the Communication Consultative Group who have contributed to communication and social mobilization for immunization and polio eradication during the last several years.

Particular thanks go to the following individuals and partners, whose work has been adapted for and directly shaped much of the content and lessons learned in this document: Grace Kagondou, Mike Favin, Robert Steinglass, Rebecca Fields, Judy Graeff, Scott Wittet, Yaya Drabo, Thilly deBodt, Mary Harvey, Ellyn Ogden, Elizabeth Fox, Peter Gottert, Nancy Harris, Mary Carnell, Josoia Samson Ralaivo, Aime Randriamahalina, Michel Othepe, Antoine Sakasaka, Yolande Vuo Masembe, Humphrey Megere, Patrick Isingoma, the Democratic Republic of Congo Inter-agency Coordinating Committee (DRC ICC), the Madagascar ICC, the Uganda National Expanded Program on Immunization (UNEPI), and the Ghana ICC and Communication Standing Committee-Expanded Program on Immunization (CSC-EPI).

Acronyms

AFP	Acute Flaccid Paralysis
BASICS	Basic Support for Institutionalizing Child Survival
CASC	<i>Comité d'Action de Sante Communautaire</i> (Community Health Action Committee)
CBC	Communication and Behavior Change
COGE	<i>Comité de Gestion</i> (Management Committee)
CORE	Child Survival Collaborations and Resources Group
COSAN	<i>Comité de Santé</i> (Health Committee)
CPSSD	Community Problem Solving and Strategy Development
CSC	Communication Standing Committee
CVP	Children's Vaccine Program
DPS	<i>Direction Provinciale de la Santé</i> (Provincial Health Department)
DPT	Diphtheria, pertussis, and tetanus vaccine
DPT/HepB	Diphtheria, pertussis, tetanus and hepatitis B
EPI	Expanded Program on Immunization
GAVI	Global Alliance for Vaccines and Immunization
GF	<i>Groupes de Femmes</i> (Women's groups)
ICC	Inter-agency Coordinating Committee
IEC	Information-Education-Communication
JSI R&T	John Snow, Inc. Research and Training Institute, Inc.
MOH	Ministry of Health
NAC	<i>Nutrition à Assiste Communautaire</i> (UNICEF-funded community-based nutrition projects)
NGO	Non-governmental Organization
PVO	Private Voluntary Organization
RED	Reaching Every District
SANRU	<i>Santé Rurale</i> (Rural Health Project in the Democratic Republic of Congo)
SBC	<i>Agents Sanitaires de Base Communautaire</i> (Community-based Health Agents)
TFI	Task Force for Immunization
UNEPI	Uganda National Expanded Program on Immunization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VOA	Voice of America
WHO	World Health Organization

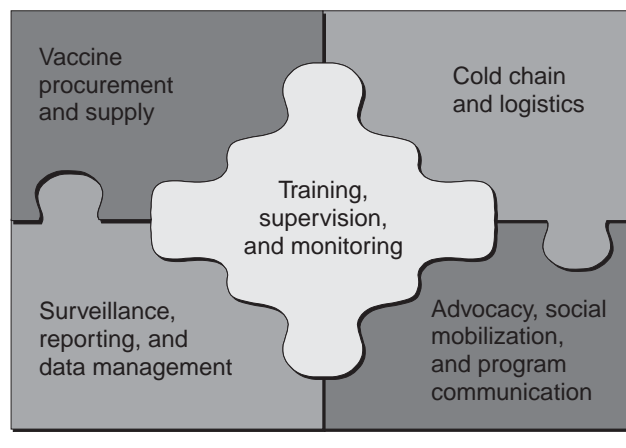
Introduction

In the public health arena, immunization is often perceived in terms of availability and cost of vaccines, their storage and handling, and the ability to prevent, control, and monitor vaccine-preventable diseases. The physiology of an immunization program, however, involves additional key components, as illustrated in Figure 1 below.

As part of a complete immunization program, communication efforts should be inextricably linked to and complement the other immunization technical components, including the provision and quality of services, health worker capacity-building and skills, and disease reporting and surveillance.

The primary audiences for this document are immunization technical experts and communication specialists who work with immunization programs at global, regional, national, and sub-national levels. It provides an overview of the communication component in immunization and how the contribution of communication can be maximized in immunization programs. The discussion and examples focus on communication's place within immunization planning, activities, and partnerships, based on lessons learned from behavior-centered analyses and programming.

Figure 1. Immunization Program Key Components



The Role of Communication in Immunization Programs

In most situations, communication efforts alone cannot raise coverage; in concert with other immunization components, however, they play an important role in achieving the goals of improving coverage and reducing drop-outs. If service delivery is of good quality and outreach to the population is active, effective communication will assist in raising awareness, creating and sustaining demand, and encouraging acceptance of vaccination services.

Various interventions and strategies fall within the broader headings commonly used in the immunization arena—“communication” and “social mobilization.” For ease of discussion in this document, an immunization communication program generally includes advocacy, social mobilization, and program communication (including behavior change activities), all of which function to increase and sustain demand, acceptance, and utilization of immunization services. Examples of communication activities include advocating to make immunization a priority of decision-makers, mobilizing communities to participate in immunization services, and educating caregivers about the importance of immunization (thereby influencing them to have themselves and their children completely vaccinated according to schedule).

Communication activities that are sufficiently planned, funded, and integrated with service delivery can help Expanded Program on Immunization (EPI) programs:

- **Achieve higher coverage rates for all antigens and reductions in missed opportunities, un-reached children, and drop-out rates** by mobilizing sectors and resources from national to community levels to support immunization;
- **Reduce morbidity and mortality due to vaccine-preventable diseases** by facilitating community awareness of immunization as a public health priority and by ensuring commitment and participation in immunization services and disease detection and reporting;
- **Implement immunization policies and action plans** through effective communication of facts and figures on vaccine-preventable diseases, as well as through intensive advocacy to ensure participation of leaders and communities;
- **Mobilize financial resources** and lobby other donors and organizations from various sectors and the community to support immunization;
- **Strengthen understanding** between the Ministry of Health (MOH) and EPI staff and other government agencies, the Inter-agency Coordinating Committee (ICC), non-governmental organizations (NGOs), the community of financial backers and donors, and provincial or district officers;
- **Improve quality of services to meet demand, improve interaction between health workers and communities, and improve safety of injections and safe handling of vaccines;** and
- **Prevent or dispel misinformation and doubts** related to immunization through the use of multiple channels, information sources, and media that influence the population and public opinion.

Barriers and Challenges to Immunization Communication

Various barriers and challenges (e.g., lack of community involvement in program planning and service utilization, lack of information provided to target audiences explaining the benefits of immunization) can impede the effective implementation of the communication component within immunization programs. For example, some policymakers and community leaders may not be aware of immunization services or may not view immunization as a priority compared to other health, societal, or political issues. Caregivers may not know when or even understand that they need to bring their children back for additional vaccinations, particularly if health workers have not carefully explained the vaccination schedule to them.

Potential barriers to communication include:

- Poor communication skills or practices of health care workers, community leaders, or policymakers;
- Lack of a well-defined communication strategy for determining appropriate messages, channels, materials, and needed inputs;
- Messages that focus on the desirability of immunizing one's children (which the majority of caregivers already accept) rather than on information relevant to the local context;
- Failure to address or sufficiently address communication in EPI meetings, or failure to properly integrate communication into EPI plans, budgets, or activities;
- Few agencies, communication specialists or institutions, or community partners involved in communication for and support of EPI;
- Lack of community involvement and interaction in planning and communication related to service delivery and outreach, resulting in problems with compliance or perceived resistance to immunization;
- Lack of human, financial, and material resources;
- Insufficient communications infrastructure (e.g., few radio stations, few radios, insufficient transport and equipment for mobilizers and communication teams, inadequate publishing capabilities); and
- Competing health priorities and over-committed staff.

Barriers to communication may therefore relate to service delivery, interaction with communities, channels of communication, or content or clarity of the messages themselves. They can occur at national, provincial, and district levels and can also be institutional, given organizational differences. If not addressed within the immunization program, these barriers weaken the effectiveness of the communication component.

Although some of the barriers noted above should be dealt with as part of the overall immunization program, many can be addressed through implementation of strategies and approaches that are more specific to communication and that are outlined in this document.

Partners and Coordination in Immunization Communication

At the Global and Regional Levels

Global and regional partnerships among technical experts and donors are important for helping to define and advance the immunization agenda. One example of such a partnership is the Global Alliance for Vaccines and Immunization (GAVI), which brings countries and partners together to strengthen routine EPI and introduce new and under-utilized vaccines. In addition, the regional Task Force for Immunization (TFI), an 11-year partnership of various organizations, has helped to shape and guide immunization support for Africa. A sub-group specific to supporting immunization communication has grown out of the TFI (see box, *The Communication Consultative Group*).

Partner coordination can serve to solidify funding, provide specialized technical expertise to countries, and utilize the comparative advantages and strengths of various organizations. In the area of immunization communication, partnerships involve a variety of experts (e.g., immunization technical experts, health communication specialists, behavioral scientists, journalists, radio and television producers and distributors, public relations experts, training

The Communication Consultative Group

In the mid-1990s, the role of communication in intensified efforts to eradicate polio in the Africa region, as well as in supporting improvements in routine immunization and surveillance, was recognized by partners. The Task Force for Immunization (TFI) recommended the formation of a social mobilization sub-committee in 1996. A communication consultative group was formed in 1997 and comprised communication and immunization experts from international organizations and countries, including the Expanded Program on Immunization (EPI) and Health Education Units of Ministries of Health (MOHs), World Health Organization (WHO), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID), Basic Support for Institutionalizing Child Survival Project (BASICS), CHANGE project, Child Survival Collaborations and Resources (CORE) Group, Children's Vaccine Program (CVP), Voice of America (VOA), and others, all working at national, regional, and global levels.

Through an annual meeting (hosted by the WHO's Regional Office for Africa, held in November, and coordinated with the TFI) and an extensive communications network involving e-mail, telephone communication, and issue-specific sub-regional meetings and workshops, the group has developed and implemented joint work plans and coordinated technical assistance to countries throughout Africa. Regional and country communication focal points have been trained and serve as field representatives for this broader network of partners. Meetings, workshops, and other coordinated activities provide a forum for countries to share their lessons learned and exchange country-to-country and regional information and experiences to improve immunization communication program activities and support.

In addition, successes and challenges are shared at global meetings of immunization communication partners. Every June, UNICEF (New York) hosts one such meeting, which is attended by communication experts from around the world and which facilitates regional exchanges, particularly between Africa and Asia. The discussions during and recommendations that emerge from these annual communication meetings are shared with immunization technical experts through TFI, the Polio Consultative Group of Experts, the Global Alliance for Vaccines and Immunization (GAVI), and EPI Managers' meetings, in order to influence global, regional, and national immunization agendas and programs. Maintaining this network requires not only committed partners and focal persons from the various organizations, but also sustained financing for immunization communication activities and positions. Financing is a challenge: Additional sources must be secured as polio eradication funding is reduced.

organizations, social marketing companies, and financing experts). Partners should include national technical experts from various levels and those who can provide international and cross-country, state-of-the-art immunization and communication experiences for adaptation and use within the country. Consistency and adaptability of programming (among partners and over time) assist with technical implementation and sustainability of initiatives. Although diversity of interests among donors exists, finding common ground and complementarities in the support provided will assist in achieving long-term goals. Continuity is further achieved if projects and donors agree and build on a strong communication framework that utilizes existing communication, immunization, and public health networks.

Partnering is an investment, particularly of time and human resources, to enable harmonized approaches, joint planning, meetings, and coordinated activities that will work effectively and efficiently in the field. For these networks to function well, commitment and transparency are needed. Clearly articulated and agreed-upon work plans, strategies, and timelines should guide the process in order to ensure quality and adherence to implementation schedules and priorities. Well-coordinated, inter-agency collaboration facilitates consensus on technical interventions, standardized materials and approaches, leveraging for additional financing and sustainability, as well as joint rapid responses when faced with unforeseen challenges such as natural disasters and political crises.

To achieve success, it is essential for program partners to leverage investments (e.g., financial resources, human resources, and equipment and supplies). Securing these investments is often accomplished through advocacy, negotiation, and agreement on the value added by the initiatives. Memoranda of Understanding and joint work plans signed by partners are effective mechanisms. Data supporting and documenting the achievements of the program are also helpful for leveraging partners, particularly those partners with broad development priorities that include health.

Key activities for a global or regional communication partnership to support immunization include:

- **Establishment and implementation of a comprehensive advocacy, information, and communication strategy** that encourages investment and support for immunization, meets the needs of routine EPI, and promotes interventions that control, eliminate, or eradicate vaccine-preventable diseases;
- **Provision of communication technical support** to strengthen the quality of communication plans and their implementation within country immunization programs, as well as to ensure their integration with GAVI initiatives and disease-specific interventions;
- **Strengthening of coordination** among international organizations and partner agencies, particularly at regional and country levels, in the areas of communication, information, and data on immunization indicators and vaccine-preventable diseases; and
- **Documentation, sharing, and dissemination** of country and inter-regional advocacy and communication experiences, lessons learned, tools, and activities.

At the National Level

Advocacy activities, supportive policies, and a favorable and inclusive program environment are important elements in developing the framework and foundation for immunization communication interventions. As the interventions are implemented and supported at different levels, advocacy and a mechanism for information exchange and feedback are needed at the national level and between provincial, district, health center, and community and household levels.

For a favorable policy environment, advocacy among inter-agency partners, with the leadership of governmental organizations, is critical. Collaboration for immunization

communication at the national level can be greatly facilitated through a functioning communication committee that works with the immunization ICC (see box, *Partner Coordination for Immunization and Child Health Communication in the Democratic Republic of Congo*). This relationship requires meetings and technical exchanges to revise, standardize, and clarify the technical policies that communication activities are to support. Achieving this buy-in may require several months, but it is absolutely necessary if institutional change is to be ensured. Time commitment and advocacy efforts need to be factored into the planning and development process.

An important follow-up step is to ensure that these policy changes are disseminated, understood, and implemented at sub-national levels. To foster a system of feedback and support within the health system, all levels need to be engaged in the decision-making process. High-level, in-country decision-makers (e.g., MOH, medical and nursing schools, other government ministries, and government and private institutions) must be informed of and support health initiatives to facilitate technical quality and consistency by inter-agency partners.

Numerous stakeholders and partners ensure adoption, success, and sustainability of health initiatives. The needs, priorities, and concerns of various stakeholders, including political and government leaders, inter-agency partners, NGOs, and community and traditional leaders, must be addressed for program continuity and success. These stakeholders can promote the program, leverage other partners and funds, interact with communities and focal points who understand local culture and communication channels, “champion” initiatives, and serve as an institutional memory for the program. Visionaries and champions—with technical vision as well as skills to implement ideas with colleagues at various levels—enable program success. These individuals and groups need to be dynamic as well as linked with the political and community networks that can put their ideas into action. Similarly, influential and respected colleagues working in the field can convince others to support and implement initiatives.

Communities are complex structures involving myriad groups and individuals with different priorities, concerns, and motivations. In mobilizing communities, immunization programs need to function within these structures to ensure support, participation, and success in improving coverage and reducing vaccine-preventable diseases. A variety of actors, therefore, should be engaged in program planning, implementation, and monitoring. These actors include:

- Political authorities;
- Local and traditional leaders;
- Religious leaders and institutions;
- Women’s groups and other community groups or associations;
- School-affiliated programs (e.g., clubs, scouts);
- Local media (e.g., radio stations, television broadcasters, journalists);
- Health providers (e.g., doctors, nurses, midwives, traditional and private practitioners); and
- Individuals in the community who are dynamic and who can serve as *animators* and mobilizers.

Partner Coordination for Immunization and Child Health Communication in the Democratic Republic of Congo

Inter-agency Coordinating Committees (ICCs) have been formed in countries to improve coordination among partners in support of immunization programs and control of vaccine-preventable diseases. In the Democratic Republic of Congo (DR Congo), the ICC for immunization, led by the Ministry of Health (MOH), was initially formed in 1996 to harmonize approaches and support for polio eradication. It quickly expanded to address the needs and encourage national-level consensus among donors and key health colleagues for routine immunization. The immunization ICC serves as a partnership between:

- The MOH (e.g., Expanded Program on Immunization (EPI), and the epidemiological, nutrition, and primary health care units);
- World Health Organization (WHO);
- United Nations Children's Fund (UNICEF);
- Foreign government donor partners (e.g., United States Agency for International Development (USAID), the Government of Japan, the European Union), and their technical sub-contractors (e.g., Basic Support for Institutionalizing Child Survival (BASICS), *Santé Rurale* (SANRU));
- Non-governmental and private voluntary organizations (NGOs/PVOs) (e.g., Rotary International, Doctors Without Borders, Catholic Relief Services); and
- Missionary groups (e.g., Catholic Medical Bureau, Protestant Church of Christ in Congo).

The technical functions of the immunization ICC are divided into two sub-committees with multi-agency representation: one to address technical and logistics issues; and the other to plan and implement communication, social mobilization, advocacy, and resource mobilization.

This latter sub-committee, the Social Mobilization and Resource Mobilization Sub-Committee, comprises communication experts in health and multimedia from the various partner organizations. The sub-committee has worked with the ICC to ensure that communication strategies and activities are included in immunization planning at all levels in the country, as part of technical documents produced to improve immunization service delivery and community engagement, and as a key component in immunization technical support. During the last several years, this relationship has resulted in:

- National, provincial, and health zone immunization and health staff receiving standardized training and support in communication techniques;
- Implementation of strategy-specific and annual immunization plans and technical documents that include sections on communication; and
- Development and use of immunization communication guidelines for community mobilizers and health staff, as well as numerous communication materials (e.g., radio spots, briefing materials, counseling cards, theater sketches).

Since 1999, this communication sub-committee model and the approaches described above have been applied to other child health areas, notably with nutrition and malaria task forces. As with the immunization ICC, these nutrition and malaria task forces are composed of various partner organizations and include a communication component within their structures. A Task Force for Communication for Health has also been formed to address overall child health and HIV/AIDS in DR Congo. Meetings and workshops have brought together NGOs, government agencies, and donor organizations to build and reinforce communication capacity in the country, identify key target behaviors and standardized and acceptable messages, and involve the media and other communication channels in providing child health and HIV/AIDS information throughout the DR Congo.

In order to develop a common vision, one key approach was the *matinée scientifique* (technical meeting of experts, officials, and media) to share technical expertise on a particular health topic and to advocate for governmental policy and societal behavior change for child survival. The *matinée scientifique* has been used by the multi-agency task forces, and has been organized by their communication sub-committees, to present and discuss critical child survival policy issues and recommended solutions with an audience of government officials, scientists, medical officers, health professionals, donors, media representatives, and other experts. Topics have included the efficacy of oral polio vaccine and eradication efforts, vitamin A supplementation and the importance of reducing vitamin A deficiency, changes in first-line treatment of malaria to reduce morbidity and mortality, and strategies and the epidemiological basis for measles control. Media coverage of these events has assisted in bringing critical health issues to the general public, building public trust, and building awareness of the importance of child health.

Fundamentals of Immunization Communication for National EPI Programs

Effective immunization communication requires integration of communication activities into EPI planning, structural support, management and technical inputs, and community involvement.

Integration of Communication Activities into EPI Planning

Communication activities must be included in overall EPI plans, modules, and other tools. A *communication component* should be included in the following documents:

- Multi-year EPI plan;
- Annual EPI action plans, in which a schedule of communication activities should be specified;
- EPI budget (prepared in time to permit disbursement of the necessary funds to cover expenses for communication materials production, equipment, training, organization of meetings, and transport);
- EPI training modules and technical guidelines (e.g., a section or module on communication, social mobilization, and advocacy can be incorporated);
- EPI reports (indicators and strategies to measure communication activities and link them to impact in improving immunization should be included in EPI assessments, reviews, and documentation of program activities and achievements); and
- Immunization records (as part of child health cards and immunization registers, as well as in training staff to use immunization cards as management tools for tracking vaccination status and as informational tools for caregivers).

Structural Supports

Focal Point within the Ministry of Health

To ensure involvement in day-to-day EPI activities, it is preferable to have a communications specialist whose position is secured within the EPI office. This focal point can also be placed within a health education or promotion unit in the MOH, provided that there is a system and defined terms of reference with the EPI to ensure regular and consistent collaboration and communication with the EPI.

Inter-agency Coordinating Committee

As noted above, many countries have an umbrella ICC composed of high-level authorities and donors in the country. In addition, countries will often have a technical branch or sub-committee that handles immunization technical and programmatic activities. A communication or social mobilization representative should be an active member of this immunization technical committee. The communication representative(s) should be involved in the planning, implementation, and evaluation of EPI activities in order to provide the necessary input on communication needed to create and sustain demand for immunization services.

Ideally, a communication person from the EPI office or representatives from the Social Mobilization/Communication Committee (discussed below) should actively participate in the technical committee meetings. This requires that communication focal points be identified and

included on participant lists, regularly attend and actively participate in technical meetings, receive meeting minutes, and contribute to and receive copies of other technical reports and documents.

Social Mobilization/Communication Committee

In many countries, immunization partners, donors, and technical support organizations are represented in a separate Social Mobilization/Communication Committee that specifically addresses communication needs (particularly for polio eradication) and provides input as a sub-committee of the ICC. Like technical sub-committees for other EPI components (e.g., logistics and cold chain or surveillance sub-committees), the Social Mobilization/Communication Committee provides technical input and strategies specific to Information-Education-Communication (IEC), social mobilization, and advocacy. Partners should understand the terms of reference for the committee, and the committee should have a designated chairperson to unite partners for regular meetings, planning, and reporting.

Joint Planning and Networking/Integration with Other Programs

Part of the EPI and ICC's roles should be to ensure communication activities and strategies are included in immunization program functions, particularly in planning and implementation with partners. To ensure cross-fertilization, immunization technical experts need to work with a mix of communication professionals, including those who have program management and design backgrounds, others who are in multimedia and advertising or are specialists in working with communities, and experts in social science and behavior change.

Management and Technical Inputs

As with the other elements of an EPI plan, the communication component needs to be explicit, data- and research-based, and supported by reasonable timeframes and an appropriate budget. The communication plan should address all aspects of EPI (routine immunization, surveillance, and disease control). Communication program management instruments and inputs include:

- Technical support documents (policies, guidelines, and general EPI technical documents that have communication indicators included with the EPI data being tracked); a first priority is a detailed and realistic communication strategy (see box, *The Importance of a Communication Strategy*);
- Strategic communication work plans that are jointly developed and have clear objectives, activities, and targets; that are revised through systematic annual, quarterly, or other reviews; and that define what type of support should be provided at the facility and community levels and how support should be provided;
- Budgets for communication inputs that are planned early in the process to secure the necessary funds for materials, training, activities, transport, support and operational costs, etc.;

The Importance of a Communication Strategy

Immunization communication programs are often insufficiently funded and supported to address all inputs. A first priority for immunization communication partners should be to have a detailed and realistic communication strategy that provides overall vision and is included with the Expanded Program on Immunization (EPI) strategic documents. The strategy should be based on formative research and behavior change communication analysis as well as on immunization assessment findings and recommendations. The communication strategy should outline how, to whom, and through what means communication interventions will be targeted and measured to demonstrate their contribution to improving immunization. This strategy should have realistic objectives, indicators to monitor progress, defined audiences and how they are to be reached, a timeline for implementation, and an illustrative budget that is ideally less than 15% of the overall immunization budget.

If funding is limited, advocacy with the Inter-agency Coordinating Committee (ICC) and other partners for additional resources to support communication should be conducted, using the strategy as a resource document. The initial focus should be on cost-effective interventions that can be combined with or developed within existing program activities (e.g., health staff training in communication skills as part of EPI training; focus on tools that are less costly or already in use, such as immunization cards and communication guidelines for health workers, media, and mobilizers).

- Coordinated and relevant/prioritized multi-channel and multimedia communication materials that are pre-tested, evaluated, revised, and disseminated;
- Monitoring and evaluation tools and indicators for communication (including clear definitions and methods on how these indicators are to be measured), and a communication monitoring and evaluation plan within the EPI plan (see box, *Note on Communication Indicators*);
- Supervisory and monitoring systems for performance improvement that include communication and community engagement skills (e.g., questions on and indicators for communication, advocacy, and social mobilization as part of supervisory checklists; communication skills of health workers observed during vaccination sessions; exit interviews conducted with caregivers);
- Package of communication-related tools (e.g., immunization cards with key information for caregivers, counseling cards for health workers, advocacy and media guides, key immunization messages, and guidelines for community involvement);
- Capacity-building structure to support communication interventions (e.g., communication focal points and experts, networks, training and supervision plans, reporting system); and
- Program for health staff on communication skills development and motivation (notably in relations-building and interpersonal communication with communities and caregivers) that involves training, team-building, performance monitoring, and working with partners.

Note on Communication Indicators

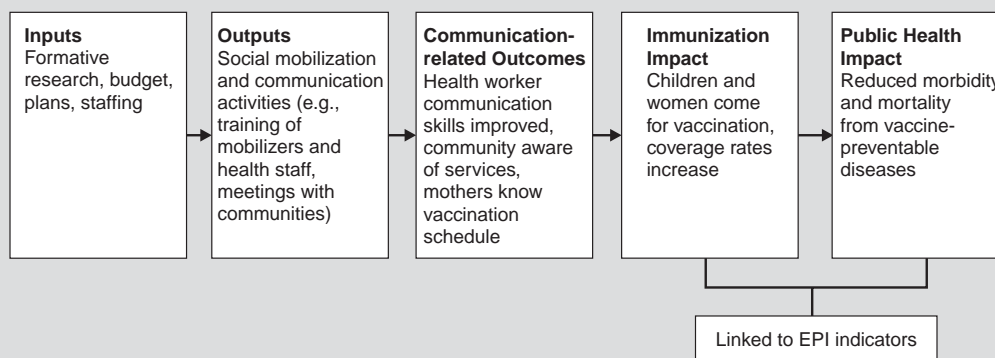
Indicators are needed to demonstrate that interventions are meeting their objectives and goals. Advocacy and communication activities alone cannot improve immunization programs, because they are a part of the various components (e.g., service delivery improvements and disease control efforts) that contribute to Expanded Program on Immunization (EPI) achievements. Most communication indicators are therefore process-oriented and measure inputs and outcomes of activities conducted. Indicators are most effectively measured and monitored at district or community levels through a combination of qualitative and quantitative methods, such as:

- Focus group discussions with mothers, health workers, and mobilizers;
- Exit interviews with mothers;
- Observation of immunization and mobilization sessions;
- Household surveys that include behavior or knowledge questions related to understanding of vaccination schedules and services;
- Determination of the number of health workers and mobilizers trained in communication; and
- Determination of the number of mobilizers working with the health center.

The impact of communication is tied to other EPI indicators and must therefore be measured within that context (e.g., increases in the number of women and children vaccinated, reduction in the number of drop-outs, increases in outreach sessions, and the number of local governments funding and supporting immunization activities).

If a priority of the EPI is to improve demand and utilization of services, the figure below provides an illustration of suggested inputs, communication outputs, and outcomes that could result, as well as their link to immunization indicators to be able to demonstrate immunization and public health impact.

A variety of immunization communication indicators are useful for measuring progress. Some examples of these indicators are listed below. The means of data collection for each group of indicators is also noted under each group heading.



Coordination

Possible data sources: Work plans, program reports, meeting minutes, program reviews, and assessments

1. Is there a communication/social mobilization sub-committee of the Inter-agency Coordinating Committee (ICC)? (y, n)
2. Does this committee include members of all major organizations providing EPI communication technical expertise? (y, n)
3. Does the communication sub-committee meet at least quarterly? (y, n)
4. Along with other topics, does this committee regularly address how to improve routine immunization? (y, n)

(continued)

Note on Communication Indicators (*cont'd*)

Planning/Input

Possible data sources: Work plans, financial documents, program reports, program reviews, and assessments

5. Is there a communication and advocacy section in the EPI multi-year plan? (y, n)
6. Is there a communication and advocacy section in the annual immunization work plan? (y, n)
7. Does the communication and advocacy component of the annual immunization work plan include a budget, with a schedule for the release of funds? (y, n)
8. Is a communication and advocacy component included in training, supervision, and monitoring activities outlined in the work plan? (y, n)
9. What is the percentage of the current annual EPI budget that is set aside for communication/advocacy activities?
10. Is there a focal person responsible for EPI communication activities? (y, n) If so, who is it, what position, from what organization or office?
11. Do communication/advocacy plans lay out ways in which the national level should provide technical and financial support to provinces/regions and districts? (y, n)
12. What is the number of districts with social mobilization and communication committees?
13. What is the number of outreach sessions planned in each district and health facility?

Outputs

Possible data sources: Work plans, program and training reports, program reviews, meeting summaries, and minutes

14. What are the percentages of the current annual EPI budget for communication/advocacy used for (a) broadcast media, (b) print materials, and (c) strengthening of interpersonal communication?
15. What percent of planned activities to reach the major un-reached or under-reached population groups were actually conducted?
16. What is the number of materials produced, disseminated, and visible/used in health facilities and by mobilizers?
17. What is the number of health workers and mobilizers trained in immunization communication? How many training sessions were conducted?
18. How many meetings were held by district social mobilization committees?
19. How many meetings were held with district and community leaders?

Outcomes (Linked to EPI Indicators)

Possible data sources: Supervisory checklists, field observation, exit interviews, grab sampling, key informant interviews, and program reports

20. What is the number of health staff providing key messages during immunization sessions?
21. What is the number of mothers with vaccination cards?
22. What is the number of vaccination cards correctly completed?
23. What percent of the budget was spent on communication activities according to plan?
24. How many mothers (women) know when to return for the next vaccination?
25. What is the number of households visited by mobilizers?
26. What is the number of unvaccinated children identified by mobilizers?

Impact (EPI Indicators)

Possible data sources: Program reports, coverage surveys, routine data, and supervisory checklists

27. How many women and children were vaccinated?
28. What are the drop-out rates (percentages)?
29. What is the number of planned outreach sessions actually conducted?
30. What is the number of district and local governments funding and supporting immunization activities?

Community Involvement

In order to enhance their understanding of the importance of immunization for the protection and quality of life of children, EPI plans should involve not only system improvements and health staff capacity-building but also consider how the program is linked with communities, including opinion leaders, traditional authorities, religious leaders, and caregivers. To support effective communication, EPI staff should collaborate with communication and behavior experts who can contribute their expertise to the planning and implementation of communication activities.

A situation analysis that identifies and involves key stakeholders should be a starting point for planning an immunization program in districts and with communities. Stakeholders may include religious, traditional, and political leaders, as well as media representatives who have access to and influence within these communities. Involving them during the planning phase is important for ensuring compliance and aid with implementation.

Consulting with the community and using participatory planning techniques will engage key local partners in the program from the beginning. During the planning phase, an assessment of the public health situation should identify the target audiences, reflect the social environment and community priorities and needs, identify current and proposed health behaviors, and address program resources and constraints. The assessment should elucidate communication issues relevant to the proposed intervention, particularly local means of information dissemination, persuasion, and social exchange, all of which are important socio-cultural issues.

Traditional communication channels add value to immunization programs, especially when the channels used are highly credible, and when they are combined with messages transmitted through service delivery. Examples include communication between health staff and communities (including local leaders, community groups, and other networks) on the dates and locations of vaccination, as well as interpersonal communication between health workers and caregivers on the child's vaccination schedule and how to understand and use the immunization card.

Programs can also use traditional communication channels to collect and disseminate information, because these channels offer opportunities for participation by local people. Traditional methods should be combined with modern methods of information dissemination, such as use of radio and television. Use of these communication channels will assist in informing communities and mobilizing them to participate more actively in services. An example from Uganda illustrates how improved communication between communities and health staff can be beneficial in building community awareness and more effectively engaging communities in planning and implementation of services (see box, *Community Problem Solving and Strategy Development in Uganda: Kiboga District*).

Community Problem Solving and Strategy Development in Uganda: Kiboga District

A knowledge, attitudes and practices study in Uganda in 1998 found that although communities were aware of and willing to support immunization, their knowledge about the details of immunization and their involvement in decisions about service delivery were limited. The Uganda National Expanded Program on Immunization (UNEPI) Policy and Revitalization Plan called for community involvement in health and linkages between health workers and the community. Community Problem Solving and Strategy Development (CPSSD) activities were designed to help health staff communicate with communities to understand their knowledge and perspectives about services, to use communication to encourage community support and participation in the delivery of services, and to raise and sustain immunization coverage.

Through CPSSD, a team of district facilitators (initially supported by UNEPI and the Basic Support for Institutionalizing Child Survival (BASICS II) staff) train health workers in health facilities in activities that involve community participation in immunization programming. The CPSSD approach is as follows:

1. Health workers are encouraged by district facilitators to interview parents in their communities to discover what these parents know about immunization services and what their perceptions are about services.
2. Health workers then attend a three-day consultation with fellow health workers from their Health Sub-District to compile and analyze the information gathered. During this consultation, they learn new ideas for working with people in the community and develop action plans to apply this new approach and communicate more effectively with individuals and communities.
3. Two months after the initial consultation, health workers attend a two-day second consultation, during which they share their experiences, progress, and lessons learned; this consultation encourages workers to learn from others' experiences. Use of the Drop-out Rate Monitoring Wall Chart is explained and data tracking and interpretation are practiced.
4. Following the second consultation, health workers return to their communities and perform outreach activities, such as making home visits, holding community meetings, calling sessions with local civic groups (Parish Development Committees) and Local Council leaders, having regular discussions with community leaders, and forming partnerships with community mobilizers. During these activities, the health workers discuss information regarding immunization, identify problems, and agree consensually on solutions to increase coverage in the community.
5. At the end of each consultation, health workers develop a new action plan, then agree on a date for the next meeting for a continuous stream of information and education.

What are the Results of CPSSD?

In addition to the health workers' individual plans, a strategy for each of five project districts has been developed, based on each district's priorities. Activities and results have varied from district to district, but so far the results are showing improvements in immunization services.

The CPSSD strategy was initiated in the Kiboga District in September 2002, with the second consultation in May 2003. After health workers and the District Health Team shared the low immunization coverage figures with local political leaders, the two groups held community meetings and conducted home visits during which they encouraged communities and families to get their children immunized. Additional and more convenient outreach sites were also planned.

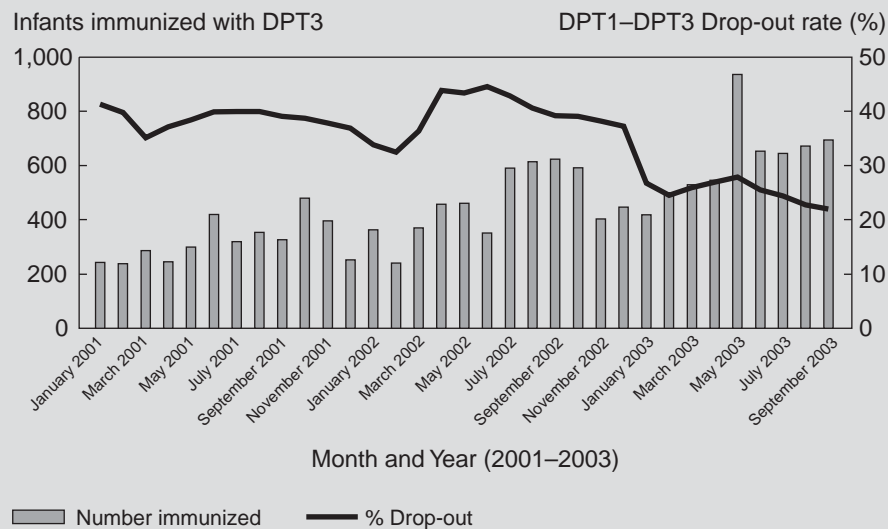
As a result, there has been a steady increase in coverage, as well as a distinct improvement in the drop-out rate. The district's drop-out rate for diphtheria, pertussis, and tetanus vaccine (DPT) has declined from 39% in September 2002 to only 22% in September 2003 (see figure). This improving trend is even more impressive when the very low ratio of health workers per capita is considered.

While immunization coverage in the district had increased for a few months prior to the implementation of CPSSD, this increase was short-lived, and probably resulted from the one-time release of funds from UNEPI headquarters to pay allowances for mobilizers. The central level cannot sustain such financial support. But the relatively low cost of implementing the CPSSD strategy in a district, approximately USD \$7,000, is leading not only to long-term and sustained reductions in morbidity, mortality, and disability, but also to more cost-efficient health services.

(continued)

Community Problem Solving and Strategy Development in Uganda: Kiboga District (cont'd)

Infants Immunized with DPT3, and DPT1–DPT3 Drop-out Rates by Month, Kiboga District (2001–September 2003)



The current trend in the Kiboga District indicates a steady and sustained increase of fully immunized infants.

Lessons Learned

- Effective communication and planning with communities contributes significantly to reducing drop-outs and ensuring that children are fully vaccinated. Although communication and community involvement also assist in increasing coverage, they are most effective when combined with service delivery and logistics improvements that address access constraints (e.g., overcoming difficulties in transport, infrastructure, and geographic barriers).
- Health workers recognize the gap between medical culture and local culture and how best to bridge this gap through improved communication.
- Interpersonal communication between health workers and parents, and attitudes and perceptions of roles, can dramatically change. These alterations, which are key to the success of the approach, are demonstrated by the quotes from CPSSD participants below:

“Communication between the health workers and the community has improved. Before we just assumed that the mothers knew [about immunization].”
—Participant from Ikoba Health Centre III, Masindi

“Mothers are now more free and friendly. So am I.”
—Participant from Inomo Health Centre II, Apac

“I talk with the community now, and more children are being brought for immunization. Before, I was telling people what to do. Now I am discussing with them.”
—Participant from Masode Health Centre, Kiboga

Source: BASICS II. 2003. *Increasing immunisation coverage in Uganda: The community problem solving and strategy development approach*. Arlington, Va.: BASICS II.

Immunization Communication in Practice

How do the various immunization communication issues, inputs, and strategies outlined in this document come together into a comprehensive approach within the immunization program? A case study from Madagascar (Annex) is included to provide an illustrative example that can be referenced and adapted for immunization communication programs and activities in other countries.

Efforts for long-term and institutionalized improvements in immunization communication require continuing inputs, monitoring, and adaptation. As each country's needs and funding situation are different, there is no single, standardized set of communication approaches that can be used as a model or template for every country to follow. As a priority, country immunization programs and their partners need to commit funding and staff to focus on the communication component, while ensuring that an immunization communication strategy exists and its activities integrated into EPI initiatives. The strategy should be implemented, monitored, and revised with the EPI as well as with the ICC and its sub-committees. The challenge is to determine which advocacy, social mobilization, and communication activities will take precedence. A core set of activities should be outlined, to avoid having an exhaustive list of possibilities that are never implemented or defaulting to communication materials or activities that have been used in the past but never assessed for their quality or impact. Strategy development can be best accomplished through a situation analysis and a focus on key behaviors and target audiences that will participate in immunization services at various levels in the country. Using this analysis, communication activities should be prioritized to concentrate efforts and finances on those activities that are most cost-effective and feasible within defined timeframes. These activities should then be implemented, tracked, and reported as part of other EPI activities to demonstrate their contribution to achieving immunization goals.

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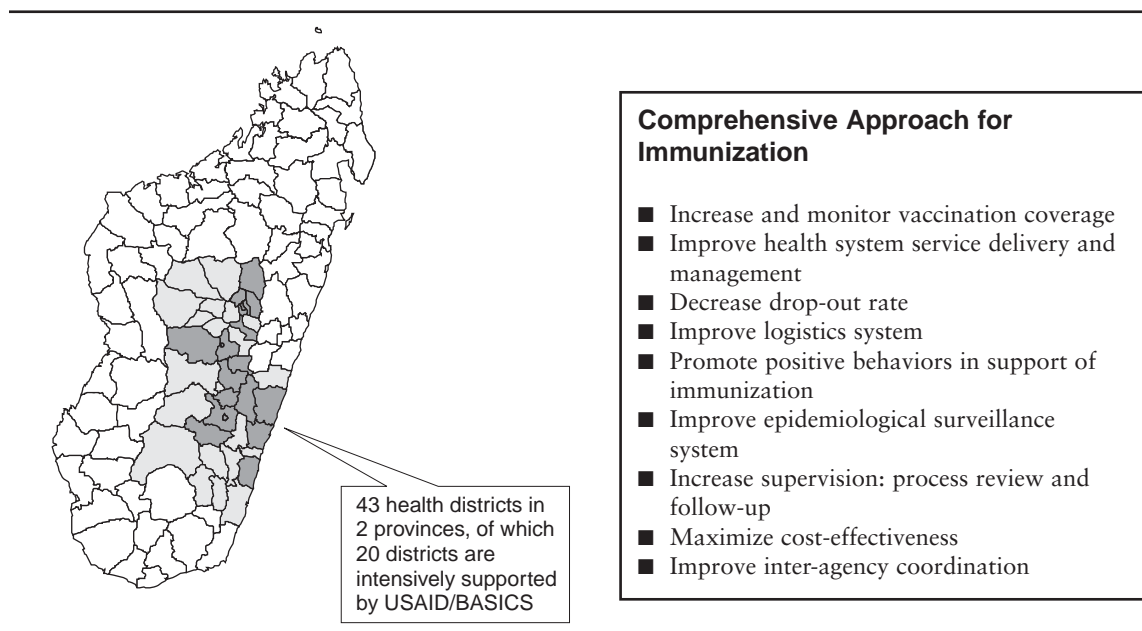
ANNEX

Demonstrating Communication Impact: Madagascar Case Study

Overview and Context

The Madagascar Vaccination Service (EPI) has been working with its Inter-agency Coordinating Committee (ICC) partners to improve vaccination coverage nationwide and introduce a new vaccination (hepatitis B) as well as system improvements through approaches like Reaching Every District (RED).¹ The United States Agency for International Development (USAID), through its Jereo Salama Isika project (which ran from 1999 to 2003) and Basic Support for Institutionalizing Child Survival (BASICS II) immunization support, has been a key partner in this initiative. Assistance has been provided along with the EPI in the USAID-supported districts and provinces of Antananarivo and Fianarantsoa (see Figure A-1 below). These provinces include more than half of the Malagasy population, including over 300,000 children less than 12 months of age. ICC partners (notably EPI, USAID and its contractors, United Nations Children's Fund (UNICEF), World Health Organization (WHO), World Bank, and local non-governmental organizations) are currently applying the approach developed nationwide to reach the approximately 604,000 children less than 12 months of age in Madagascar.

Figure A-1. Immunization Activities in USAID-supported Districts, Antananarivo and Fianarantsoa



1. Reaching Every District (RED) is a multi-faceted approach supported by immunization partners globally for improving routine immunization at the district level in countries. The main components of RED include re-establishing outreach vaccination, supportive supervision, linking communities and services, monitoring for action, and planning and management of resources.

With support from the Global Alliance for Vaccines and Immunization (GAVI) beginning in 2001, increasing attention was given to improving EPI in Madagascar, particularly at district and provincial levels. From December 2001 until April 2002, health services, including EPI, were disrupted throughout the country, largely due to lack of resources and fuel shortages related to the political crisis in the country. This disruption had a negative impact on immunization services and resulted in reductions in coverage in 2001 and 2002.

The return of political and economic stability, improved coordination of the ICC, and continuing GAVI support in the second half of 2002 led to a reinvigoration of immunization activities, including a focus on district-level immunization tracking and reporting. Renewed efforts have resulted in more complete monitoring of immunization indicators through routine reporting at district and provincial levels in 2003 and 2004.

USAID partner and EPI support for immunization in the focus provinces and districts has involved a comprehensive set of activities, predominantly based on a three-pillar approach:

1. Increase demand for vaccination;
2. Improve quality of and access to services; and
3. Improve staff performance, including their interaction and planning with communities and caregivers.

In addition to systems strengthening activities to increase coverage, to reduce drop-out, and to ensure the availability and reliability of immunization services (e.g., vaccine distribution and stock management, cold chain equipment and maintenance, and fuel), the focus in these districts since 2003 has included more active engagement of the community in improving utilization of services.

Situation Analysis

The need to improve the communication component of EPI was discussed with the ICC during micro-planning for 2003. In investigating ways to improve implementation of the immunization communication strategic plan, BASICS II and John Snow, Inc. Research & Training Institute, Inc. (JSI R&T) agreed to assist with operations research in several districts to identify barriers, needs, and opportunities to improve communication between the various groups for immunization. Problems identified with health staff and communities included:

- Poor knowledge about the advantages of vaccination;
- Low awareness of services;
- Concerns related to reactions to injections and adverse events following immunization;
- Poverty and lack of time to go to health centers (including distance to services);
- Lack of outreach services;
- Undesirable health worker behavior;
- Insufficient community mobilizers and mobilizers not always well-received by parents;
- Lack of involvement of local leaders; and
- Various beliefs, customs, and rumors, and use of traditional practitioners who either discourage immunization or cause doubts related to immunization.

As a result of these findings, a new strategy for EPI communication was implemented. The strategy incorporated supervisory guidelines for community activities that included EPI communication, further elaboration of key EPI messages and materials, and further involvement of local leaders and other government programs outside of the Ministry of Health in re-launching EPI within community development.

Process and Implementation

The immunization communication process conducted in the focus districts and provinces involved advocacy efforts, mass media (e.g., local radio), and sharing of immunization data and results through trainings and meetings with health staff, community leaders, and a variety of community groups and existing networks. Details on the program components are outlined and described in the list and sections below:

- Communication strategic plan developed and directives in place at central level;
- Production in local languages and distribution of a package of Information-Education-Communication (IEC) materials related to maternal and child health, including immunization, through partners working in all 111 districts;
- Media campaigns on child health, including importance of routine immunization and community involvement in acute flaccid paralysis (AFP) reporting, on national and provincial radio;
- Regular health education sessions conducted in health centers and IEC materials utilized and visible in health centers;
- Designation of an IEC focal person in supported districts;
- Active involvement of local authorities in community mobilization and reinvigoration of community agents in 10 intensive districts;
- Advocacy with leaders at all levels to lead coordination of health interventions and to support application of immunization policies, and better planning and use of services with communities; and
- Communication skills of health facility and district staff in districts strengthened through on-the-job training and supervisory activities to improve coverage and reduce drop-outs (focusing on key behaviors related to immunization).

Advocacy with Local Authorities and Community Leaders

Advocacy focused on mobilizing local political, administrative, and religious leaders in the provinces, with the general objective of encouraging resource people to support polio eradication and revitalization of EPI. Local leaders were to support and participate in these initiatives, assist with fostering community participation, and motivate health staff to improve their activities.

Formative Supervision and Monitoring of Community and Health Agents

Provincial, district, and health center staff were engaged in monitoring and documenting the impact of communication on vaccination services and providing technical support for integrated communication planning to engage authorities, health staff, and communities. In the two supported provinces, 40 communities in 10 districts benefited from this training and monitoring. These communities were chosen based on low vaccination coverage, high drop-out, an elevated population, and weak community engagement. Table A-1 shows the number and affiliation of the various community representatives engaged in this effort, including volunteer *animators* who provide basic information on immunization and track missed and defaulting children within their communities.

Activities involve EPI and AFP awareness meetings with community leaders and refresher training for district IEC representatives. With health centers, the focus is on use of standardized management tools—a monthly filing system to track defaulters, mother and infant tracking records, maternal and child health cards, and vaccination and stock notebooks—and presentation of indicators, coverage graphs, monitoring of defaulters, and data analysis for improved self-monitoring by health staff. This system also involves a community agent monitoring curriculum

and administrative documents focused on health agents; it includes a situation analysis, terms of reference for community mobilizers, guidelines on planning sessions and working with communities, and a feedback system for health staff and communities. Team-building activities were conducted with District Health Teams for clarification of their role. Supervisory teams were formed to monitor progress and included two district staff, the health center head, a community leader, and a BASICS II or JSI R&T technician. In addition to this system and commitment by the health staff, key to successful implementation was having the IEC materials (see Figure A–2) in place (health cards, vaccination flags, lists of defaulting children and women, diplomas for completion of immunization series, and the monitoring tools noted above).

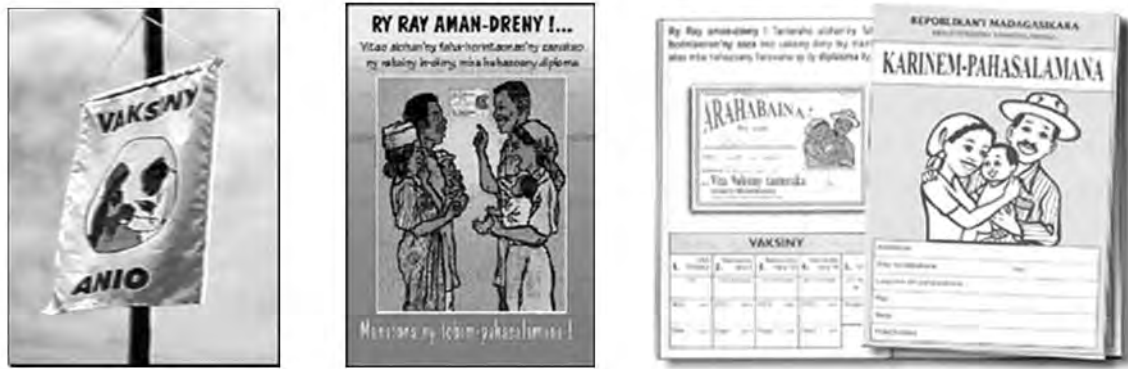
Table A–1. Number and Affiliation of Community Representatives

	<i>Direction Provinciale de la Santé</i> (DPS) (province)	Antananarivo	Fianarantsoa	Total
	Commune	36	44	80
	Health personnel	113	71	184
Community leaders	Leaders	186	311	497
	Religious leaders	1	19	20
	<i>Comité de Santé</i> (COSAN) & <i>Comité de Gestion</i> (COGE)	59	32	91
Community agents	Animators	1,065	1,344	2,409
	<i>Comité d'Action de Santé Communautaire</i> (CASC)	55	129	184
	<i>Agents Sanitaires de Base Communautaire</i> (SBC)	74	19	93
	<i>Groupes de Femmes</i> (GF)	69	82	151
	Teachers	7	32	39
	Matrons	1	15	16
	<i>Nutrition à Assiste Communautaire</i> (NAC)	17	11	28
	Others	116	67	183
	Total trained	1,763	2,132	3,895

Media Partnerships

In addition to the community mobilizers involved with immunization, partnerships with the media are an important component of the program. Contracts with local radio stations to air EPI spots have been signed and monitored. Payment is based on validation of the broadcasting of the spots (which include “bonus” spots on AFP and EPI in addition to the agreed-upon timeslots) and on interviews and discussions with health staff, authorities, and communities on immunization. On average, four to five spots per day have been aired on 15 radio stations (four in Antananarivo, five in Antsirabe, three in Ambositra, and three in Fianarantsoa).

Figure A–2. Information-Education-Communication Materials



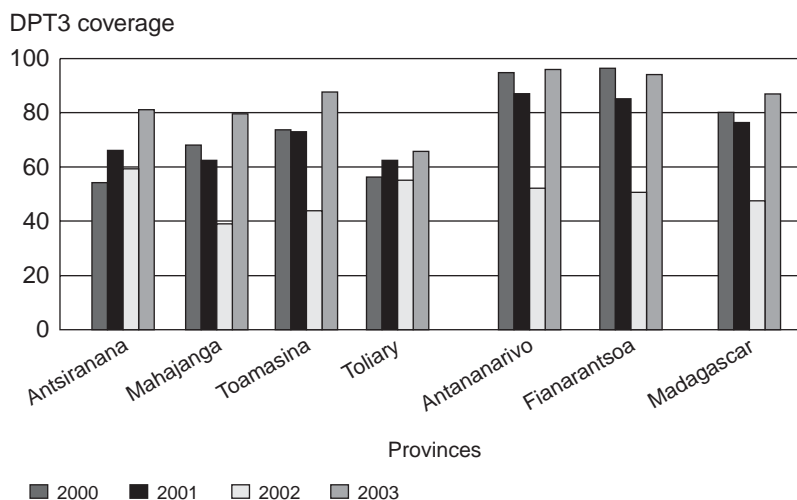
Elaboration of Technical Guidelines on Community Involvement and Monitoring

In September 2003, as a result of the above experiences, BASICS II, the Provincial Health Team in Antananarivo, three District Health Teams, and the Vaccination Service developed a monitoring guide for use with communities and immunization staff. These technical guidelines are being used in all 20 districts to validate their utility, for eventual dissemination and application nationwide through ICC partners.

Measuring Impact

In the focus districts and the provinces of Antananarivo and Fianarantsoa, immunization activities implemented by BASICS and its partners built upon the Jereo Salama Isika lessons learned and strategies applied in 2000 and 2001. Although the political and economic crisis had a negative impact on immunization coverage and all health interventions in 2002, the combined communication and service delivery improvements implemented in these areas helped to lessen the negative impact. Through intensified efforts in system strengthening and community mobilization in 2003, a further improvement in immunization coverage and reduction in drop-out were realized. As seen in Figure A–3, although coverage for the third dose of diphtheria, pertussis, and tetanus vaccine (DPT3) declined in 2001 and 2002 from its higher level in 2000, Antananarivo and Fianarantsoa were among the provinces with the highest coverage and

Figure A–3. Madagascar DPT3 Coverage by Province, 2000–2003



Source: Madagascar Vaccination Service routine immunization reports.

remained above the national average.

In the USAID-supported districts within these provinces, diphtheria, pertussis, tetanus and hepatitis B (DPT/HepB3) coverage is equal to or higher than the average for these provinces, as well as nationally, as shown in Figure A-4. (It should be noted that as of 2003, quadrivalent DPT/HepB vaccine has been fully integrated into the immunization program.)

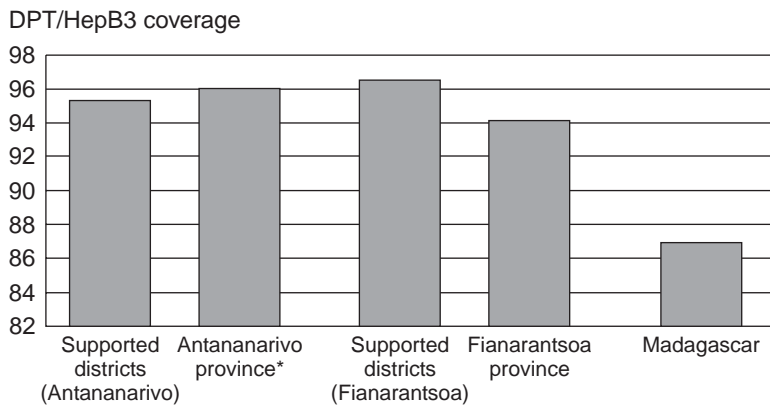
Given the focus on reaching every district and reducing drop-out, the DPT/HepB1 and DPT/HepB3 drop-out rate is now also a key indicator for the EPI. Reducing drop-out to below 15% in the supported districts and provinces was an objective of the activities for 2003. As seen in Figure A-5, there has been a significant improvement in drop-out reduction in Antananarivo province, with drop-out reported at less than 1% for 2003. In Fianarantsoa, which has traditionally had lower coverage and higher drop-out, the situation is improving as well, with drop-out reported at approximately 10% and below the national average of 12%.

Lessons Learned

Community Mobilization

- Crucial role of an entirely mobilized community (including political leaders, traditional leaders, community groups, health staff, and volunteer mobilizers) in achieving clear objectives for an integrated public health program. The involvement of authorities was important early in the process, not only to garner their support for reinvigoration of EPI and polio eradication, but also to motivate health staff and promote community participation.

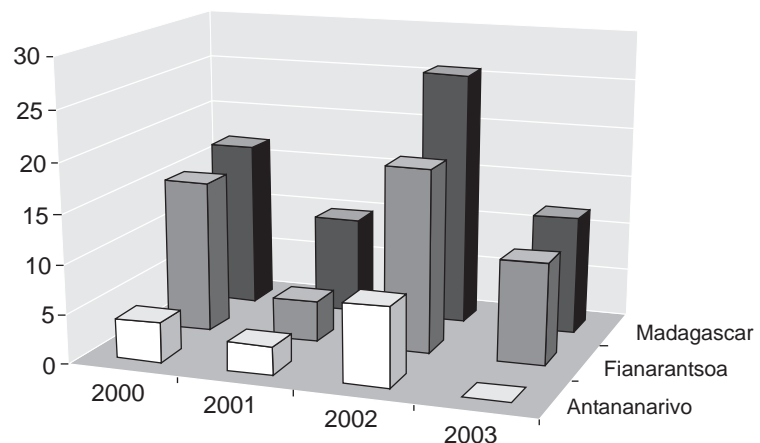
Figure A-4. 2003 DPT/HepB3 Coverage in USAID-supported Districts (Compared with 2003 DPT/HepB3 Provincial and National Coverage)



* Several districts in Antananarivo have reported coverage slightly higher than 100% in 2003, artificially elevating the provincial average by approximately 2–3 percentage points. A similar trend is evident in some districts in other provinces as well.

Source: Madagascar Vaccination Service routine immunization reports, 2003.

Figure A-5. DPT1–DPT3 Drop-out Rates, 2000–2003 (Antananarivo and Fianarantsoa Provinces and Nationally)



Source: Madagascar Vaccination Service routine immunization reports, 2003.

- **Success of community approaches that utilize existing networks and focus on key indicators and messages.** Indicators and messages may include completion of the vaccination schedule before 12 months of age and tracking of newborns and defaulters, Champion Community and child-to-child initiatives,² use of child health cards with parents, and use of child tracking cards and a tracking system with the health center.
- **Constant focus on monitoring of community agents and ensuring communication and collaboration with health centers.** This monitoring includes regular meetings and information exchange, use of tools (coverage data and child tracking cards) to monitor progress and identify gaps and defaulters, formative monitoring of community agents through feedback and clear terms of reference, and participation of district staff in supervision and “informational/awareness-building” meetings at health centers.

Communication and Behavior Change

- **Importance of reinforcing IEC activities and having standardized materials that can be adapted to the realities of each region.** These materials should be used not only by the communication specialists and targeted communities, but they should also be applicable to the health system and used by health staff. For example, child health cards should be used by parents and health facilities, and diplomas should be used to track the completed vaccination schedule and as a motivational tool.
- **Promotion of “small, do-able” actions and messages that support and reinforce these actions.** Actions and messages should be tied to anticipated results and indicators, such as vaccination coverage of 80% for DPT3 and measles in children under one year for a community, or an increase in the number of AFP cases detected in the province. This latter case would involve awareness-building activities with religious and community leaders on the AFP case definition, as well as the need to monitor polio eradication indicators.
- **Use of mixed media and mixed channel approach.** Communication activities involving the community and targeted to the community are important. In addition to advocacy and interpersonal communication channels, the local media—particularly local radio stations—have been important partners. Radio stations broadcast health messages and aired radio spots each month (four to five spots each day) on increasing vaccination coverage (including completion of vaccination and awarding of diplomas before one year of age) and “bonus” spots on AFP detection. Some payment for media is often necessary, but this can be negotiated for a reasonable rate and payment can be tied to a monthly contract to ensure that information is broadcast according to an agreed-upon schedule.

2. A community that receives the designation of "Champion Community" fulfills certain fundamental criteria regarding vaccination levels, family planning meetings, cleanliness of public spaces, and other prerequisites. The child-to-child initiative is a school- and youth group-based initiative for development of peer counseling and health promotion activities.

