A Critical Leap
to Polio Eradication in India
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The world is about to turn the page on polio, a viral disease that cripples young children since the dawn of civilization.

The disease has vanished in most corners of the globe at the turn of the 21st century. As many as 209 countries, territories and areas have succeeded in cutting down wild poliovirus cases to nil by 2003. Among them, 134 have been certified polio-free after maintaining zero case performance for three consecutive years.

Yet polio continues to menace the health and lives of children in seven countries: Afghanistan, Egypt, India, Nigeria, Niger, Pakistan and Somalia, the last frontiers of humankind’s battle against the virus. In the age of global mobility and increased human contact across borders, the ominous prospect of a reversal: the virus’ re-transmission, overshadows the impressive milestone reached thus far.

This report examines the context, process and impact of India’s communication effort and UNICEF’s contribution to this enormous undertaking. A full range of interventions were put in place over the years by a variety of partners, including high level political advocacy, mass media campaigns and innovative approaches to social marketing, mobilization of government and non-governmental institutions. In Uttar Pradesh, the epicenter of the disease, UNICEF also supported the assembly of an interpersonal communication channel known as the Social Mobilization Network to reach the marginalized, underserved, high-resistant and high-risk communities. A close examination of why polio eradication is confronted with mistrust, resentment, fatigue and complacency sheds light on the host of factors that shape India’s communication strategy, and its role in making the final leap towards eradicating the disease.

As a partner with WHO, the US Centers for Disease Control and Rotary International, UNICEF has utilized its traditional strength in communication and collaborated with a multitude of players, including children themselves, to garner broad-based support for OPV vaccination in India. The strategy’s vigorous implementation owes much to the commitment of the Government of India, specifically the Ministry of Health and Family Welfare, the State and District governments, NGOs and the assistance of major donors in particular USAID, the Government of Japan, DFID, CIDA and Rotary over the years.

The lesson learnt attests to the need for sustaining the rigour of extensive and intensive outreach and continued engagement of the underserved and marginalized, to track down the last of India’s unreached child.

By taking a close look at how strategic communication has resolved major attitude and behavioural barriers, the approach lends itself to wider application both within and beyond India. We hope the analyses will elicit new interest among partners and within UNICEF in response to the challenges ahead.

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A critical leap to polio eradication in India

No democracies in the world have undertaken a public health initiative as monumental as India’s Pulse Polio Immunization in its resolve to wipe out a childhood disease: poliomyelitis. Few have confronted the enormity of challenges of synchronizing the actions of a huge populace around a single mission: immunizing as many as 165 million young children on a single day.

UNICEF has been involved in the initiative from the start, working with a multitude of partners and motivating millions of families to bring children to the vaccination booth, at least twice a year, and over many years. The agency has applied a full array of communication approaches, ranging from mass media to interpersonal communication, advocacy to social mobilization, to galvanize public support for the immunization drive.

This paper looks at how the communication approach has evolved as the technical strategy advances to tackle the dynamics of changing demography and public attitude. In particular, how interpersonal communication is brought to bear to achieve a public good: eradication of the polio disease – as fatigue sets in and resentment mounts.

With the journey still on, UNICEF continues to adapt its strategy to the needs of the programme that began when the Government of India signed the 1990 Declaration of the World Summit for Children, committing itself to eradicating polio by 2000. Realizing that existing routine immunization services could not ensure fulfillment of the time-bound goal, the Ministry of Health & Family Welfare (MOHFW) adopted a well-tested method known as National Immunization Day (NID). Inherent in the approach was large-scale mobilization of parents to bring all eligible children to fixed or temporary vaccination sites to receive two drops of OPV vaccine.

In the initial years – 1995 to 1996 – the NID, a supplementary immunization activity (supplementing routine immunization), covered some 93 million children under three years of age. Later, it was expanded to include children under the age of five. In India, the annual birth of 25 million children made a cohort of 0 – 5 years old a formidable 125 million children as the minimum target of vaccination each year, and for every round.

The first two sections are a brief description of India’s “Pulse Polio” from a people’s programme involving volunteers to a more institutional approach that relies on paid workers. The background lends historical perspective to the expanded effort to isolate the virus, and the need for a viable, active channel for interpersonal communication to bridge critical knowledge gaps and tackle resistance to OPV.
The People’s Programme: Pulse Polio Immunization

By UNICEF’s definition social mobilization is “a broad-scale movement to engage people’s participation in achieving a specific development goal through self-reliant efforts. It involves all relevant segments of society: decision and policy-makers, opinion leaders, bureaucrats and technocrats, professional groups, religious associations, commerce and industry, communities and individuals.” The broad-based support garnered usually accelerates the pace towards a social goal, which cannot be achieved when it is left to an automatic process of development.

Pulse Polio Immunization had in the beginning enjoyed enormous popularity as a people’s programme, unleashing an immense spirit of volunteerism that brought the prevention of a communicable disease beyond the realm of public health. Large numbers of volunteers, including teachers, students, religious leaders, medical practitioners, community leaders, housewives, came forward with the Programme’s inception in December 1995. They manned over 700,000 vaccination booths, talked to families, made public appeals and organized students’ rallies. Throughout the country, school children took to the streets in droves to raise awareness of National Immunization Day. Villagers pedaled loudspeakers around while rows of young people marched to the rhythmic beat of drums, publicizing the day with much fanfare and colour.

The hope of eradication, built around the vision of freeing India from the disease at the turn of the century, elicited a sense of pride: “we can do it!” The volunteer’s movement was spontaneous, with people responding to TV spots, news articles, posters, leaders’ calls to action and above all, the common sight of children in calipers, dreams partially dashed by disability. People’s participation was the programme’s hallmark, and the optimism emanated from India’s success with eradicating smallpox in the 1960s. That earlier success gave the nation a reason to believe that polio could be put into extinction the same way.

The movement successfully delivered OPV coverage from 85% in 1995 - 96 to 96.1% in 1999. And the number of children paralyzed by wild poliovirus was brought down to 1,126 from 4,791 in 1995. It was the year when the movement reached its height, and also a year when India had to stage a final showdown with the virus to meet the 2000 goal.

In 1999-2000, the Government of India stepped up the frequency of immunization from two national campaigns per year, which normally took place 4 – 6 weeks apart between December and January, to six. It also introduced a series of five Sub-National Immunization Days (SNID) with intensive vaccination of children in eight states where cases of paralytic polio were reported: Assam, Bihar, Gujarat, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. And the activity was renamed Intensified Pulse Polio Immunization (IPPI).

From people to professional: Intensified Pulse Polio Immunization

The escalated pace was driven by the question of reaching the remaining 3.9% of children. Among them were 1.6% not vaccinated at all and another 2.3%, who received only one dose during the 19998 - 99 campaigns. In 1998 – 99, 3.9% meant an estimated 5.3 million eligible children, between 0 – 5 years of age, who either did not turn up at the booth or dropped out of the vaccination exercise.

Based on an action research and recommendation from the India Expert Advisory Group (IEAG), a policy advisory body, the Government of India introduced a house-to-house (HTH) approach experimentally to reach the unreached in polio endemic states. The positive outcome led to a change in the booth strategy. Vaccination at a fixed location - booths that had been set up all over the country for the day - was to be complemented by another two to three days of outreach to bring OPV to the home of families who might be unaware of NID.

The new approach demanded that volunteers spent two to three extra days to move about the neighbourhood. Incentives were needed. An honorarium of Rs 50 per day (~US $1.20) for volunteers was introduced to cover house-to-house visits after each NID or SNID.

The new policy effectively changed the nature of the programme. It discouraged many people from participating, especially teachers, who had to work on weekdays. Volunteers began to drop out. The average number of people manning each booth plunged from an average of 10 to 14 since 1995 - 1996 to 2.9 by 1999 – 2000. A core of paid workers, essentially public health employees took over the work, each receiving the additional allowance of Rs 50 per day. It marked a shift from a people’s programme to one run by professionals, essentially Auxiliary Nurse and Midwives (ANMs) and health workers, who were routine vaccinators from the health system.

The additional rounds of vaccination, however, required more volunteers, not fewer, to help mobilize families to the booth on NID, especially in rural areas. The Inter-agency Co-ordinating Committee (ICC), responsible for resource mobilization and partnership coordination, then constituted a National Social Mobilization...
Working Group, and appointed Mr. Gautam Basu, Joint Secretary, Ministry of Health and Family Welfare (MOHFW) as Chairperson. UNICEF was requested to lead and coordinate a substantial outreach exercise with the Group’s major partners: MOHFW, WHO, Rotary International, USAID, DFID and a number of NGOs, including a Core group of international NGOs.

The Working Group set forth to engage members of legislative assemblies, religious leaders, journalists, and health workers in awareness-raising, including a WHO-sponsored workshop aimed at motivating health workers to actively seek out the unreached. For nationwide publicity, the Working Group partners utilized the celebrity effect of featuring the Prime Minister, Bollywood stars and cricket players on television advertisements, urging parents to come forward on booth day. There was no explicit mention of the house-to-house service with the concern that it might confuse the public, encouraging them to stay at home, thus undermining the established booth strategy.

A series of four TV spots were put out in 1999 – 2000 during popular drama series one to two months before the NID, with increased frequency 2-3 days before the round. A novelty for the two years was a special arrangement with India’s national telecoms authority to replace the ring tone with a recorded message that reminded the public of the NID date whenever a call was dialed. Print advertisements to announce the date were placed on 18 national local language dailies, along with the distribution of posters and pamphlets explaining the need for polio drops, in village primary health centers, sub-centres, government hospitals, and posted on strategic points such as bus stops and railway stations. In addition, banners were mounted at road junctions, stickers pasted on doors, and polio drop messages painted on walls.

The multiple channels of communication focused on reminding parents of the importance of vaccinating all children below 5 years old with polio drops, right from infancy. And UNICEF’s involvement in the programme was largely in the arena of awareness-raising, commonly known as Information, Education and Communication (IEC) activities, and working in partnership with a host of other organizations to garner support for immunization days.

The increased number of rounds in 1999 – 2000, combined with the house-to-house strategy, boosted vaccination coverage impressively. In 2000, India vaccinated more children than ever, reaching 151 million children during one NID round. The table below provides a glimpse of performance up to 2000 – 2001:

Table 1: OPV coverage and no. of poliomyelitis cases by year

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of children vaccinated</th>
<th>% OPV Coverage (at least 2 doses)</th>
<th>% zero dose</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994 – 95</td>
<td>4,000 (94)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995 – 96</td>
<td>95 million (0 – 3 years)</td>
<td>85.5</td>
<td>2.5</td>
<td>4,791 (96)</td>
</tr>
<tr>
<td>1996 – 97</td>
<td>119.8 million (0-5 years)</td>
<td>93.2</td>
<td>1.8</td>
<td>2,534 (97)</td>
</tr>
<tr>
<td>1997 – 98</td>
<td>122 million</td>
<td>92</td>
<td>3.2</td>
<td>1,934 (98)</td>
</tr>
<tr>
<td>1998 – 99</td>
<td>137 million</td>
<td>96.1</td>
<td>1.6</td>
<td>1,126 (99)</td>
</tr>
<tr>
<td>1999 – 00</td>
<td>151 million</td>
<td>98.6</td>
<td>0.7</td>
<td>265 (00)</td>
</tr>
<tr>
<td>2000 – 01</td>
<td>131.5 million</td>
<td>96.3</td>
<td>1.2</td>
<td>268 (01)</td>
</tr>
</tbody>
</table>

The joint approach had enabled the system to locate and vaccinate millions more of “missing children”, resulting in a drastic reduction of paralytic cases from 1,126 to 265 by the end of 2000. But the decline had not hit bottom – zero – which in epidemiological terms, signified successful interruption of the virus’ transmission. India, along with 19 other polio endemic countries, had to look to their new target: 2002 in order to attain polio-free certification in 2005, a goal apart from that of the World Summit for Children. The 2005 goal was established by the World Health Assembly’s Global Commission for the Certification of the Eradication of Poliomyelitis in 1996.

Graph 1: Distribution of poliomyelitis cases by year, India (Source: GOI/WHO NPSP)

The OPV conundrum

The accelerated pace of vaccination, notwithstanding its success, had sown the seeds of fatigue. While the disease had disappeared in most parts of the country, the intensity of the exercise had left a lingering sense of weariness among service providers, volunteers and the millions of families: just how much longer this would continue? But for epidemiologists, the 0.7% children left unvaccinated meant yet more rounds of campaign to vaccinate all 151 million children again.
The science, applied in repeated vaccination campaigns, had also begun to perplex the public. While most Indians had come to embrace the NID as something good, and which protected children from disability, the question that dominated the public mind – the vegetable vendors, factory workers, construction labourers, slum dwellers, farmers and above all, illiterate mothers – was: why repeated doses? Hasn’t my child been protected enough? Why must we do it round after round, year after year? And why is my child still infected by polio when he has been vaccinated many times?¹⁴

**Eradication strategy is rocket science to most**
The dynamics of disease eradication, in particular, polio, made the task daunting by its imperative that every targeted child had to be immunized with the live-polio vaccine. In industrialized countries, children were sufficiently protected after receiving three doses of OPV (one dose of OPV comprises two drops), usually through routine immunization⁵. For developing countries, epidemiologists had yet to determine exactly how many doses were enough due to the presence of a host of other viruses in unhygienic environments. The practice of open defecation and faecal contamination of drinking water easily precipitated viruses’ transmissions. Children’s vulnerability to infections and diarrhoea somehow reduced the efficiency of each dose of OPV in fighting the poliovirus. More than three doses were thus required for developing countries, delivered through the NID, a supplementary immunization activity to bring additional dosage to children, including newborns. For India, where 80% of its rural population had no toilet at home, the Ministry of Health and Family Welfare recommended eight to ten doses for each child.

There was also a difference between protecting the child from the virus and eradicating the disease, the complexity of which often confounded the laymen, let alone illiterate parents. A child adequately protected from the virus would not lead to disappearance of the disease in the environs. As long as there were other children unvaccinated or inadequately protected with enough dosage, the virus would continue to thrive. As the virus was discharged from the guts of infected children or adults by means of faeces, the untreated human waste – often ending up in open sewers, lanes and rivers – would become the source of transmission for others. Once out in the open, the virus looked for human bodies to host it. Children in the surroundings who were either inadequately immune or worse still, unvaccinated at all, would succumb to its lethal, crippling effect. The eradication of polio thus called for rounds after rounds of campaign to vaccinate every targeted child, including the annual cohort of 25 million newborns in India. The synchronized

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¹⁴ EPOS Study on Understanding Barriers to Polio Eradication in Uttar Pradesh, 2002, UNICEF India
⁵ Routine immunization targets children below 12 months in both industrialized and developing countries. Children are to be vaccinated with five antigens: BCG (childhood tuberculosis), DPT(diphtheria, pertussis and tetanus), measles and OPV for polio
vaccination of all children on a single day was proven the most effective way of interrupting transmission of the poliovirus.

While public health specialists and national planners were fully conversant with the technical approach – the need for multiple doses for all children under five - just how much of it had been communicated to the man and woman in the street, in the village? There were, indeed, many questions in people’s minds.

“Earlier it was given twice a year, and now it is given very frequently. There must be something wrong about it,” said a Muslim man during a focus group discussion in Ghaziabad, Uttar Pradesh. “It is said that there will be no polio after giving three doses, why are they giving it again and again?” queried an opinion leader in Ambedkarnagar district.

“Because this vaccine is being given again and again, people are becoming very suspicious. Last year we were told this was the last dose of the polio vaccine. But now they are coming virtually every month. What is this mystery?” another Muslim man in Ghaziabad district groused.

“They are coming in such quick frequency. This is why the people are suspicious, and they are giving this medicine totally free! Why is the government doing this? Why only this medicine and not any other? Why only polio? If they have to give they should give all medicines. What could be the reason?” questioned Sirjit Kaur, a young mother in Moradabad district.

A study conducted by the All India Institute of Medical Sciences summed up the issue. “Most of the men and women with children below five years of age interviewed were aware that polio drops are given to protect the children against polio. Not many perceived that the intensive efforts were aimed to eradicate polio by interrupting the transmission of wild polio virus. Thus the rationale behind administering OPV drops to children 0 – 5 years through repeated rounds over the years was poorly appreciated.”

**Pattern of resistance**

The need to address knowledge gap was increasingly critical, especially among marginalized, underserved communities. The sudden intensification of the rounds of NIDs and Sub-NIDs with the rationale not readily understood by segments of the population, who were mostly illiterate and deprived of access to information, had
raised doubts, especially of the government’s motive. And doubts left unanswered easily bred rumours.

1. **OPV causes infertility in children**

   In many states, the frequent OPV rounds had discernibly fueled fears about the true purpose of the vaccine. Words began to circulate that OPV was a contraceptive designed to control fertility in children. “We heard this rumour that this vaccine will affect some nerve in the children which will make them unable to produce children. We then thought that our children will become useless, nobody will marry them and our family will not be able to propagate. This is why we did not give the medicine,” said Fatima Bai, a Muslim woman at a focus group discussion. “So many times in a month – it must be true that this medicine is given to stop children from propagating. This could be the only reason why it is given repeatedly,” said Asham, a mother in Mohammadpur Mafi village. “Earlier we used to give the vaccine (to our children) so they would not get polio. But now we will not give the vaccine because the entire mohalla (village) is saying that they are adulterating the vaccine, and there is now a concoction for making our children infertile. Here everybody has been warned about this vaccine,” said Bilkis, another mother.

These comments represented the prevailing view of minority communities. The hearsay was slowly transmuted into belief. A negative attitude to OPV vaccination developed, and in some communities, it persisted to the point where vaccinators resorted to the physical use of force to coerce families into accepting OPV. “In certain areas we have to give the drops forcibly so that they get the message that they cannot go without it. Some sort of a battle is going on,” said a district health official in Moradabad. And frequent reports of coercion only reinforced misbelief. “Last two months, they (health staff) were giving the drops forcibly by pulling out the children from homes. Now parents of such children started thinking that there is something wrong with these drops. They also suspect that something is being mixed with the polio drops,” a mother in Moradabad complained.

In some areas, the entire village had boycotted NIDs and blocked vehicles carrying the vaccine from entering. Some local opinion leaders also seized on the opportunity to fan public resentment, which in some cases, had mutated into organized resistance. “Printed pamphlets were distributed to inform people that these polio drops will cause sterility among children. These pamphlets were sent out by some vendors who came here for selling clothes or mending utensils, and disappear

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10 Ibid
12 EPOS Study on Understanding Barriers to Polio Eradication in Uttar Pradesh, 2002, UNICEF India
13 Remarks highlighted in “Barriers in Polio Eradication, An AIIMS-India CLEN Study, 2000 – 2001, All India Institute of Medical Sciences
later,” said a district health official. “Nobody, not even the district administration, could identify who was responsible for these pamphlets,” another official added\(^\text{14}\).

The infertility view was dominant among Muslims, but not limited to this minority group. The fear and suspicion gained currency from two factors: Firstly, the government’s family planning programme was the only other service provided freely. It was also the most extensive and visible, besides OPV vaccination. Secondly, the health workers and ANMs who administered OPV were also the ones that promoted family planning and delivered contraceptives. These health workers, rarely accessible or available for any other basic health services, enjoyed little credibility among Muslim and Hindu scheduled caste communities. Some of them reportedly charge families for services that were supposedly free. Many families also reported discrimination as most of these workers, who managed to get into the health system, were people of higher caste.\(^\text{15}\)

2. **OPV is useless since it cannot not protect children from paralysis**

Rumours and hearsay were most often reinforced by sporadic occurrence of wild poliovirus cases among children who had been vaccinated, but insufficiently protected with additional dosage. Many villagers in underserved areas had witnessed such incidents, which took away whatever little faith that was left about the exercise. Some of their views were captured in a UNICEF qualitative study\(^\text{16}\):

“One of my nephews who was 7 months old fell ill and died a year ago. He had been given polio vaccine but he still developed polio….Thus even if we give the vaccine our children are liable to get polio.” – Rahmat, Hindu Khera, Sambhal, Moradabad

“My neighbour’s son developed polio when had was two years old. He had been given the vaccine many times.” – Pushpa, 30, Karula, Moradabad in an in-depth interview

“In Ambedkarnagar, 27 people developed polio despite taking the vaccine…” – A male Muslim opinion leader, Jalalpur, Ambedkarnagar

“Recently, my young brother-in-law’s son was given the vaccine but he still got polio…. ” – Elderly woman, during an FGD at Mahmudpur Mafi, Moradabad

“Our nephew also has polio. He had been given the vaccine. How did he manage to get the disease despite taking the medicine? …. Only the Almighty knows how useful is the vaccine? If one person gets it then six people get it.” – Sabila, 30, Nahal, Ghaziabad during an in-depth interview

\(^\text{14}\) Ibid
\(^\text{15}\) EPOS Study on Understanding Barriers to Polio Eradication in Uttar Pradesh, 2002, UNICEF India
\(^\text{16}\) Ibid
“We all know that these drops have to be given to children. But the workers are giving it almost every month and there is no benefit as polio is still occurring in our area.”  
— A man in Moradabad

3. Polio drops are the cause of polio disease
Wild poliovirus paralysis cases among inadequately vaccinated children had also led many to suspect that polio drops were the cause of the disease. And those who experienced or witnessed paralytic cases would discourage others from vaccinating their children.

“My sister-in law gave these drops to her one-year-old child regularly but the child got afflicted with paralysis of the limbs. There were no cases in the last two years. But recently they started to occur. Let us tell you openly that we will not give these drops to our children anymore.”  
— A woman in Moradabad

“I know that one girl had died due to polio in our region. I think children die as an effect of taking the polio vaccine.”  
— A respondent in Ghaziabad

“We had given the vaccine to our child but after that her limbs became immobile. We rushed to the doctor and he said it was polio. Then we got her treated and now she is all right. If I catch that person who gave the drops again I will beat him up and cut him into pieces. I do not trust government people at all.”  
— Iqbal from Chaenapur, Hapur, Ghaziabad

“When the people came to give the drops, one lady said that her child had died after taking the drops. She told us not to give these drops to our children as well.”  
— A resistant mother in Moradabad

The art of polio eradication: Communication for behaviour change

I. How negative attitude was formed over time
The negative attitude was the end result of information and education not adequately delivered, especially to the deprived and to whom television and radio were not accessible. Doubts, goaded on by hearsay, had over time evolved into resistance. In the absence of an alternate source of information, it was natural for the less discerning to turn to rumour mongering or simply what a neighbour said.

The situation would have called for more diligent outreach by the ANMs and the Anganwadi (AWW), the two major groups of government grassroots workers, to explain and communicate the advantages of OPV vaccination. But the ANMs, each employed to serve a

17 Remarks highlighted in “Barriers in Polio Eradication, An AIIMS-India CLEN Study, 2000 – 2001, All India Institute of Medical Sciences
18 Ibid
19 Ibid
population of 5,000 normally scattered around a cluster of villages, and the AWWs, each covering a smaller population – 1,000 – were mostly overworked. Besides OPV vaccination, they were also responsible for other health care programmes, including prevention of tuberculosis, leprosy, HIV/AIDS, antenatal care, routine immunization and family planning. The AWWs, working alongside the ANMs in villages, were promoters of interventions to improve child nutrition and development, ranging from micronutrients to safe drinking water, sanitation and hygiene.

A large number of them were able to fulfill their demanding daily duty, and visited villages either on foot or bicycle, or taking a ride from a vehicle on lucky days. The ANMs’ work, in particular, followed a micro-plan, such as routine vaccination and antenatal checkup on fixed days. And surveys had shown that in areas where they had been providing routine services regularly, communities were less or not resentful of OPV.

In areas where ANMs performed poorly, resistance began to mount. Many ANMs, especially in the northern state of Uttar Pradesh and Bihar, had reportedly shunned remote, far flung communities, partly due to the distance from the Primary Health Care Sub-centres where they operated, and partly out of fear for personal security. A number of them had been harassed in the early days of India’s family planning programme, and they were mostly operating alone, without much support from the system.

Vaccine and medical supply was often irregular, and some of the sub-centres were located in isolated places which, by the vastness of India, made surrounding villages a trip of woeful distance. In circumstances like these, absenteeism of ANMs was invariably high. Over time, communities that went without support from the ANMs and were thus bereft of the services much needed, developed a negative attitude about the health system. Their overall condition of deprivation further bore out their distrust of the state and any state-run programmes.

Under the government’s mandate to eradicate polio, ANMs and AWWs were activated fully to deliver OPV in rounds after rounds of NID and Sub-NIDs. The house-to-house strategy had brought those in the “underserved” areas back into contact with communities they hardly attended to. Their appearance created the impression that OPV was the only service available, and the paid work inevitably invited scorn and derision from their once deserted clients. “The one who gives the vaccine gets Rs 50, that’s why they come,” said Shehnaaz of Akbarpur village, Ambedkarnagar district. “Why is the government pushing this polio medicine so much? They are fooling the public. They are merely making their own salaries….” growled Nazuk of Mahmudpur Mafi village, Moradabad district.

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21 EPOS Study on Understanding Barriers to Polio Eradication in Uttar Pradesh, 2002, UNICEF India
22 Ibid
Incidents involving forced immunization had repeatedly occurred in the underserved areas. “Our children are very scared of the madams who come to give the polio drops,” said a mother in Moradabad district. “One is Mamta and the other is Rashimi, they force the children to take the vaccine by pushing their way into the house,” she added\textsuperscript{23}. “My brain boils at the thought of the number of times they are coming…… They come quickly to catch the child, spill two and a half drops outside, and put two and a half drops in the mouth and then run away,” Munni, an old woman in Dasna, Ghaziabad, told interviewers.

“They force the children to take the vaccine, and when we resist they bring the police,” said Afsana from the same district during a focused group discussion.\textsuperscript{24}

Not all cases were handled by the police. Those remarks reflected more of families’ dismay with ANMs’ impudence than the actual use of force, which was a common impression everywhere. The attitude and lack of communication only widened the gulf of mistrust between the people and the system.

Resentment, fueled by rumours and inaccurate information, metamorphosed gradually into new behaviour. A growing number of families took to shutting their door when the vaccinators turned up during house visit. Some parents deliberately brought their children to other places. Some would leave children in the house with elder siblings, lock the door and go somewhere to avoid questions from the vaccinators. There were others who denied having a young child in the family, while some hid their young child altogether, usually at the rooftop where clothes were hung to dry.

These behaviours had later proved difficult to change without investing extraordinary time and efforts. Graph 2 attempts to chart the key factors that contributed to new behaviours, which halted the vaccination drive rather than transmission of the virus.

\textsuperscript{23} Ibid
\textsuperscript{24} Ibid
Graph 2: How new behaviours were developed

Underserved & marginalized communities

Inadequate information

Doubt

Why repeated doses?

Hearsay

Reinforced by:
- Rumour mongers & unpopular family planning programme – OPV causes infertility
- Cases of infection among (insufficiently) vaccinated children
- Absence of other basic services
- Negative experiences with health system & health workers

Inadequate information

Unaware of date, time, place & need for additional doses

Tradition - Purdah

Child is sick

Fear of side effects

Lack time – daily wage earners

Convenience – House-to-House

RESISTANCE

Further reinforced by:
- Forced vaccination
- Health workers & ANM’s lack of communication and apathy
- Self-perception as object of discrimination

NEW BEHAVIOURS (Resentful attitude)

- Shut the door – pretend no one’s home
- Leave the house/village to avoid OPV
- Hide children
- Lie – children have been given polio drops
- Deny – no children under 5
- Open refusal during vaccinators’ visit

NEW BEHAVIOURS (Neutral attitude)

Stay at home – vaccine will be delivered to my door
The flow chart maps out two courses of behavioural development among underserved communities, emanating from the lack of information, whether owing to the dearth of support from health workers or inaccessibility to the media. The left column displays how resentful attitude is formed when doubts or apprehension about repeated doses are not given proper explanation. In the absence of an authoritative source of information, people turn to hearsay. And hearsay casts OPV in the negative mode due to the communities’ negative experiences with the family planning programme and public health services. The repeated delivery of OPV in absence of other basic services gave rise to suspicion of a hidden agenda by the government to stop the Muslims and Hindu scheduled caste from having children. And hearsay, reinforced by cases of inadequately immune children infected with polio in the vicinity, also becomes evidence of OPV’s ineffectiveness, as well as a cause for polio itself. People begin to resist the vaccine, and change behaviours to avoid vaccination.

The right column shows families that are ignorant of the date, time and place of vaccination, and that do not turn up at the booth due to a host of social, cultural and economic conditions. The house-to-house strategy serves this group well, although it inadvertently encourages a new behaviour: parents now choose to stay at home, expecting vaccines to be delivered to the door. The risk is this group will eventually expect all other basic health services to be brought to the home in the same way as OPV. And when nothing else happens – other than OPV – their attitude is susceptible to influence by the other group, who co-exists in the same community.

II. Strategic communication to meet new challenges

Communication and social mobilization strategies, prior to 2000, were focused largely on raising awareness. As it became clear that the 0.7% of children un reached, unvaccinated or inadequately vaccinated could hold up India’s eradication goal, and set back the enormous progress made, a revision of strategies and messages was necessary.

The challenge confronting the government, UNICEF and the Social Mobilization Working Group was two-fold. Firstly, how to bring information to the unreached, underserved communities and tackle resistance to OPV vaccination? Secondly, how to continue motivating the majority already reached to participate in OPV vaccination for the next two years.

The marginalized, underserved communities were ones with little or no access to the mass media, and most vulnerable to doubts and rumours about OPV. These were also places where ANMs showed up only to administer polio drops. One might believe it would be easy for MOHFW to put pressure on them to perform. The nature of disease eradication, however, was more than routine work. It required a high degree of commitment from all involved, in particular ANMs, health workers and house visit supervisors, to sustain the search for unvaccinated children. Even for those who diligently carried out their duty, the frequent rounds of immunization in 2000 had left many feeling exhausted and daunted.
Lax supervision within the system also affected their morale: “We should be given Rs. 50 per day for all the 3 days. Now, they are giving only for 1 day,” said an ANM. “Money plays an important role – no one will work without pay. And the amount that we are paid cannot even meet the daily expenses on food and travel during the campaign,” complained another. “We only get Rs. 75 for 3 days. Then to get the money, we have to go to the Block office at least 2 to 3 times. We even have to spend our own money to travel to the Block office for our training programmes,” another AMN said.

The formation of a special outreach team to interact with families, using persuasion to reduce resistance to lay the ground for vaccinators’ visit was thought a workable solution. The Social Mobilization Working Group proposed the plan to the Inter-agency Coordinating Committee, and UNICEF agreed to finance the outreach effort. Thus for the new rounds of vaccination in 2001 – 2002, a judicious mix of mass media and interpersonal communication approaches was adopted. The objectives:

i. Raise awareness, and change parental attitude and behaviour in high risk districts of UP and Bihar

ii. Inform and remind people of new NIDs and Sub-NID dates

The combination of approaches was termed, within UNICEF, programme communication: “A research-based, consultative process of addressing knowledge, attitudes and practices through identifying, analyzing and segmenting audiences and participants in programmes, and provide them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass media channels, including participatory methods.”

A. Formative research

UNICEF was entrusted, from the start of the polio eradication programme, with the task of commissioning two types of surveys: Coverage Evaluation and Process Evaluation. The reports, jointly published by the Ministry of Health and Family Welfare, GOI and the agency, yielded a wealth of information on OPV coverage nationwide, by state, by religious group, caste, and campaign quality, including distance between booth and villages, booth workers’ ability to determine vaccine quality and whether a micro-plan for house visits was in place. The data enabled administrators to fine-tune the coming rounds of campaign, and provided an overview of families’ awareness of NID, sources of information and reasons for not going to the booth.

Coverage evaluations conducted over the years showed that while there was overt resistance or general reluctance, there were also families who were genuinely unaware about the date, time and place of booth vaccination. Even when brightly-coloured posters were mounted to draw attention, the message remained meaningless to most mothers in villages and urban slums, who were largely illiterate. The table below showed the major reasons cited by parents for not vaccinating children over four years:

26 UNICEF supported social mobilization in Bihar through a network of NGOs. Bihar state had a less heterogeneous population and less rigid caste and ethnic line among groups than UP, and is not the focus of this paper.
Table 2: Reasons cited by families with children not receiving one or more OPV doses during NIDs/Sub-NIDs

<table>
<thead>
<tr>
<th>Year</th>
<th>% Lack Knowledge</th>
<th>% Lack Motivation</th>
<th>% Fear</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unaware of date, time &amp; place</td>
<td>Unaware of need for additional doses</td>
<td>Unaware of the program</td>
</tr>
<tr>
<td>1999-00</td>
<td>21.8</td>
<td>10.1</td>
<td>Not asked</td>
</tr>
<tr>
<td>2000-01</td>
<td>27.9</td>
<td>5.3</td>
<td>4.5</td>
</tr>
<tr>
<td>2001-02</td>
<td>23.4</td>
<td>5.8</td>
<td>9.3 (Unaware of home visit)</td>
</tr>
</tbody>
</table>


A behavioural change communication strategy for the underserved thus had to take into consideration two types of families: the resentful and the neutral. The latter whose access to information was equally low (see GRAPH 2: How new behaviours were developed), carried an indifferent attitude toward OPV but did not vaccinate their children for a variety of reasons. These included the practice of purdah, a tradition that prohibited the mother and the newborn from leaving the house in the first 45 days after delivery; superstitious belief that the newborn should be protected from the “evil eye”; vulnerability to infections; the child was sick and there was no one to take the child to the booth, etc.

In the rural village setting, these families co-existed side-by-side with the resentful group, and were vulnerable to influence by rumours or prevailing opinions.

The dynamic nature of human behaviour
A noteworthy trend was the increased percentage of families claiming they had “no time for the booth” from 4.8% in 1999 – 2000 to 25% in 2001 – 2002. While this category could mostly be daily wage earners whose three meals for the family depended solely on their income for the day, it could also include parents who gave low priority to preventive health, and eventually parents who resented OPV, even though they might be aware of the date, time and venue.

The House-to-House strategy, designed to serve these groups by bringing vaccinators to the door, had also set off a new trend. A growing percentage of people were staying in-door on booth day, expecting OPV to be delivered to their home. A strong indicator was the rise in the number of people who said: “Vaccinators did not come to my house” from 2.6% in 1999 – 2000 to 28.3% in 2001 –2002, reflecting the change in health-seeking attitude. Those were families
who once went the extra mile to bring children to the booth and now stopped going. It was mirrored by the shrinking percentage of booth turnout nationwide—from 97% before 1999 to 81.8% in 2002—demonstrating a glaring change in public behaviour.

Table 3: OPV Coverage by Booth Attendance and House-to-House, all India, 1997 - 2002

<table>
<thead>
<tr>
<th>Year</th>
<th>% Received at least two doses</th>
<th>% Only at booth</th>
<th>% Only at home</th>
<th>% Others (Mixture of home &amp; Booth and/or urban mobile teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997 – 98</td>
<td>93.2</td>
<td>97</td>
<td>---</td>
<td>3</td>
</tr>
<tr>
<td>1998 – 99</td>
<td>96.1</td>
<td>97.1</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>1999 – 00</td>
<td>98.6</td>
<td>79.5</td>
<td>3</td>
<td>17.5</td>
</tr>
<tr>
<td>2000 – 01</td>
<td>96.3</td>
<td>86.9</td>
<td>6.3</td>
<td>6.8</td>
</tr>
<tr>
<td>2001 – 02</td>
<td>95.6</td>
<td>81.8</td>
<td>10.5</td>
<td>7.7</td>
</tr>
</tbody>
</table>


Graph 3: OPV Coverage by Booth Attendance and House-to-House, all India, 1997 - 2002

The technical strategy, designed to effectively track down the unreached, now had to accommodate not only the underserved families and within them, the resentful families, but also a swelling number of neutral families who chose to stay at home on national immunization days. Progress toward the eradication objective was more challenging than ever. It called for new energy and resources to undertake intensive micro-planning at state, district and block level, foremost, to track families that were unreached, and those previously reached but who had stopped going to the booth.

The behaviourally trend demonstrated the need for a two-prong communication strategy: mass media and interpersonal.

B. Social advertising through mass media

The high level of vaccination coverage was a strong indication that over 90% of the population had crossed the stage of awareness. Polio drops were a well-known “product” to protect children from disability of the limbs. With palpable sign of fatigue beginning to show after the intensified rounds of NIDs and Sub-NIDs in 1999 - 2000, it was important to find a way to renew public interest and at the same time, motivate the likely drop-outs to return to the vaccination effort. Based on the findings of process and coverage evaluations, and in consultations with key partners, UNICEF proposed a national media campaign, focusing on social and emotional factors that motivate people to bring their children back to vaccination booths. A professional advertising agency, Ogilvy & Mather, was engaged to develop social advertising messages.
The analysis of formative research findings helped segment target audience into four groups. Those who:

1. Accept polio drops and would go to the booth
2. Accept polio drops but whose interest in taking children to the booth might wane
3. Indifferent about polio drops and unaware of date, time and venue for booth vaccination as well as home visits
4. Reject polio drops because of misconceptions and rumors

Each of these target groups had a distinct need and different concerns and questions in mind, which entailed the creation of separate messages to address their concerns:

(i) Why the need for NIDs again?
(ii) Why the need for repeated doses?
(iii) The concern and doubts of parents with children below 3 months – my child is too young to be immunized, and there might be side effect.
(iv) The concern of parents with children above 2 years old – my child has already received all doses under routine immunization and during earlier NIDs, so no need to get more doses.
(v) Misconceptions that polio drops would cause impotency/sterility in children, and
(vi) Rumour that poor quality vaccine was administered to minority groups.

To reach the maximum number of Indian families, all three major media channels – TV and radio and newspaper – were utilized. The campaign, which took off in 2001, comprised the following:

**Thematic film**
A one-minute film clip was produced for cinema screening, describing achievement of IPPI for all Indian children, and the challenges that remained before reaching the final goal of polio eradication. It appealed to all sectors of the Indian society to participate in this monumental public movement.

**TV advertisements**
Three spots were produced and telecast on national and regional networks 10 days before the NIDs in 2001 – 2002, to address concerns of the public:

1. **The Parvez spot** - correcting the widespread misconception among minority groups, including some Hindu communities, that polio vaccine would cause infertility. The spot featured a Muslim man, named Parvez, who realized it was too late when his son was paralyzed by the poliovirus due to his belief in rumour. With tears in his eyes, he asked parents to make responsible choices for their children, and take them to the nearest booth to receive polio drops.

2. **The Pediatrician spot** - explaining why repeated doses were necessary for every child and the meaning of polio eradication.

3. **The Paro spot** - dispelling the myth that children younger than three months were not fit for polio vaccination. It emphasized that children of this age were more susceptible to polio and other infections, urging parents to send them for both OPV and routine immunization.

**Radio advertisements**
Five radio spots, highlighting the same issues as the TV spots and film, were produced and broadcast on 184 stations throughout India about 15 days prior to NIDs and Sub-NIDs. For the first time ever, radio spots were dubbed in four
regional languages of the Northeastern states. A customised media programme, carrying a message from the Prime Minister, was also designed for Rampur All India Radio to reach the most endemic districts of western UP. A theme song that embodied the same issue as in the theme film was also aired by 184 radio stations as a filler item.

**Print advertisements**

Four advertisements, produced in 13 languages and published in all the major publications in India, focused on the following messages:

1. Informing people of achievement and challenges, expressing gratitude for the public’s continuous support;
2. Explaining why repeated doses were necessary;
3. Reminding parents of new dates of NID, emphasizing they should take their children under five years old to the booth, even if they had completed routine immunization, or had received polio drops on previous NIDs, and that it was safe for sick children to receive polio drops;
4. An appeal from chairpersons of the Indian Academy of Pediatricians (IAP), and the Indian Medical Association (IMA), urging parents and convincing them of the need for polio drops.

The mass media campaign, led by UNICEF, was an outcome of multi-agency collaboration. For the first time, the Government of India agreed to route its print advertisement budget to UNICEF to ensure the timely release and good positioning of ads in newspapers. WHO financed workshops to sensitize journalists in Bihar and UP with a view to enhance the journalists’ knowledge and understanding of the need of frequent rounds of NID and Sub-NID, to reduce negative reporting due to their own misconceptions. Rotary produced roadside banners, posters, vertical boards, caps, aprons, newspaper ads in 3 language versions, and a film which was shown in 4 high-risk districts of UP through video vans.

**C. Intensive social mobilization and interpersonal communication in endemic states**

Mass media, however far-reaching, lost its persuasive edge when it came to communities that were marginalized, and where radio, TV and printed words figured little in daily life. Most people turned to neighbours or community members, rather than the media, for happenings in their own universe. To reach this group, mass media was of limited use. Word of mouth communication remained the best means of disseminating information and imparting knowledge.

The trade off, however, was the sacrifice of visibility that came with mass communication. While the latter stood out with eye-catching posters, advertisements, radio & TV messages, instantly creating a presence in people’s mind, interpersonal communication (IPC) relied heavily on one-to-one persuasion. What UNICEF was to introduce in the endemic states – discussed in the following sections – was a strategy that centered on IPC but supplemented with mass communication on a narrower scale, using wall writings, hoarding boards, posters and banners to create a visual presence. The latter was commonly described as IEC (Information, Education & Communication) activities.
Social Mobilization Network in Uttar Pradesh

Uttar Pradesh alone reported 179 polio cases in 2000, and 216 cases in 2001, constituting 67% and 80% of all cases in India, respectively (see Graph 4). The state, with a population of 170 million, also reported more polio cases than any country in the world. Persistent transmission of the virus in Uttar Pradesh and to a lesser extent, Bihar, partially signaled the limitations of a mass media approach toward reaching the hard-to-reach.

Graph 4: Distribution of confirmed wild poliovirus AFP cases Source: GOI/WHO NPSP

Within UP, polio transmission was most intense in four districts of the west: Moradabad, Rampur, Badaun and Bareilly, where localized resentment over repeated polio rounds was also high. Coverage evaluation in 2001 – 2002 showed that in the state, in particular, these “Hot 4” districts, interpersonal communication was the most frequently quoted source of information (Table 4) compared to the mass media (Table 5).

Table 4: Sources of Information through interpersonal communication on Pulse Polio Immunization, UP, 2001 - 2002 (Question with multiple responses)

<table>
<thead>
<tr>
<th>Year</th>
<th>Base</th>
<th>Any interpersonal</th>
<th>Health worker/ ANM</th>
<th>Anganwadi worker</th>
<th>Pediatrician</th>
<th>Relative/friends</th>
<th>Teachers</th>
<th>Religious/community leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 - 02</td>
<td>Uttar Pradesh</td>
<td>65.2</td>
<td>41.4</td>
<td>3.3</td>
<td>1.8</td>
<td>19.2</td>
<td>12.8</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>Badaun</td>
<td>78.6</td>
<td>55.5</td>
<td>1.5</td>
<td>1.4</td>
<td>22.2</td>
<td>15.1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Bareilly</td>
<td>78.3</td>
<td>53.1</td>
<td>1.0</td>
<td>1.5</td>
<td>28.4</td>
<td>15.6</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Moradabad</td>
<td>55.8</td>
<td>6.7</td>
<td>3.1</td>
<td>4.1</td>
<td>15.9</td>
<td>20</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Rampur</td>
<td>36.6</td>
<td>25.2</td>
<td>3.4</td>
<td>0.4</td>
<td>4.2</td>
<td>9.8</td>
<td>0</td>
</tr>
</tbody>
</table>


Table 5: Sources of Information through mass media on Pulse Polio Immunization, UP, 2001 - 2002 (Question with multiple responses)

<table>
<thead>
<tr>
<th>Year</th>
<th>Base</th>
<th>Any mass media</th>
<th>TV</th>
<th>Radio</th>
<th>Newspapers/Magazines</th>
<th>Wall paintings/posters</th>
<th>Miking/Drum Beating</th>
<th>No, never heard of IPPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001 - 02</td>
<td>Uttar Pradesh</td>
<td>39.4</td>
<td>14.5</td>
<td>5.6</td>
<td>3.5</td>
<td>2.6</td>
<td>21.9</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Badaun</td>
<td>24.2</td>
<td>4.8</td>
<td>1.8</td>
<td>1</td>
<td>1.2</td>
<td>18.4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Bareilly</td>
<td>41</td>
<td>15.4</td>
<td>5.2</td>
<td>3.8</td>
<td>3.4</td>
<td>24.3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Moradabad</td>
<td>54.7</td>
<td>14.5</td>
<td>3.6</td>
<td>3.8</td>
<td>4.2</td>
<td>46.1</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>Rampur</td>
<td>53.1</td>
<td>13.6</td>
<td>14.7</td>
<td>2.2</td>
<td>1.3</td>
<td>42.3</td>
<td>0.1</td>
</tr>
</tbody>
</table>


Infrequent contact with ANMs, health workers and Anganwadis in some districts, such as Moradabad (6.7% and 3.1%, respectively) and Rampur (25% and 3.4%), also gave insight into the cause of resistance. Where contact with health worker and ANMs was limited, families derived information from teachers, relatives, friends and

29 WHO NPSP/GOI data showed UP as India and the world's last reservoir of the virus with 25% of the world's cases in 2000 and 45% of the world's total in 2001.
religious leaders. Its relative irresponsiveness was indicative of how perceptions of OPV might be distorted along the way. An IPC intervention that aimed to re-establish contact and change mindsets of these high-risk, high-resistance communities toward OPV was clearly necessary.

The question then was how? A common development approach would have called for cooperation with local NGOs to design a series of outreach activities. There were numerous community-based organizations in UP; they knew their territories well. But UNICEF’s experiences in the state had not brought forth much confidence in their accountability or reliability. There were also few NGOs of sufficient capacity for intervention of a scale required to counteract growing resistance and reluctance among communities.

The alternative was to engage committed, experienced individuals. And there were many around, silently fulfilling developmental mandates in various government, non-governmental, bilateral and multilateral programmes. In early 2001, UNICEF decided to take this route and set about recruiting a team of coordinators in the “Hot 4” and six other polio endemic districts, primarily to serve the densely populated western Uttar Pradesh. These temporary staff, called Social Mobilization Coordinators (SMC), were selected for their experiences in running development projects in the district or region to which they were assigned.

The SMC’s major function was to initiate interpersonal contact with families in between the vaccination rounds to pave the way for vaccinators’ house-to-house visit in high-risk, high-resistant blocks and villages. Locations were largely identified by the government’s block-level Medical Officer-in-Charge (MOIC) and WHO’s Surveillance Medical Officer (SMO) based on recent cases and transmission pattern.

The coordinator was also to participate in joint planning with the district administrator, health authorities, the GOI/WHO National Polio Surveillance Project office (NPSP), Rotary, and the Core Group of NGOs, which were members of a District Task Force (DTF) for Polio Eradication chaired by the District Magistrate, the highest governing authority. Together, they were to galvanize decision-makers, opinion leaders, journalists, young people, influencers, teachers and school children into actions to improve public recognition of polio drops, and invent a spirit of festivity around immunization days in the district capital, towns and villages.

For districts that reported a high number of polio cases such as the “Hot 4”: Badaun, Bareilly, Moradabad and Rampur, the SMCs were supported by a group of community mobilization coordinators (CMC) in villages, a hundred per district.
For districts with relatively lower transmission of poliovirus, the SMC would work directly with the CMC in villages. With the intent to eventually transfer capacity to the local government, UNICEF also funded the recruitment of CMCs in 10 high-risk districts to work directly under the Chief Medical Officer (CMO), the highest public health authority in the district. Cash was transferred to the CMOs for them to hire CMCs directly.

The selection of districts was determined by the distribution of cases:

Table 6: Distribution of cases in 57 districts of Uttar Pradesh, 2000 - 2001

<table>
<thead>
<tr>
<th>DISTRICTS</th>
<th>2000</th>
<th>2001</th>
<th>DISTRICTS</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 AZAMGARH</td>
<td>1</td>
<td>0</td>
<td>30 HARDOI</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2 AMBEDKAR NAGAR</td>
<td>4</td>
<td>3</td>
<td>31 MUZAFFARNAGAR</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>3 MORADABAD</td>
<td>20</td>
<td>45</td>
<td>32 PILIBHIT</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>4 SITAPUR</td>
<td>2</td>
<td>0</td>
<td>33 AGRA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5 J P NAGAR</td>
<td>6</td>
<td>7</td>
<td>34 BASTI</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>6 BADAUN</td>
<td>7</td>
<td>20</td>
<td>35 CHANDOLI</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7 JAUNPUR</td>
<td>1</td>
<td>0</td>
<td>36 MIRZAPUR</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8 MAU</td>
<td>5</td>
<td>0</td>
<td>37 PRATAPGARH</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>9 MEERUT</td>
<td>10</td>
<td>8</td>
<td>38 SANT KABIR NAGAR</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10 BAHRAICH</td>
<td>2</td>
<td>2</td>
<td>39 SHAHJAHANPUR</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>11 BIJNOR</td>
<td>7</td>
<td>3</td>
<td>40 ALIGARH</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>12 GHAZIABAD</td>
<td>18</td>
<td>4</td>
<td>41 DEORIA</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13 BARABANKI</td>
<td>0</td>
<td>1</td>
<td>42 FARRUKHABAD</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>14 FEROZABAD</td>
<td>3</td>
<td>2</td>
<td>43 GORAKHPUR</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15 BADOHI</td>
<td>1</td>
<td>3</td>
<td>44 HATHRAS</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>16 FAIZABAD</td>
<td>2</td>
<td>1</td>
<td>45 LUCKNOW</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>17 RAEBARELI</td>
<td>2</td>
<td>1</td>
<td>46 MAINPURU</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18 RAMPUR</td>
<td>9</td>
<td>22</td>
<td>47 SHAHARANPUR</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>19 KHERI</td>
<td>4</td>
<td>0</td>
<td>48 SIDDHARTHANAGAR</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>20 ALLAHABAD</td>
<td>0</td>
<td>0</td>
<td>49 SRAWASTI</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>21 GHAZIPUR</td>
<td>0</td>
<td>0</td>
<td>50 FATEHPUR</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>22 BULANDSHAHAR</td>
<td>6</td>
<td>6</td>
<td>51 GONDA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>23 ETAH</td>
<td>2</td>
<td>0</td>
<td>52 KANPUR(DEHAT)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>24 SULTANPUR</td>
<td>9</td>
<td>8</td>
<td>53 KANPUR(NAGAR)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>25 VARANASI</td>
<td>0</td>
<td>0</td>
<td>54 KAUSHAMBHI</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>26 BALRAMPUR</td>
<td>0</td>
<td>0</td>
<td>55 LALITPUR</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>27 BAREILLY</td>
<td>2</td>
<td>29</td>
<td>56 MATHURA</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>28 BAGPAT</td>
<td>0</td>
<td>0</td>
<td>57 SONBHADRA</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>29 G B NAGAR</td>
<td>1</td>
<td>1</td>
<td>Total</td>
<td>179</td>
<td>216</td>
</tr>
</tbody>
</table>

30 The number of districts had increased to 70 by 2002 – 2003 under a re-organization plan of GoUP
31 Districts in bold print were supported directly by UNICEF with the presence of SM Network, 2001
The SMCs, brought on board for three months through a UNICEF Special Service Agreement (SSA), were in essence a “SWAT” team created to identify and respond to areas where opposition to OPV vaccination was most acute. The number of polio cases, at 179 in 2000 and still occurring in 2001 was deemed small and limited to local areas, relative to the tremendous size of the state and the immensity of success in controlling the disease in other parts of India.

The initial months, however, had proven exhausting for the SMCs, who each took care of 100 CMCs, all of them from poor, marginalized communities, and unreachable by phone. The time spent on the road had eaten into their plan for district-level activities. In India, the administrative structure is divided into state, division, district, block and village\(^32\). Coordinating with various layers of bureaucracy to drive changes in the lowest administrative division – the village – was consuming the SMCs’ time and energy, and affecting the quality of intervention at the block and district level. After several review meetings to weigh the cost and benefit, UNICEF decided to bring in another tier of support: the Block Mobilization Coordinators (BMCs).

The combined SMC with BMC and CMC structure was first tried out in the “Hot 4” districts, where vaccination efforts had encountered hardcore resistance. The four SMCs were given a quota of hiring a number of block mobilizers (BMC) selected from high-risk, high-resistance blocks to support some 400 community mobilizers (100 CMCs per district), while the other six districts without a BMC continued on with 600 CMCs\(^33\). UNICEF also replicated the GOI/WHO NPSP structure by appointing a Sub-regional Coordinator (SRC) to supervise SMCs in the “Hot 4”.

The deployment of community mobilizers was based on the number of reported polio cases as well as the complexity of resistance in villages within a block. The team, engaged and managed by UNICEF, along with 1,000 other community mobilizers engaged by the government and managed by Chief Medical Officers of 10 districts, was to deliver a high booth attendance as well as compliance by all resistant families for the December 2001 and January 2002 rounds. The network was intended to be dissolved as soon as poliovirus transmission was halted, with the expectation of bringing down the number of cases to zero by 2002.

The operational models for the three sets of districts, by mid 2001, were as follows:

---

\(^32\) Each Indian state is organized into a number of districts, which are divided into units variously known as tahsils, taluqs, or subdivisions. These are further divided into “community development blocks,” each typically consisting of about 100 villages. At the lowest level, each village elects its own governing council (gram panchayat). The public health system follows a similar administrative structure: The District Department of Health is headed by the Chief Medical Officer, who supervises the work of a Block Medical Officer-in-Charge (MOIC), who in turn supervises the work of Auxiliary Nurse Midwives (ANM) at village level.

\(^33\) The BMCs were paid a monthly salary under a UNICEF SSA contract. The CMCs were given a stipend for 15 days, at Rs 50 per day. Their remunerations were channeled to an NGO called BGVS, which dispatched payment to the CMCs based on the name list provided by the BMCs and SMCs.
**Model - 1:** Coordinators at sub-region, district, block and community level in the “Hot 4” districts (Moradabad, Badaun, Rampur & Bareilly)

**Model – 2:** Coordinators at district and community level in six high-risk districts (Ghaziabad, Bijnor, JP Nagar, Meerut, Ambedkar Nagar and Bahraich)

**Model – 3:** Coordinators at community level in ten endemic districts (Muzaffarnagar, Bulandshahar, Aligarh, Kheri, Sultanpur, Basti, Gonda, Sravasti, Faizabad & Barabanki)

**Graph 6:** Organizational structure and operational model of UNICEF Social Mobilization Network, 2001

### UNICEF SM Network

- **UNICEF (Delhi/Lucknow Offices)**
  - **SRC**
  - **6 high-risk districts**
    - **SMC - 6**
  - **The “Hot 4” districts**
    - **SMC - 4**
    - **BMC - 58**
  - **Direct cash assistance to CMO of 10 high-risk districts**
  - **CMC – 2,000**

### Training of the Social Mobilization Network

In preparation for the job, UNICEF engaged a specialist to design a Facilitator’s Guide for the Social Mobilization Coordinator. The SMCs would train BMCs who in turn, would train CMCs. All three were oriented on their role and tasks (see Annex A, B and C). The guide, focused on interpersonal skills, emphasized how to tackle miscommunication, misinformation and misbelief. The two-day training imparted knowledge of polio and skills building through participatory learning such as role play and discussion. An audio cassette, explaining the whys and how of polio eradication in plain, simple language, was distributed to SMCs and BMCs for the training of a much larger group: CMCs, the frontline workers selected from the resistant and underserved communities.

The mobilizers were also oriented with the house-marking system, devised since the house-to-house strategy was introduced, to track families in urban and rural areas:

- **P** - Pass! Children were already vaccinated
- **P** - (Read as P Zero) to indicate there was no targeted children in the house
- **X** - No one in the house during vaccinators’ visit or Door was locked during vaccinators’ visit or Some children not immunized, vaccinators to return
- **XR** - Obvert resistance to vaccination

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34 There is no postal and address system in rural India, and houses are not numbered.
While training was underway, the NPSP office also made efforts to improve the interpersonal skills of vaccinators and outreach team supervisors at the block level. Its SMOs conducted training for the health service providers, including ANMs, Anganwadi workers, supervisors and volunteers. UNICEF-supported CMCs were encouraged to attend as trainees and BMCs as facilitators, to build IPC skills and strengthen relationships with vaccination teams.

Forging the relationship was important as CMCs effectively represented the community that the team would visit time and again. The district health department and the NPSP Office had also devised a system of organizing the vaccination team:

**A Team:** Responsible for the first 2 – 5 days of house-to-house vaccination

**B Team:** Responsible for revisiting X and XR-marked houses after the round was over. The B team members were drawn from A Teams, usually vaccinators who had a positive attitude and performed better.

The CMC, a known member of his or her community, usually possessed ready knowledge of families, which came in handy when the B Team arrived. The mobilizers would be able to provide information X and XR houses, whether parents were around and whether there were target children in the house. The mobilizer would prove vital when many of the Po and P houses were later found to be false as parents hid the truth about their children’s vaccination status or hid their children altogether.

**Major activities of the SM Network**

The SM Network was assigned a fixed set of activities designed around the assumption that an overemphasis on behaviour change, without addressing conditions of poverty and inequities that reinforced negative attitude, would be ineffective. In designing the activity plan, UNICEF was fully aware of the many historic, social, cultural and economic factors that shaped resistance and of which it had no control. Further, mistrust of state-run programmes was not forged overnight. Interventions had to centre on building trust, and regaining community confidence in the polio eradication programme through intermediaries, respected figures such as Imams, teachers, medical doctors and local activists.

Improving understanding and awareness about polio, particularly with mothers and mothers-in-law, continued to be mandatory in order to address concerns about repeated doses, side effects and vaccination when a child had fever. Community resentment over the lack of service other than polio drops was another major consideration that called for special events such as a day-long Health Camp to offer general curative care for children, routine immunization and preventive health counseling for parents.

The following set of activities constituted the SM Network’s work-plan, which reflected the core of the IPC strategy:

1. Organizing Health camps
2. Holding community meetings with mothers
3. Sensitizing religious leaders
4. Organizing meetings with influencers
5. Interacting with resistant families
6. Coordinating with NGOs and community-based organizations for family visits
7. Briefing journalists
8. District & block level IEC (posters, banners and pamphlets) distribution
9. Organizing IEC events before immunization days, eg. drum-beating & announcements through megaphones
10. Orientating children and teachers for organizing rallies
11. Wall writings through Community Mobilizers

The work-plan followed a “Consolidated District Social Mobilization/IEC Activity Matrix” (see Annex D) that essentially structured SMC’s coordination mandate with government, NGO partners and volunteers, to ensure all of these activities took place prior to the NID, and on the day itself, in high-resistant and underserved communities jointly identified by the District Task Force.

Advocacy initiative
Recognizing the importance of enlisting support from the medical professionals, UNICEF and the Social Mobilization Working Group partners urged the Indian Academy of Paediatricians to participate more actively in the polio eradication programme. As a result, 12,000 of its members had kept their clinics open during NIDs/SNIDs to inform as well as motivate their clients. Three regional meetings were organized at Bijnor, Saharanpur and Bareilly of UP to engage the members of Indian Medical Association (IMA) and the Indian Association of Pediatrics (IAP). This effort led to their support in many ways: explaining the need of repeated polio doses to parents, mobilizing other professional bodies to join the efforts, and using their clinics as polio booths on NIDs.

Results of the SM Network
The presence of the SM Network had generated a high degree of visibility for the NIDs in December 2001 and January 2002 in the marginalized, underserved communities. An assessment of block data later in the year, noted by the India Expert Advisory Committee, indicated that villages with CMCs had fewer refusals than those without CMCs. The need for B team was redundant in many cases as the CMCs would have convinced families to accept OPV when the A team arrived.

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Minutes of the Informal Meeting of Experts for Polio Eradication, India, 13 - 14 August 2002, NPSP, JNU Stadium, New Delhi
There was also consensus among partners that the network was making a difference in areas with entrenched resistance. Where IPC activities were conducted and mobilizers were present, communities were more willing to open their door to vaccinators and there was lesser need to send in B Teams. In many instances, resistance or reluctance was progressively reduced.

An analysis of 394 villages without the CMCs and 112 villages with CMCs in two high-risk, high-resistant districts, Bareilly and Badaun, showed the difference between the March and April 2002 rounds:

Graph 7: Houses that rejected OPV by month, 394 villages without CMCs, Bareilly & Badaun, Uttar Pradesh, 2002

Graph 8: Houses that rejected OPV by month, 112 villages with CMCs, Bareilly & Badaun, Uttar Pradesh, 2002

As with many communication and social mobilization interventions in developing countries, the SM Network primarily measured its output in terms of activities or processes. The drawback from its initial year of operation was the lack of systematic monitoring and evaluation of impact. There was no methodical tracking of exactly how many X and XR-marked houses had been converted or false P and Po houses found as a result of CMCs’ daily interaction with families. In 14 out of the 20 UNICEF-supported districts, the network operated without block mobilizers to
monitor tally sheets of villages where CMCs had actively persuaded families to the booth. The block medical office, responsible for compiling a colossal amount of data filed by hundreds of vaccinators at the end of the booth day, could not have immediately singled out villages where CMCs were working. The need for data to be submitted to the Chief Medical Officer within 24 hours made it a remote possibility. The absence of a BMC thus left a gap in performance monitoring.

The work-plan was, however, largely implemented, and the SM Network had delivered within a very short period of time, a heightened level of activities that would not have normally taken place within the underserved communities. For instance:

- **Health camps:** (known in Hindi as Health Melas): The exercise, primarily aimed at building confidence in health services, was conducted in 90% of the 150 locations planned;
- **Wall Paintings:** Targeted toward various sections of society like parents, influencers and other volunteers, wall paintings addressed the need and importance of routine immunization, polio drops and for increasing booth attendance. UNICEF commissioned five designs, and selected 1,000 locations in the same 10 districts for wall paintings with 100% implementation rate.
- **Kala Jathha/Folk performance/Street dramas:** staged to raise awareness on the need for repeated polio doses, routine immunization and to clarify misconceptions and myths about OPV. A total of 300 events were planned with an implementation rate of more than 90%.
- **Community Meetings:** held to sensitize and galvanize support of influencers to seek out the last un-immunized child in the concerned community. Some 2200 meetings were planned out of which more than 75% had been conducted with all influencers agreeing to help.

The network’s impact in the “Hot 4” districts with a full, cascaded level of UNICEF support was, however, more obvious. With the combination of improved service quality, under close supervision of the government and the NPSP office, and enhanced interpersonal and mass media communication, the number of cases in 2002 had come down in all districts, to the extent they were no longer the “Hot 4” (see Table 8: Distribution of polio cases in the “Hot 4” of UP, 2000 – August 2002, in the Section: Expanding the SM Network).

Of the three models, the third where CMCs were appointed and supervised through government channels was found less effective. The name list of CMCs, totaling 1,000 in 10 high-risk districts, was hardly recorded; many were often not paid after salaries had been advanced to the local authority. There was no opportunity for UNICEF to provide direct supervision to the thousand community mobilizers.

### The resurgence of polio in 2002

Between 2000 and 2001, the number of polio cases in India had hovered around 260, an impressive record compared to the time NIDs started with nearly 5,000 cases. Despite its hopes of zero transmission and polio-free certification, India suffered a major resurgence of poliomyelitis in 2002. The country ended the year with 1,599 children paralyzed. The vast majority of cases - 80% - occurred in Uttar Pradesh and of all 1,271 cases there, 59% were Muslim children, most of them below two years old. Endemic transmission continued in Bihar, and the wild poliovirus was spreading to West Bengal, Gujarat, Delhi and 11 other states and union territories.
India suddenly topped the world’s record by spawning 83% of the globe’s total cases in 2002, and found itself returning to the situation in 1999:

**Graph 9: Distribution of polio cases in 2002 compared to 1999, India** *(Source: GOI/WHO NPSP, 2002)*

The IEAG attributed 2002 firstly, to a cyclical outbreak of the virus which occurred once in a few years when the pool of susceptible children – those who were unvaccinated or insufficiently immune – was building to the breaking point.

Secondly, the less intensive and less frequent rounds of NIDs and Sub-NIDs throughout 2001 had created a time lapse for the virus to thrive. An immunity gap developed when no vaccination round took place, and a reservoir of virus built up in eastern and central UP, which subsequently spread to neighbouring Bihar and other states. Further, children in the highest risk communities in western UP continued to be missed when the rounds took place. Most of them were poorly vaccinated in the first place, as routine immunization in these areas was not well implemented. Routine immunization coverage had remained unacceptably low in UP and Bihar as a whole, at 22.3% and 11.6% respectively, contributing to an expanding pool of susceptible children.

Thirdly, the IEAG pointed to a lack of accountability and supervision in the health system as a key reason for the large proportion of children remaining under-immunized, despite multiple rounds of OPV vaccination earlier and expenditure of hundreds of millions of rupees. The quality of these supplementary immunization activities was also a critical factor. About 13 – 17% of houses were repeatedly missed during house-to-house vaccinations.

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36 Two NIDs were organized: in January and December 2001 along with one Sub-NID in October 2001.
37 India’s national routine immunization coverage was 50.1%. Figures drawn from “PPI, Routine Immunization and Maternal Care – Coverage Evaluation Survey”, March 2003, UNICEF & Social and Rural Research Institute
38 Minutes of the Informal Meeting of Experts for Polio Eradication, India, 13 - 14 August 2002, NPSP, JNU Stadium, New Delhi
Missed houses were identified by the WHO surveillance network of block monitors randomly dropping in a number of villages after each round. Many of the P-marked houses (families who told vaccinators that their children had been given polio drops) were later detected to be false. And houses marked X, indicating door was locked or no one was at home, should have been converted into P if children under five were found in the house and vaccinated, or Po if there were genuinely no children, when the B team arrived to follow up. The NPSP office measured missed houses by a combination of P-houses falsely marked and X-houses left at the end of each round. The higher the percentage, the higher the number of children unvaccinated\(^{39}\), and the clearer it showed whether vaccinators were fulfilling their duties.

There had been many reports of vaccinators chalk-marking P on houses, taking whatever parents said as true, without probing or checking. There were also incidents when X-marked house remained locked whenever the team arrived, and no one bothered to check or ascertain whether children were hidden inside.

The intensive house-to-house vaccination had also unintentionally, over the years, encouraged more parents to stay at home, necessitating a more extensive and strenuous search for both unvaccinated and under immunized children. Although vaccinators in the state had delivered high coverage of 97.3% in early 2002, the rise in children vaccinated at home from 5.1% in 1999 to 23.9% in 2002 revealed a disturbing change of attitude toward polio drops. A greater number of parents were no longer interested in taking children to the booth, indicating the absence of a shared aspiration to eradicate the disease. This stood in stark contrast to the perception of national policymakers and the epidemiologists community, who had declared 2002 an emergency for polio.

### Table 7: OPV coverage in UP, 1998 - 2003

<table>
<thead>
<tr>
<th>Year</th>
<th>% with at least two doses</th>
<th>% At booth only</th>
<th>% At home only</th>
<th>No. confirmed wild poliovirus cases - UP</th>
<th>No. confirmed WPV cases – All India</th>
<th>UP as % of All India (WPV cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998 – 99</td>
<td>91.8</td>
<td>99.9</td>
<td>0</td>
<td>881 (98)</td>
<td>1,934 (98)</td>
<td>45</td>
</tr>
<tr>
<td>1999 - 2000</td>
<td>98</td>
<td>62.1</td>
<td>5.1</td>
<td>773 (99)</td>
<td>1,126 (99)</td>
<td>68</td>
</tr>
<tr>
<td>2000 – 01</td>
<td>96.6</td>
<td>62.5</td>
<td>16.1</td>
<td>179 (00)</td>
<td>265 (00)</td>
<td>68</td>
</tr>
<tr>
<td>2001 – 02</td>
<td>97.3</td>
<td>64.3</td>
<td>23.9</td>
<td>216 (01)</td>
<td>268 (01)</td>
<td>80</td>
</tr>
<tr>
<td>2002 – 03*</td>
<td>34.6</td>
<td>65</td>
<td>1,241 (02)</td>
<td>1,599 (02)</td>
<td></td>
<td>77</td>
</tr>
<tr>
<td>Mar 2003</td>
<td>20</td>
<td>64</td>
<td></td>
<td></td>
<td></td>
<td>31</td>
</tr>
</tbody>
</table>

*Provisional data based on tally sheets returned from booths – pending Coverage Evaluation Survey 2002 – 03.

Source: Coverage Evaluation Surveys 98 – 02, Ministry of Health & Family Welfare, GOI & UNICEF
WHO/National Polio Surveillance Project Office

The behavioural shift also coincided with increased reports of false-P and X-marked houses, as well as a growing number of Po houses where parents claimed there was

\(^{39}\) The absolute number of children unvaccinated varied according to the population base by which missed houses were measured at any given round.
no child under five in the family. While genuine cases could not be ruled out, there were, in the array of markings, a hidden resistance to OPV and the “polio wallahs” (“polio people” in Hindi). Returning to Graph 2: How new behaviours were developed, the markings could well mask, or reflect, the following behaviours:

**Expansion of the Social Mobilization Network**

The continued occurrence of polio cases in 2002 was an advance notice to India that it would not achieve polio-free certification by 2005. Certification required a country to sustain zero case status for three consecutive years, and India, at the recommendation of IEAG, reset its target date to 2008.

In the course of 2002, the regular surveillance of cases reflected a dire need for quality improvement of house-to-house and booth operation, and greater accountability of state, district and block level political, administrative and public health authorities to ensure it happened. It also called for greater engagement of Muslims, who made up 18% of UP’s 170 million population, and other underserved communities, including Hindu scheduled caste, in these supplementary immunization activities.

While endorsing UNICEF’s existing strategy, the Expert Group suggested further involvement of the SM Network to tackle the 13% – 17% of “missed houses” in all high-risk districts.

The occurrence of each case was a reflection of poor immunization coverage in a community. For one case of paralysis induced by the poliovirus, there would be about 200 children infected though not necessarily paralyzed. Special catch-up

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40 Minutes of the Informal Meeting of Experts for Polio Eradication, India, 13 - 14 August 2002, NPSP, JNU Stadium, New Delhi

41 WHO NPSP defined “missed houses” as % false P + % X houses. See explanation on page 24 under “The cyclical outbreak in 2002”
vaccination thus had to be organized for children in the vicinity for additional protection. Surveillance reports, however, revealed the scale of effort required with cases spanning the entire western part of UP, northern and eastern UP! (See graph below)

**Graph 11: Distribution of polio cases in Uttar Pradesh, 2002** *(Source: GOI/WHO NPSP 2002)*

Budgetary constraints, however, necessitated the prioritization of UNICEF’s resources to sections of districts at highest risk of further viral transmission. UNICEF decided, in consultation with the Social Mobilization Working Group, to continue focusing its IPC interventions in western UP where high number of cases had made it the world’s epicenter of polio. It would also buttress outreach effort in parts of eastern UP where new cases had cropped up.

A UNICEF review after the January 2002 round concluded that supervision was more effective when all three levels of the social mobilization network were in place – district, block and village. Block Mobilization Coordinators (BMC), contracted by UNICEF were able to identify CMCs jointly with their counterparts in the government. The block coordinator could enhance field level activities, and allow for information to flow upward more efficiently to the district level. Improved coordination at all levels also tallied with an apparent reduction of cases in the “Hot 4”. The table below, provided by the WHO NPSP, showed case distribution in the hot 4 by August 2002:

**Table 8: Distribution of polio cases in the “Hot 4” of UP, 2000 – August 2002**

<table>
<thead>
<tr>
<th>DISTRICTS</th>
<th>2000</th>
<th>2001</th>
<th>August 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MORADABAD</td>
<td>20</td>
<td>45</td>
</tr>
<tr>
<td>2</td>
<td>BADAUN</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>RAMPUR</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>BAREILLY</td>
<td>2</td>
<td>29</td>
</tr>
</tbody>
</table>

*Source: GOI/WHO NPSP, 2002*

The cascade approach of placing SMC, BMC and CMC at district, block and village-level, respectively, required UNICEF to re-channel resources from the original twenty to a fewer number of districts, and undertaking intensive rather than extensive social mobilization. The outcome was the investment of a full network – from district to block and village – in the highest risks pockets of 13 districts in June 2002, 20 districts by December 2002, and 25 districts by March 2003 (see graph 8). Replicating this model on a larger scale also required a new way of identifying, training and remunerating block and community level mobilizers. A consulting
firm was engaged to undertake the screening, selection and payment of the temporarily contracted workers, while financial services to support the project were outsourced to an NGO - CERPA. Some of the existing SMCs were reassigned, and new ones recruited to cover the initial 13 and eventually 20 with district-level coordinators42. A total of 175 blocks coordinators were brought on board, covering both urban and rural areas. UNICEF also directly contracted two sub-regional coordinators (SRCs) to ensure closer supervision and monitoring of the network’s performance in all 13 districts on a day-to-day basis.

Graph 12: Districts with UNICEF-supported SM Network, Uttar Pradesh, 2002 - 2003

The SRCs essentially represented the “senior management” of the network and the first line of contact for UNICEF, in particular, the Health Section in New Delhi and the Health Programme Officer in its UP State Office, Lucknow. In summary, the changes consolidated the three operational models into one, using SMCs, BMCs, CMCs in all UNICEF-supported districts.

The criteria of selecting high-risk/resistant villages were fine-tuned to allow greater focus on known pockets of resistance and areas where children were being missed, either hidden or residing in remote areas. SMCs and BMCs obtained these data from the district’s Chief Medical Officer (CMO), block Medical Officer-in-Charge (MOIC) and the WHO Surveillance Medical Officer (SMOs), and deployed CMCs as follows:

- Villages with the largest cluster of X & XR-marked houses and suspected false-P houses from previous round
- Villages with the large numbers of X & XR-marked houses not converted to P following B-team activities from previous round
- Villages with polio cases (priority first quarter of previous year, followed by recent cases
- Anecdotal information regarding pockets of resistance
- Socio-economic conditions and areas targeted for strengthened routine immunization

In the absence of ready channels of information delivery, the entire structure was, in essence, an instrument assembled to conduct interpersonal communication (IPC) with families in underserved communities. It was also a means of garnering broad-based support for OPV under the rubric of child health.

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42 UNICEF supported the SM Network in 20 districts with 19 district-level coordinators (SMC). The SMC for Aligarh also covered Varanasi.
Tackling a bellyful of polio
- Community mobilization in Meerut City, Uttar Pradesh

It is a tempest, howling from somewhere, cutting a swathe through a monumental effort whose end is within sight.

It hits the polio vaccination drive, now snowballing throughout Uttar Pradesh, a state which alone accounts for 68% of all poliovirus infections in the world. It also bears down on Meerut District, where cases of infection had ebbed - to 8 in 2001 - and surged to 29 in 2002, setting back the goal of freeing every child from the virus’ grip.

“Why only OPV? What happens to other basic services for us, for our children?”

“Go away! We don’t want OPV! We don’t need you!”

Day after day, the 19 Community Mobilization Coordinators (CMC) of UNICEF are enduring a tempest of this kind – of a different cause - as they call on each of the 15,000 families in the teeming Tharatpuri settlement of Meerut City. They have been labeled “The Polio People”, chased out of houses, rejected at first by angry housewives, by men desperate for jobs, by squatters who care about nothing more than their next meal.

Economic hardship taxes the nerve even more as huge loads of unattended solid waste chokes up sewers, pollutes water pipes, spills over open drain, permeating the air with a foul, putrid stench. Human and animal faeces, wet ones, dried ones, line every alleyway. Year after year, Meerut’s sprawling shantytowns attract yet more migrants looking for jobs in nearby factories. Everyday, new families settle in from villages, from other states, compounding the district’s unplanned state of urbanization. For some, the new address is merely a charpoy behind an open, broken wall next to a festering marsh of garbage.

“Don’t talk about polio, my children are all older than five, just look at my squalid conditions,” raged a middle-age woman, pulling Subaida Khatoon, a Muslim CMC, to her make-shift kitchen, pointing to the sink overflowing with oily, brownish water congealing into mud. “And then the latrine, the cracked pipes, look, look,” Subaida did not have the heart to examine. She was already stepping on the mire of sewers. She left the house, and promised she would try to bring it up with the elected representative.

“You talk about polio when they are coming to cut off my electricity,” Subaida was howled down by a loud rebuff as she entered the next house.

“What’s the use of free vaccine when they charge me so much for lighting up two bulbs?” roared the labourer, a Muslim father of 10 children. With one child in his arm, the man stuffed the power bill in Subaida’s hand, showing her an outstanding payment of Rs 1,178 (US$ 25)for two months, with another Rs 526 (US $11.2) for January. As he groaned about the insanity of it all, one of his sons, apparently a target for vaccination, stumbled to the door. He picked up a bottle lid from the mucky ground, stuck it into his mouth, and waved cheerily to a hairless, hungry dog.

Subaida knew she could not win the argument, not for the moment. She retreated to the entrance, lifted the crawling child from the ground, took out the mud-stained lid in his mouth, and reluctantly chalk-marked an XR1 and date, the fourth, indicating the 4th failed attempt, on the labourer’s door.

“When can I taste the sweet fruit of success?” Subaida would start questioning herself in moments of dejection. Not that she had achieved nothing. Out of 80 houses she visited on an average day, she would have sailed through 60 who agreed to OPV vaccination. A housewife and mother of three before becoming a CMC, Subaida was picked for the job because she knew her neighbourhood well. “But there are many new arrivals each day, new faces that I don’t know from the past,” she recounted.

“Even then, I have to approach these families. The government wants polio eradicated, I’ll have to convince each and every one,” she said, bracing her back. “Some of the migrants’ children are already vaccinated in the village before moving to the city. But a lot still don’t, and they are very suspicious of their new environment.”

Subaida is certainly not alone. The other 18 CMCs, mobilizing parents for polio vaccination in the Meerut City with a population of 1.2 million, confront similar challenges. Iqbal Baig, a community doctor, is made a UNICEF CMC because he has been treating most of the families in his neighbourhood. A practitioner of the Unani and Ayurvedic medicine, Dr. Baig is a household name in parts of Tharatpuri, with his clinic long used as one of the OPV vaccination sites.
“I used to know everyone in this area. Now I dare say I know only 75%. New residents are constantly coming in, the settlement is unbearably cramped, living conditions are deteriorating,” he said.

Personal rapport counts much in breaking interpersonal barriers. However, it figures little in tracking the fluid demographics of an urban settlement where the population constantly swells and regroups. Even the 2001 Population Census, of which data is not yet officially released, could not sufficiently capture the rapid mobility of India's millions between states and districts.

The mobilization team relies on the 1991 population census, multiplied by a projected growth rate, to get a sense of the number of households and children to be targeted in each administrative area, from village or urban settlement to block and district. Meerut is but one of 70 districts that constitute Uttar Pradesh, a populous state of 170 million.

As with all other CMCs, Dr. Baig is tasked with organizing up to 18 types of activity to advocate and raise community awareness of polio vaccination. A huge amount of time is spent sustaining the interest of converted families. Regular meeting with mothers is a must - to instantly answer queries, such as whether a child with fever could receive OPV, and dispel rumours, sometimes a wild speculation of OPV as a chemical weapon, devised by India, to wipe out Muslims in order to spite Pakistan.

Mistrust, easily escalated into mass resentment, makes it mandatory for the CMCs to work with the Pesh Imam, coordinator of every mosque in the area. Dr. Baig and other Muslim CMCs run regular meeting with the Imams, who have been effective in taming charged sentiments, redressing misplaced concerns. The mosque leaders also allow them to announce the exact location of vaccination booths and date of NID and Sub-NID, after the call to prayer, twice a day before the round.

“This is the easier part,” said Mohammed Farhat, the UNICEF Block Mobilization Coordinator (BMC), who manages the activities of all 19 CMCs in his area. “The harder part is interpersonal communication interventions to change the attitude of resisting families.” Farhat and his team know they need to build up a force of influence. They actively seek out local opinion makers and community-based organizations, enlisting their support to tackle XR households in focused outreach.

Recently, under strong pressure from political leaders in New Delhi and Lucknow (capital of Uttar Pradesh), Meerut’s district officials and elected representatives are starting to take part in house-to-house visits. “Economic hardship is a larger issue that cannot be tackled in the short run,” said Rama Raman, District Magistrate, in one of his community visits. “There are too many competing demands, and the need for basic services is so great. But we will try to solve their problem if and when we can, and on the spot!”

A bold promise indeed. At one such visit, trailed by two vaccinators and a long line of officials, the District Magistrate was unable to progress as fast as he would. Every few steps were halted by disgruntled squatters. “You come in, come in, you come and see the filth I have to put up with,” cried an old woman. “Why can’t you bring other health services to our house? Why only give us polio vaccine when my child is sick with diarrhea?” another woman bawled from behind. The DM strode straight to the XR houses, knocked at each door, at which every resisting parent, seeing the leader in front, would yield and present their toddlers obligingly.

Amid the hubbub, Dr. Baig sighed: “What I worry most is the monsoon. We must convert every resisting family, new comer, and parents of newborns, before the rain sets in.” The neighbourhood is usually flooded between June and September. Torrential rain carries with it soaring rates of child death and morbidity from diarrheal infection, dysentery and food poisoning. It is also the high transmission season of the polio virus.

With five more months to the monsoon, the CMCs are determined to work harder. The Department of Health and WHO’s National Polio Surveillance team have stepped up vaccination activities targeting at XR families. The string of intensified outreach requires CMCs to put in extra time to accompany the vaccination team, essentially health workers responsible for collecting and delivering vaccines, and administrating polio drops preserved in cold boxes. “We’re now working the full month even though we are paid for only 15 days,” said Dr. Baig. “It is difficult to draw the line when there is so much to do.”

By the sheer size of mobilization effort, the number of resisting households is coming down, from 5,000 in November 2002 to 2,500 in January 2003 in Meerut City alone.

“The job isn’t finished yet,” Dr. Baig stressed, gazing into the distance, “we just have to try harder.”
Social mobilizers at the district level had to work with government departments, NGOs, religious institutions and schools to publicize new rounds of NID and Sub-NID being planned (see Annex E: Partnership in Action: District Mobilization Plan). They also needed to undertake intensive social mobilization from the block level on. SMCs had to gain an idea of booth location plan and house-to-house visit arrangements from the Chief Medical Officer and WHO’s Surveillance Medical Officer (SMO). The information was then passed on to mobilizers at block level, who had to work with MOIC at the block to look at the mapping of high-risk areas with the largest number of X, XR, false P and false Po houses. At the same time, BMCs would recruit, train and supervise community members (CMCs) to track these families, convert false P into genuine P, false Po into genuine Po, and X and XR into P, round after round.

Out of the array of district partners, UNICEF undertook intensive mobilization jointly with two organizations: Rotary and the CORE Group of NGOs, diving deep into high-risk blocks and underserved communities. Rotary deployed 1,700 volunteers in 18 districts, and CORE operated in 5 districts. By March 2003, UNICEF expanded the network to 25 districts, including Rae Bareli, Sitapur, Pilibhit, Lakhimpur Kheri and Bahraich, engaging a total of 2,240 CMCs to scale up IPC with underserved, high-risk communities.


In early 2003, UNICEF also transferred management of the SM Network from New Delhi to its Lucknow state office. A full team of communication and technical staff was appointed to supervise and monitor the Network’s activities, ensuring closer coordination at each level of the 25 districts. The presence of a team had helped improve coordination with the UP government in Lucknow in
preparation for each round, as well as shoring up routine immunization of children. In addition to joint planning with the public health sector, the team also built on UNICEF’s on-going collaborative programme with the state education sector, the integrated childhood development services (ICDS) and the Panchayat Raj Institute, to mobilize broad-based support in convincing families across the state to immunize children, including districts without the SM Network.

**IPC Training and IEC activities:**

UNICEF extended the training for SMCs from two to four days based on assessment in 2001, and revised the original curriculum to sharpen its focus on persuasion skills. The new version went further on a) one-on-one counseling; b) how to conduct mothers’ meetings, c) focused IPC with parents of newborns, d) how to form groups to build peer pressure to induce conformity; and e) how to persuade local leaders, especially the Panchayat Raj Institute, the village level political and administrative authority, to take on the polio vaccination exercise. A flip book, a pocket board, an influencer’s kit, press kit and promotional gifts eg. paper sun visors were developed, intended for use by CMCs to conduct IEC activities before the NIDs and Sub-NIDs.

The flip book carried six stories that illustrated why people adopted positive behaviours in different situations to achieve a public good, and equated it to polio eradication. One story, for instance, told of several farmers agonizing over their potato field, which had been invaded by pests. They could not rid pests if one farmer, Kabil, a common name among both Muslim and Hindu, was spraying insecticide only on his own tiny plot. Likewise, for polio. “Children of your neighbours and others were just as important if India were to be rid of the disease. By refusing polio drops, you are like the farmer who sprayed insecticide on a small section of the entire potato field,” a message to resistant parents couched in the context and language they understood.

SMCs, all of them trained as trainers for BMCs, were briefed about the importance of engaging communities in issues larger than polio. The major factors of resistance, in particular the general lack of basic services in contrast to polio, were ones that gave rise to suspicion about the government’s motive. The SM Network was to position itself as a health communicator and an information channel for the community.
The OPV Misconception  
- Creative thinking paying off at the Kunderki Block

The Tibirkhas village, in the eyes of most Kunderki folks, is an enclave of rogues. The village, according to Sharafat Hussein, is notorious for theft, violent crimes and mob attacks. Families in other villages seldom hesitate to hold the Tibirkhas responsible for cattle and goats stolen from their backyard.

“I prayed to almighty Allah when I pedaled into Tibirkhas,” Sharafat Hussein recalled his first visit. “I wasn’t afraid of getting beaten up, I was worried whether I could persuade the people there to accept OPV vaccination.”

His worry would soon mutate into sweats. The first family he called on belonged to Mohammed Dildha, a brass factory worker. Washing clothes in the courtyard, Dildha’s wife peeked suspiciously at Sharafat. “What do you want?” she asked, and quickly walked into the house to call her husband.

“Beti (daughter), I am the Community Mobilization Coordinator of UNICEF doing some health work for children,” the 46-year-old Sharafat replied softly.

The woman paused for a while as she stepped across the threshold, suddenly realizing something. “Huh, you must be one of those polio people trying to get my children sterilized! Go away! Go away!” she squealed, turning around to shut the door.

“Wait a minute, Beti, can I talk to you for five minutes? It’s good for your children,” Sharafat stuck out his arm to push back the squeaky wooden door. He barely completed his sentence when a stocky man appeared from behind, raising his head and questioned: “Hey, why are you bullying my wife?”

Sharafat quickly explained: “Bhai Sahab, I am here to promote health care for your children, and I am not bullying her.” The man, obviously in a foul mood, took a rod from behind the door, and stepped out to confront Sharafat. “I am telling you to go now, if not you will feel sorry,” he raised the stick, threatening to beat the taller, leaner man in front.

Sharafat rapidly hopped onto his bicycle, and pedaled at top speed back to his own Imratrapur Sirsi village, about 3 km away.

Dejected, he told himself, nonetheless: “I must find a way.”

A respected teacher of the Madarsa (a Muslim religious school), Sharafat Hussein is assigned seven villages composed of a total of 6,500 households in the huge Kunderki Block of Moradabad District, Uttar Pradesh. There are twelve other Community Mobilization Coordinators (CMC) working around this Block, primarily made up of Muslim families who have long regarded OPV as a sinister plot to wipe out Muslims from India. The high resistance resulted in 9 cases of poliovirus infection in 2001, an additional 14 cases in 2002, the highest of all 13 blocks in the district of 4 million people. Like all other CMCs, Sharafat is picked from the Block to raise awareness, change attitude, dispel myth and rumour about polio vaccine to his own community members.

Holding a firm belief that the public could be educated, as all teachers would by their vocation, Sharafat decided to give Tibirkhas another try. A week later, he returned, bringing two police officers along.

Nothing, however, prepared the trio for the sight as they entered Tibirkhas. The villagers, getting wind of Sharafat’s visit, shut their door tight. There was no activity, not a single sign of the usual morning hustle when women would bustle about, and children run round. There were only a few stray dogs barking, and a lazy cat that skipped from its nap, skirted around, staring right into the intruders.

The eerie silence filled Sharafat Hussein and the police with unease. They looked at each other, decided to walk toward one house, and knocked. Peering closely from their window, the residents signaled to each other. Still hoping the door would open, Sharafat and the police suddenly saw people dashing out of their houses. Within a split second, an angry mob had gathered behind them, armed with staff and bamboos. The silence had broken out into fumes of fiery swears and glares.

Sharafat and the police were numbed by the scene. Their immediate reaction was to run for their lives, for even the police did not anticipate a cornering of this kind. “Please, please, we are only trying to promote child health, we are not here to arrest you,” one of the officers uttered feebly. The three of them inched their way toward the exit, hands half raised to urge the mob to stop, retreated slowly backward until they reached a safe distance, and started to run.
“What am I to do?” Sharafat pondered that evening. After a decade of teaching at the Madarsa, imparting Urdu, Arabic and the Koran to children 5 – 15 years old, Sharafat Hussein was unaccustomed to such fury and violence. In moments of reflection, however, he got another idea. “Why not talk to my own Village Pradhan (headman)?”

The next day, he went to the Pradhan’s home, and sought his help. The Pradhan, supportive of Sharafat’s work in Imratapur Sirsi where all children had been vaccinated with OPV at least twice, agreed to pay a visit to the Pradhan of Tibirkhas village. “Let me go on my own for you are likely to be attacked again,” the Pradhan said gently. He patted Sarafat on his back, and set off.

The discussion between the two chieftains resulted in a meeting called by the Tibirkhas Pradhan the next day. All of the families turned up, for no one dared go against their elected representative who held all the power on permit applications and papers requiring signature, among other things.

“OPV is OPV, and contraceptive is contraceptive. OPV is not a contraceptive, and there isn’t such a thing as OPV contraceptive,” the headman spoke through a microphone. “The community mobilizer is here only to protect your children against the crippling disease,” he stressed. “All other villages have participated in the vaccination exercise, you are the only ones resisting it,” the Pradhan shook his head.

The third day, Sharafat got the green light from his own Pradhan, “Son, you can now enter Tibirkhas safely.” Happily, he rode on his bicycle, and returned to the once threatening place. The women now obligingly came to the door. Though still unfriendly, they would spare a few minutes to listen. Some of them would argue back. The false belief in OPV as a sterility measure was so strong that a number of mothers simply hid their toddlers at the rooftop, vehemently denying there were any children eligible for OPV in the house.

Round after round of visits had honed Sharafat’s persuasion skill. He would devise all kinds of justification, and one that worked well with most resisting mothers was: “Beti, please do not think the government is dumb. If it really wanted to have your children sterilized, it could mix contraceptives in your ghee, cooking oil or turmeric powder. Why would they do it through a vaccine, and get someone like me to talk to you?”

Over eight months of intense house-to-house communication, Sharafat has built up a rapport with the Tibirkhas. “They aren’t as bad as others said. If you had won their trust, you would find them friendly and truthful.” Sharafat is proud that the number of resistant families, whose door is marked XR, has been reduced to 10 in all of the seven villages he serves, including 4 in Tibirkhas. He also helped out on Booth Days, pedaling around to bring children to the vaccination site set up in each village. Despite the good record, he knows it is not time to let up. Many families can reverse their decision. All it takes is a skeptic to spread another round of rumours.

The Dildha family in Tibirkhas, for instance, is not convinced yet after his seventh visit. The brass worker is citing his own source – a doctor - he claims, who warns that two doses of OPV will end the procreative function of his progeny forever.....

Sharafat Hussein, in the mean time, steps up his mobilization activities for the next National Immunization Day, which will take place on 9 February 2003.

In one of the regular meetings of all CMCs in Kunderki Block, he discovers that Dr. B.K. Dutt, Moradabad’s most famous pediatrician, has been going around other villages to convert resistant families. At a recent health camp organized by the CORE group – World Vision, ADRA and PCI India – together with the block’s Medical Officers in-Charge (MOIC) and the CMCs of UNICEF, Sharafat met Dr. Dutt and followed him to all of the XR houses. He witnessed the effect of having a medical doctor dispelling the myth of the “OPV contraceptive”.

Dr. Dutt, Chairperson of Moradabad’s Pediatrics Association, usually leaves his ward early for 15 days before the NID or sub-NID to volunteer his time for polio eradication. With three weeks left to the February round, there are still 452 houses marked XR in the Kunderki Block. “We must join forces, work together to change attitude if we want polio eradicated from India,” said Dr. Dutt, who has diagnosed 80% of poliovirus infection cases in Moradabad, long an epicenter of polio and the source of one strain found in cases as far as Bulgaria and China.

Quietly observing the doctor’s tireless refutation of every doubt and OPV myth of unyielding mothers, Sharafat Hussein is reassured of his difficult mission. Not only that, it also gives him a new idea on how to tackle the Dildhas in Tibirkhas....
The flipbook thus emphasized the concept of the whole child, from the moment the child was conceived to the moment it was born, and the care it needed for the first three years, life’s most vulnerable period. It drew links to the type of services parents should seek, especially routine immunization, and the prevention of acute respiratory infections and diarrheal dehydration, two of the major causes of child death in UP.

The UNICEF in-house trainer and the contracted training institute – UP Voluntary Health Association – also provided a range of materials addressing unrelated issues such as old age pension, prevention against malaria, improved disposal of waste water through community participation, etc. The network, in short, was a temporary “service team” to redress the protracted paucity of support from the system as the first step toward changing attitudes. One could not force trust on a skeptic unless there was visible proof of alternate actions that could induce a paradigm shift. It was easy for families to shut the door, and shut out polio drops altogether. It took a great deal more for them to open it and accept an idea they previously disowned.

The BMCs who were trained would encourage CMCs, their trainees, about 10 to a block, to use the flipbook and materials for meetings with religious leaders, local influencers, essentially people in position to invoke respect and sway opinions. By bringing influencers on board – teachers, medical doctors, social workers, village pradhans – the BMCs and CMCs would have cultivated additional IPC channels to advocate for polio eradication. Most communities, based on Coverage Evaluations, took to medical doctors for advice on issues of health. The BMCs and CMCs were not deemed at times qualified to answer child health issues, and there were simply too many questions in parents’ mind, especially mothers, whose only other reference was folk wisdom passed down from generation to generation.

Findings from a qualitative survey commissioned by UNICEF, “Understanding Barriers to Polio Eradication in Uttar Pradesh, 2002” also enabled the training institute to fine-tune some of the communication materials. A frequently asked questions brochure was developed based on concerns raised by respondents, to help CMCs answer very specific questions about repeated drops and whether OPV was the cause of polio.
Other activities that contributed to booth coverage included rallies and door-to-door visits of school children on immunization day. These activities were supported with communication materials structured into the training through the use of pocket board, containing a pack of cards, to address polio from a life cycle approach and a snake and ladder game with a polio theme to help CMCs orientate school children about polio. The exercise was intended to raise students’ interest in street rallies several days before the round. Door to door knocking on booth day was especially effective for parents without the time or interest to bring their children to the vaccination booth. Older school children, wearing an identity badge, usually came to the door offering to carry the toddlers to the booth. Some districts had developed innovative system of tracking by giving those parents at home a slip of matching numbers to ensure that the correct babies were returned to the house!

The four-day training could realistically cover only the minimum given the long list of activities the network was to conduct at the grassroots. A lot depended on the CMCs’ own ability to exercise creative and critical thinking to deal with different situations as they arose. Beyond the training, however, many CMCs had met together with their BMCs at the end of the day to compare notes, and to exchange ideas on how to apply, for instance, doorstep counseling to mothers, a common way for villagers and neighbourhood folks to interact.

Additional training, usually a one-day refresher session for CMCs, was conducted at times before the NID, to reinforce skills learning and use of the flip chart, given that most CMCs had no public health background and were often confronted with a barrage of questions from mothers. Such training was supplemented by use of the influencers’ kit, giving tips on how to enroll doctors and teachers - relative elites of the communities – in various mothers’ meetings to explain the ‘sciences’ of preventive health, and of course, polio eradication

The network followed essentially the same type of activities designed in 2001. But a new form had been devised to allow SMCs and BMCs to monitor the dates of planned events that comprised the following (see Annex G: Social Mobilization District Plan):

1. IPC with resistant families
2. Community meeting with NGO
3. Mother’s meeting
4. Saas-Bahu Baithak (family courtyard meeting)
5. Imam meeting (orientation and mosque announcements)
6. Eztma –Milad (Muslim activity)
7. Health camp
8. Baby show
9. School orientation with students and teachers
10. CMC meeting/training
11. Block level meeting with partners
12. Planning meeting
13. Contacting resistant houses
14. Routine immunization session
15. Mosque appeal from religious leader
16. Rally
17. Bulawa Toli
18. Door-to-door immunization

These activities were categorized into two major components: social mobilization and interpersonal communication. The strategy was structured through this set of activities to shift public attitude toward polio, generating an enabling environment for behaviour change during vaccinators’ visit.

Community Mobilizers (CMC) – the backbone of the SM Network:
A major feature of the SM Network was the 2,000 CMCs who served as the interpersonal communication channel to ensure dialogues and actions. The average age of CMCs was 30 – 35, comprising 45% women, with 60% of the total Muslims and 40% Hindu. They were selected based on the following criteria:

- Reside in key village to be covered by him/her
- Must belong to the resistant community in that area
- Preferably women (the aim was that 80% of CMCs would be women)
- Must demonstrate strong interpersonal communication skills and dynamic personality
- Well respected in their community, although not necessarily the most influential
- Able to give time required for the 15-day per month assignment
- Preferably with some formal education

The CMCs were selected and recruited by the BMCs, who had a better grasp of situations in their own block and advertised for the job by word of mouth. A premium was placed on communication skills and/or position of influence in the selection process. Given generally low education attainment among marginalized communities, it was not always possible to find someone who was completely qualified. The aspiration for achieving a gender composition of 80% women was also made difficult by cultural prohibitions against females from playing an active role outside their home. Most often, the BMCs had few choices but to accept individuals who fulfilled some criteria. In some villages, the Pradhan (Village Headman) had been brought on board as a CMC. In others, the
one and only school teacher, the social worker, and even students, the latter mostly assigned to work with local youth groups that took to a peer, more than an elder. There were also CMCs engaged from beggar communities, from among fishermen along the Ganges, from among nomads to track unvaccinated children in families that were constantly on the move.

The idea of engaging community members was built on the concept of community participation with a view to improve capacity for self-help initiative in other areas of child health. UNICEF had long held the view that polio eradication could not be implemented as a stand-alone programme. Routine immunization, the mainstream immunization service vital to achieving and sustaining zero case for polio, was ironically, at an abysmal coverage rate of 22.3% in UP in 2002.

CMCs thus gave a start to greater engagement of underserved communities, especially Muslims, to achieve the objective of converting resistant families. The ANM, a lone member visiting from outside, was in no way able to accomplish it unless she had established a rapport with them through years of service (in which case mass resentment would not have occurred.)

The “hiring” of CMCs for 15 days in preparation for the round was one way of ensuring results within a short period of time, and jumpstarting a communication process that was never in place. Each CMC who was trained on interpersonal and persuasion skills, was also tasked with as many as 18 activities (see annex F: Social Mobilization District Plan) to support, including working with local NGOs, influencers and religious leaders to convince resistant families. And many were retained after the vaccination round to continue to implement the IPC plan in preparation for the next round. They also provided a link to accelerating routine immunization coverage and helped facilitate community participation in the promotion of child health. In 2002, as many as four Sub-NIDs were held in UP, from April to November, followed by two NIDs in January and February 2003.

One of the most solid measures of CMCs’ performance was the tally sheet on booth day. A 100% attendance in his or her village was reflective of general community support for the programme, as well as a decline in localized resistance to polio immunization. Another measure was the reduction in percentage of missed houses. CMCs were informed clearly that the end-goal was to work themselves out of business, ensuring that X and XR were converted during catch-up vaccination at home. And they were in the best position to monitor whether P-marked houses were true, and whether children in false P houses were vaccinated.
A bonus from eradicating polio
-- Meeting health care needs in villages of Bareilly

Dr. Sher Mohammed woke up to the rapping on his door at 2 am. A weary mother stood outside with a three-month-old baby in her arm, accompanied by a man who looked distraught.

“Doctor, we have come all the way from Salinpur because we don’t know what’s wrong with our son,” said the woman.

The child’s body was covered with rashes; Dr. Mohammed brought them promptly to the living room and took out his stethoscope. He moved the disc on the tiny body, stuck a thermometer in the armpit of the crying toddler. The temperature was 104° F, he was alarmed.

“Bhai Shab and Behenji, have you given him measles vaccination?” he asked.

The parents shook their head, searching his eyes for an explanation. “By the look of it - red, watery eyes with tears and nasal discharge, your son appeared to be infected with measles,” the old physician said.

“But not to worry, it is a common disease of children,” he put away the thermometer. “We’ll first bring down his fever, and the rashes should go away after a few days.”

“However, if the fever doesn’t subside by tomorrow, you must rush him to the district hospital,” the doctor cautioned, fearing secondary bronchopneumonia could infect the toddler’s bronchial tubes, and it could be fatal.

Dr. Mohammed got up, walked to a shelf artfully chiseled out of the wall, where boxes of drug, including iron folic tablets and ORS packets, were stacked neatly. He tore off a row of antibiotics, handed it to the mother, advised: “You must let the child rest, protect his eyes and if possible, give him steam inhalations to reduce irritations to his throat and lung.”

A visible sign of relief returned to the young couple. They joined their palms together, and bowed to thank the old doctor at the door.

Ever since Dr. Mohammed opened his Health House two-and-a-half months ago in Haharpur Marokeeru Village, Bareilly District, he had been receiving patients not only from his community, also those from surrounding villages.

Set up with a small seed fund from the Polio Social Mobilization Group (SMG) of his village, the Health House is a spin-off in UNICEF’s effort to reach and vaccinate every child against polio in Bareilly.

“I have diagnosed five cases of measles for the past months,” the bearded elder told Arish Syed, UNICEF Sub-regional Coordinator (SRC) for Bareilly, Moradabad, Rampur and Badaun districts, during his pre-round monitoring of the National Immunization Day (NID).

“It all started with an outbreak in the neighbouring village...... a toddler died of secondary bronchopneumonia,” he sighed. “A month ago, I convinced the ANM (Auxiliary Nurse and Midwife) to start a vaccination campaign against measles in villages within 5 kilometers of Haharpur Marokeeru.”
The ANM agreed, and Dr. Mohammed quickly pedaled to four other villages – Kaina, Salinpur, Pantnomala and Santoshpur - where he once served as a UNICEF Community Mobilization Coordinator (CMC). He informed the Social Mobilization Groups (SMG) of each village about the measles vaccination exercise in his Health House, asking them to send parents over.

The SMGs sprang into action after the discussion. The team in each of the villages went around, knocking at the door of every family to announce the vaccination date: next Wednesday, at the Haharpur Marokeeru village.

“We were able to vaccinate nearly a thousand children over two weeks,” Dr. Mohammed said with a contented smile.

The ANM, a government health worker, was required to conduct routine immunization every Wednesday in the village. But she showed up only once a month, and sometimes, once in two months. Thousands of rural communities in Bareilly, and millions more in the State of Uttar Pradesh, were underserved due to the health system’s poor supervision of ANM’s work from the Block level on.

But now that she had a resting place and a fixed location to deliver her service, the ANM was coming to Haharpur Marokeeru weekly. The arrangement also spared her the trial of hauling a bagful of essential drugs and the cold box into every village, often under the hot sun, by foot. She now kept the drugs in the Health House.

“I also invite the ANM to conduct community meetings to impart knowledge about routine immunization to parents,” he said. “Many do not know what BCG, DPT and measles immunization are given for, and their children are only protected with OPV.”

Though Dr. Mohammed is no longer paid as a CMC, he is happy with the honorary title conferred to him: “UNICEF Volunteer”. He continued to maintain regular contact with the five Social Mobilization Groups he had set up for the polio eradication campaign, organized children’s rally and street dramas to remind parents about Booth Day on NID. Each Group, led by the Village Pradhan (Headman), consisted of 10 to 12 influential people, including Imam, teachers and social workers.

“A mother used to tell me: ‘I’m fed up with polio. Polio drops, polio drops all the time. I will go to the booth only if you provide other health services to my family,’” he recalled.

“The Health House is the answer to her need, and the need of numerous others,” he added with a grin. “Since starting the 24-hour service at my courtyard, I no longer had a hard row to hoe.”

The number of resisting households in his village had gone down from 45 last year to zero in January 2003.

“I’ve also cultivated a Health Garden,” said the local practitioner of Urani and Ayurvedic medicine, as he strolled across the road to a small, open field opposite the Health House. An array of green, leafy vegetables came into view, blossoming from the ground, fed by a furrow consisting of a narrow stream of water.

“I show the mothers here how simple it is to enrich their children’s diet with Vitamin A,” he plucked a stalk of spinach, “and it is so easy to grow.”

“Everyone is happier with this holistic approach to child health, they don’t gripe about polio drops anymore.”

Dr. Mohammed (right) with a mother who comes to his Health Home for iron frolic tablets
Multiplying effect:
In fact, many CMCs had become partners of the programme even after successfully getting all children in their village vaccinated. In Bareilly district, for instance, all former CMCs had gone on to become volunteers, directing actions for the next round. The SMC had also leveraged these community resources to set up a number of Social Mobilization Groups in each village. As families in one village were converted a new CMC in another village would be appointed. The rotational engagement of CMC now spawned 1,400 voluntary SM groups in Bareilly, harnessing enormous potential for better village health care. About a hundred Groups have gone on to set up Health Houses, conducting regular health education, distributing iron folic tablets, ORS packets and cold medicine to communities. The concept was a plus not only for families but also the government’s ANMs. “The ANM now has a place to conduct routine vaccination, talk to families, and drink a cup of tea,” said Vijay Kumar Sharma, a CMC and a young college student, who had offered his own courtyard as a Health House.

In Moradabad district, a local pharmaceutical company donated Rs 12,000 ($255) worth of cough and cold tablets, antibiotics and other basic medicine to a health camp organized by the Core Group of NGOs (ADRA, World Vision and Population Council of India) and UNICEF. CMCs in the Karula Block where the camp was to be held had conveyed families’ dissatisfaction with the lack of drug supply in the area to their BMC, who in turn alerted the SMC to the issue. The SMC then called up her contacts, and lobbied the director of this company to help. The drug arrived the day before the Health Meal where ANMs would also be around. Most of the parents flocked to the camp site with their child, and over a hundred young children were vaccinated, not only with OPV but other routine antigens.

The SM Network abounds with narrative of local donations, successful mobilization of resources around issues close to the heart of underserved communities, in particular Muslim communities: health care. The Health Mela and more recently, baby shows, were invariably a success with parents who had endured years of deprivation of services, medical supply and information directed at them.

Feedback loop:
CMCs’ daily contact with families had also contributed to booth location selection. The distance between home and the vaccination booth had always been one of the discouraging factors for parents. Many CMCs had related community’s views to
their BMCs, who in turn conveyed it to the MOIC at the block, and to the SMC who shared such information with the Chief Medical Officer (CMO). A number of social mobilization groups formed by CMCs had also volunteered to set up their own booth, in locations closer to their communities. The BMCs then notified the SMC, who consulted with the CMO and Surveillance Medical Officer, and down the line to ensure vaccines were delivered to the volunteer-manned booth on immunization day.

Earlier experiences had demonstrated relative ineffectiveness for the SMC to manage village-level activities without a BMC in between. In a huge state like UP, the distance between the district headquarters and a village could mean two hours on a vehicle. And like most families in rural areas, CMCs had no telephones at home. The BMCs usually maintained contact by moving around the CMC villages on bicycle or motorbike, and the proximity had certainly helped brought about closer supervision, timely coordination and actions.

Advocacy with Muslim leaders
Building on the positive experience of engaging paediatricians in 2001, UNICEF took a step to advocate the cause to Muslim leaders in 2002. Together with Rotary, it initiated a new partnership with Aligarh Muslim University (AMU) in UP, convincing the Vice Chancellor, a venerable national figure, to issue an appeal to all Muslim communities. A press conference took place in Moradabad, and the appeal was reproduced in Urdu pamphlets, giving SMCs, BMCs, and CMCs an additional but vital tool to engage local imams in the cause. Although many of the Muslim CMCs had successfully mobilized imams and local mosques, for instance, in using the call to prayer to announce date, time and venue of NIDs or SNIDs, not all parents had come forward due to the concern that OPV would lead to infertility. Endorsement by a respected Muslim institution or leader would lend authenticity to OPV as simply a vaccine to free India of polio. A number of Aligarh’s alumni were also paediatricians and specialists in community medicine, whose presence in health camps and mothers’ meetings had made a difference.

The appeal aside, the Vice Chancellor, Naseem Ahmed, addressed 2,500 people at a Friday prayer to imams, including the “shehri imams”, clerics from some of the highly resistant areas of Moradabad. Together, they exhorted Muslim communities to accept polio drops without fear, and assured them of OPV’s safety and effectiveness. The partnership had engendered great visibility of Muslim leaders’ involvement. It also activated young Muslims under the National Service Scheme (NSS), essentially scouts made up of college students, to fan out to different neighbourhoods to talk to families, and bring young children to the booth.

Setting targets
UNICEF learned the lesson in 2001 and proceeded to set clear objectives for the SM network. The Sub-regional and district coordinators, directly contracted by UNICEF, were accountable for the following results:

In resistant communities where UNICEF supports community mobilizers and intensive mobilization activities, there would be, by the end of the NID rounds in 2003:

1. 20% increase in under-5 children immunized on booth day during NIDs 2003
2. 25% reduction in X-marked houses during House-to-House vaccination following each round
3. 100% conversion of X-marked houses to P-marked houses following B-team activities
Strictly, these were not communication objectives, but good proxy indicators of behaviours integral to the programme and its target result. Under the dominance of the technical strategy and exigency of tracking and controlling the disease, the data collected invariably centered on booth turnout, Xs and Ps. Much as there was wide recognition that improvement of these indicators depended on families’ attitude and behaviours (apart from a SIA well operated), there was relatively little capacity within the health system to collect, collate and analyze a separate set of data that were exclusive to communication. Communication, in the first place, was largely perceived in terms of posters, banners, news articles and IEC activities, visibility in short, and hardly in terms of quality of information, message recall, knowledge gained and adoption of positive behaviour after the intervention.

Although the UNICEF-support Coverage Evaluation did attempt to capture some of it, such as the source of information and reason for not vaccinating children, the results, useful for communication planning, were not geared toward monitoring of IPC outcomes after each round.

Thus the closest indication, in this case, was the utilization of service by parents, where behavioural change was interpreted in increased booth turnout, reduction of X-marked and false-P houses. UNICEF monitored the SM Network’s results from the same data set – compiled each round by the block MOIC – based on booth and house-to-house tally sheets filed by vaccinators. The block mobilizers (BMCs) would go to the MOIC office, select data pertaining to villages and urban areas where CMCs were working, and inform the SMC, who in turn passed on the results to UNICEF.

**Promising results**

Over the months, between November 2002 and January 2003, the SM Network with its full-scale involvement of partners and communities themselves, had contributed to the state-wide results as follows:

- An increase in the number of children vaccinated from 30.48 million in November 2002 to 33.96 million in February 2003;
- An increase in the number of children vaccinated at booths from 8.77 million to 14.70 million over the same period, representing a 67% rise overall;
- Decrease in the percentage of ‘False P’ houses from 8.5% in April 2002 to 3.4% in February 2003;
- Decrease in the total missed houses from 11.9% in June 2002 to 6.8% in January 2003, but increased to 7.8% in February 2003;
- A fluctuation of % X-marked houses, however, from 3.5% in June 2002 to 4.4% in November 2002, and down to 3.5% in January 2003 but went back up again to 4.4% in February 2003.

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43 Often the use of this indicator also brings communication and the technical programme into the murky area of “who gets the credit”? The utilization of services could increase as a result of communication influence, but also improvement of the service itself. Situations like this makes it difficult to isolate one factor and attribute change to a dominant source of intervention.
Graph 14: Total number of children immunized (OPV) in various rounds of NID and SNID, Uttar Pradesh, 2002 – 2003 (Source: GOI/WHO NPSP, 2003)


While the fluctuating percentage of X-marked houses (Graph 17) could be attributable to many reasons, the total number was coming down along with the gradual shrinkage of % missed houses over the months. The most remarkable reduction was in the percentage of false-P houses, indicating more and more houses with target children had been detected, with children subsequently vaccinated (genuine P). The scenario coincided with the UNICEF compiled data after the January 2003 round showing a higher percentage of P houses in areas with CMCs, compared to areas that had no CMCs. It is an indication that CMCs, who were familiar with their own communities, had been able to effectively detect false marking through their daily interaction with resistant families.

Graph 18: % P-marked houses in CMC villages vs. district average after Jan 2003 round, by Sub-region, UP (Source: UNICEF India, 2003)
Another indication of the impact of CMCs was in the % of Po houses, where parents were likely to claim they had no children below five years old (Graph 19). In areas where CMCs were present, the percentage of Po houses was invariably lower than the district average. It was obviously more difficult for parents to hide the truth or hide their children when there was someone from the same community that knew just about everyone. But this could also reflect the slight increase in X-marked houses in that parents might choose to leave the house altogether, either by themselves or taking the children along, or simply lock the door, to avoid the vaccinators and CMCs, who usually accompanied them around. Another explanation for the slight increase was that February was the harvesting season for most farmers, who were most likely out in the field during vaccinators’ visit.

Graph 19: % P Houses in CMC villages vs. district average, by Sub-region, UP, Feb 2003 (Source: UNICEF India, 2003)

The most notable difference in areas of a district with and without IPC intervention was shown in booth coverage after each round. Graph 20 presented the result of the February round:

Graph 20: % Booth coverage in CMC villages vs. district average, by Sub-region, UP, February 2003 (Source: UNICEF India, 2003)

The percentage of children vaccinated at booths in the CMC areas in February 2003 increased by at least 50% from the previous round across all sub-regions, and at a higher rate than the districts as a whole. In April 2003, the Sub-NID conducted in UP showed an overall increase in booth coverage of all 25 districts where the SM Network was present, and where 9 districts had more than doubled their coverage (see Annex F).
When measured by absolute numbers, the graph above showed a 23.5% increase in vaccination at booths in 25 districts where community mobilizers were working, compared to 7.6% increase in districts as a whole. In both cases, the trend was moving encouragingly upward. The CMCs were assigned each round to the most difficult areas based on results from the previous round. The results generated in these areas were of particular importance since children there were often the ones being missed.

The IEAG, at its seventh meeting on 24-25 February 2003, had given due recognition to communication for its place in improving the quality of the rounds in January and February 2003. It noted a significant progress in UP that came with the following intervention:

- Intensification of communication activities and expansion of the social mobilization network in the state, and increased involvement by teachers and students in community mobilization
- Introduction of block monitors to support micro-planning and monitoring; increase in the number of teams with at least one female vaccinator and an increase in the percentage of teams with a third member drawn from the community.

It was an affirmation of the current strategy – as an approach that made the difference – in an emergency when every family, and every child counted.

**Village contact drive**

A mother of six children who had just returned from the vaccination booth at Haharpur Marokeeru village
The massive spread of polio cases over UP in 2002 evidently went beyond areas that the SM network could cover. The urgency of putting an IPC strategy in place, especially in the northern and eastern part of UP, brought UNICEF into another type of interpersonal communication activity: the use of advertising agencies working in rural areas to market and renew public interest in polio drops. The number of cases emerging every month did not allow time for replication of the network structure in dozens of districts, neither was there sufficient budget. Yet an intervention that achieved scale and matched the rate of the disease’s transmission was important since large tracts of affected areas invariable fell on families without access to the broadcasting media. An interpersonal communication blitz to push for increased vaccination in the January and February 2003 rounds, which could be quickly put together, and carried out within the shortest time possible, was deemed essential.

Like the SM Network, the Village Contact Drive (VCD) used the most effective mode of communication in rural areas – words of mouth – except it was conducted in a streamlined, rapid and business-like manner. The approach served primarily to inform, and clarify doubts in the process, in areas where resentment to OPV was less intense and entrenched than western UP. UNICEF contracted three advertising agencies: Ogilvy Outreach, the rural marketing arm of O&M India, Thomson Social and Lowe Lintas, and two NGOs: NYKS, a youth network and Rehman Foundation, a Muslim NGO, to rejuvenate booth turnout in 30 districts and the Lucknow municipality, ten days before each round.

Ogilvy sent out some 650 local marketers in teams to some 6,000 villages in 9 districts. Thomson Social dispatched 350 promoters to 3,000 villages in 6 districts while Lowe Lintas fielded 500 operators to 640 villages in 6 districts. NYKS took on 8 districts whereas the Rehman Foundation covered one district.

**Ogilvy Outreach**

Unlike the SM Network, the village contact drive was modelled on commercial marketing concepts. Brand identity was emphasized, in this case, polio drops, and all promoters were clad in bright yellow anorak and cap, heading into villages in a team of two to three members. Ogilvy, with the largest contingent, devised a series of day-long IEC activities, conducted in the following sequence:

1. Meeting with the Village Pradhan
2. Conducting an entry poll with villagers to determine baseline knowledge of polio
3. Calling a courtyard meeting with village elders, religious leaders and influencers to inform them about the date of vaccination, and clarify doubts and myths about OPV
4. Conduct mothers’ discussion
5. School rallies – organizing processions with students and children around the village
6. Drawing contest – enhancing children’s understanding of polio
7. Rallies again – taking the procession back to the village center
8. All-families meeting to pick the best drawings, and presentation of gift by village elders
9. Families’ nomination of “Vaccination Day Focal Points” to form teams, organize similar rallies on NID to remind families to go to the booth
10. Exit poll to determine information and knowledge gained

The idea was to bring an advertisement to life, using sight, sound, and actions to enhance subliminal absorption of the message: OPV was good for your children, take them to the booth on NID. Any doubts were instantly clarified through families’ interactions with the promoters. The coloured uniform served to reinforce recognition of the NID posters and banners, all of them printed in bright yellow, which would be put out everywhere two days before the NID and Sub-NID. The “Focal Points” were each given additional posters to paste on village entrances, to provide a visual reminder to parents as the day drew near, after the advertisers were gone.

What Ogilvy was able to achieve was scale over a short time. Unlike the SM Network, time for quality discussion was confined to a session when the promoters were around. But the whirlwind visit to 3,000 villages in the January round, and another 3,000 villages in February, all of which conducted 10 days before NID, had allowed the message to spread in large tracts of areas with several million children. The graph below showed the increase in number of children vaccinated in all blocks that went through the village contact drive:
An entry/exit poll conducted by O&M in April 2003, showed a visible increase in information and knowledge gained among 2,552 randomly selected respondents after going through the IEC activities:

**Table 9: Entry/exit poll conducted by Ogilvy Outreach in blocks with VCD, April 2003**

<table>
<thead>
<tr>
<th>Major findings</th>
<th>Entry</th>
<th>Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>% People relating polio to physical disability</td>
<td>85.81</td>
<td>92.05</td>
</tr>
<tr>
<td>% people of the opinion that it affects children only</td>
<td>83.98</td>
<td>96.14</td>
</tr>
<tr>
<td><strong>How to prevent polio</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot be prevented</td>
<td>10.04</td>
<td>3.05</td>
</tr>
<tr>
<td>Administering Vaccine</td>
<td>89.96</td>
<td>96.95</td>
</tr>
<tr>
<td>% of people believing that his/her children aren’t safe till every child is immunized</td>
<td>46.56</td>
<td>72.36</td>
</tr>
<tr>
<td><strong>Intentions to act after the exercise</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nothing</td>
<td>18.92</td>
<td>8.17</td>
</tr>
<tr>
<td>Motivate others</td>
<td>60.50</td>
<td>80.76</td>
</tr>
<tr>
<td>Indifferent</td>
<td>20.58</td>
<td>11.07</td>
</tr>
<tr>
<td>All children below 5 Yrs should be given polio drops</td>
<td>93.20</td>
<td>98.07</td>
</tr>
<tr>
<td>% People believing that it should be given to newborns also</td>
<td>83.97</td>
<td>93.26</td>
</tr>
<tr>
<td>% People believing that it should be given to sick &amp; weak children</td>
<td>78.81</td>
<td>84.39</td>
</tr>
<tr>
<td>% People believing that it should be given to children previously vaccinated</td>
<td>61.09</td>
<td>88.11</td>
</tr>
<tr>
<td>% of people aware of 6th Apr. as Pulse Polio Day (SNID)</td>
<td>43.90</td>
<td>93.61</td>
</tr>
<tr>
<td>% of people aware of June 1st as Pulse Polio Day (SNID)</td>
<td>29.21</td>
<td>80.81</td>
</tr>
<tr>
<td>% of people aware of both dates</td>
<td>27.63</td>
<td>79.72</td>
</tr>
<tr>
<td>Intentions to get the child Immunized on Pulse Polio day</td>
<td>94.19</td>
<td>98.59</td>
</tr>
<tr>
<td>Intentions to get the child Immunized at the booth</td>
<td>73.28</td>
<td>93.09</td>
</tr>
</tbody>
</table>
Marketing polio drops in rural India
-- Village contact drive in Ambedkar Nagar District

The mustachioed Suraj Dhasamana is long associated with the *Fair and Lovely Facial Cream* in eastern Uttar Pradesh. The tan and burly promoter of cosmetics has made his name cultivating teams of *Fair and Lovely Didi* (Ladies) in villages of Ambedkar Nagar district. Day in and day out, he revs up the subliminal yen for “strikingly beautiful skin at a low price” in women young and old.

Recently, Suraj is going through an identity change, rousing curious stares and giggles from villagers. No longer moving about with the didis, he now adorns a bright yellow anorak, a cap, and proclaims: “Two drops for life. Your children aren’t safe until polio is eradicated from your village.”

His merchandise is special for the OPV vaccine is available at retail outlets - vaccination booths set up in schools and health centers - only on National Immunization Day (NID). His sales target is something most companies covet: parents of every single child under five years of age.

Suraj’s brilliant yellow uniform is a brand identity for polio eradication. It breaks the prosaic tenor of tawny hamlets, drawing attention to the man as much as the product he advertises. The poster, the flag and the banner he carries are all coated in the same colour.

Ten days before the NID, Suraj would cram into a small jeep with nine other young men at 7.30 am, traveling 15 to 20 kilometers to a rural block daily. The driver would drop a pair of “Polio Men” in each village, speed off, drop another pair and return at 5.30 pm to pick up each team.

“Once hopping out of the jeep,” said Suraj, “my teammate, Kalif, and I will move swiftly to the home of the Village Pradhan (Headman). We explain why we are here, and seek permission to conduct several activities for the day.”

No less curious than his community members of the spectacle, the Pradhan usually gives a nod and leads the team to the courtyard. As Suraj lays out his publicity materials on a charpoy, Kalif takes out a loudspeaker, moves around briskly, calling every family to the gathering place.

“Bhai Shab and Behen, please listen. We are here today to inform you about polio eradication,” he hollers, with a pictorial flip book in hand. Page by page, he describes the Pulse Polio Immunization Programme, and why families should participate in Booth Day for their children’s benefit.

“Give them two drops at the vaccination booth on 9 February, protect them from polio,” he urges. “And your children must take the drops for each and every round, even if they have been vaccinated before.”

Suraj ends his orientation with a question and answer session. The courtyard, by now, is packed with elders, women and children.

“Are there any families you know who do not want to give polio drops to their children?” Suraj asks, to break the ice. “Yes,” an elderly man raises his hand, “my family.”

“Many people say that polio drops are a plot to control fertility in Muslim children, who’s sending you to our village?” the bearded man, obviously not Suraj’s previous target for the *Fair and Lovely Cream*, presses on.

“Bhai Shab, rumours are rumours,” Suraj retorts gently. “Think critically. If I start a rumour now saying your sugarcane is poisonous, will you believe me without double checking? Will you destroy all of your precious harvest just because I say so?” The old man is silent, the reply drawing nods from the crowd.

With good knowledge of the village’s economic mainstay, Suraj knows his argument appeals to most families who grow sugarcane for a living.

Hired by Ogilvy Outreach, a marketing agency, Suraj is one among 650 promoters to spearhead the village contact drive for UNICEF in nine districts of eastern UP: Ambedkar Nagar, Azamgarh, Barabanki, Basti, Faizabad, Gonda, Jaunpur, Mau and Sitapur.

Covering 5,000 high-risk villages, the marketing effort is part of a larger UNICEF-led social mobilization exercise to contain the surge of poliovirus infection in the state of 170 million people. The eastern districts, along with those in the west, had experienced an explosive polio epidemic in2002. When resistance was strong, fueled by rumours and the absence of other essential services, the mere availability of vaccines was insufficient to stop the virus’ rampant spread.
The answer is a three-prong strategy conceived by UNICEF to help the Government of UP change the attitude of families in high-risk districts. TV and radio advertisements are transmitted nation- and statewide, ten days before the NIDs, held separately on 4 January and 9 February 2003. Three types of messages, endorsed by India’s best known celebrity Amitabh Bacchan, run parallel to the village contact drive, which uses interpersonal communication to reinforce public knowledge of polio drops and encouraged participation in NID, especially the first day of vaccination at the booths. Besides Ogilvy, UNICEF also has brought in two other marketing agencies: Thomson Social and Lowe-Lintas, to expand its reach to 22 districts of eastern and central UP.

Concurrent with the village contact activities, UNICEF supports a network of 2,500 Community Mobilization Coordinators (CMC) in another 25 districts to broaden its outreach. Trained on interpersonal communication and partnership building, the CMCs operate in high-resistant areas to mobilize hundreds of thousands of target families to the vaccination booth on NID. The largest ever in the world, targeting 165 million children under five throughout India, the NID in UP is given a special push because the state alone accounts for 68% of the world’s poliovirus infections.

The combined approach now delivers quality information to millions of families in 47 out of the total 70 districts of UP.

With the largest operation of all three agencies, Ogilvy sends out a legion of 275 teams to conduct daily, intensive interactions with parents and children ten days before the round. As Suraj finishes his courtyard meeting, he goes on to organize a rally. Flock of children, spontaneously formed, jostles for the bright yellow banner. With a yellow badge pinned on their clothes, the group march on with the “Polio Men” chanting: “If we want to get rid of polio, we must go to the booth on 9 February!”

“Getting children on board to publicize the NID is often effective for they normally remember the event on the day itself, and will excitedly remind parents, grandparents and caregivers to bring younger siblings to the booth,” says Suraj Dhasamana. “Older children usually turn up with toddlers, especially when their parents are busy,” he adds.

At the end of the rally, the two “Polio Men” put up the brilliant yellow posters on key junctions of a village. Often torn down by kids, the posters are timed for pasting after the rally so that children understand the significance of the colourful sheets. The festive ambience gives Suraj and Kalif a chance to rally children to the village school, and organize a drawing contest. Hundreds of them – from grade 1 to 5 - sit around the open field to draw a crippled child. The best contestant – selected in the next event - will be given a certificate of recognition, an honour for every child and parent!

The highlight of the day is a village meeting – the bhaithak – after the drawing contest, at a time parents are returning from the farm, around 5 pm. The team, now trailed by hundreds of kids, gambols back to the courtyard. The crowd’s jesting and cheering advertise the meeting without much effort. As parents and elders gather to watch, Suraj personally drops in at the Pradhan’s resident to invite him over. Through the headman, he also makes contact with Imams and other religious leaders of the community, and walks them to the gathering place.

In the glare of the entire village, the “Polio Men” summarizes events of the day, thank the leader for endorsing their work. Suraj goes on to request the headman to appoint four adults from his village to assist with mobilizing children to the booth, and ensure no children are missed when vaccinators follow up with house-to-house visits. And Kalif, who puts out all of the drawings on the wall, then asks the community to pick the best three. The winners, proudly steps out to receive the certificate, are also given several bright yellow polio drop posters, imprinted with the date of NID. They will be tasked with constituting a calling brigade – mobilizing other children – to go around reminding every family on booth day, repeating the rally that has brought much merriment in the morning.

“The activities are very informative,” said Rasda, a mother of four, with an 18-month-old boy in her arm. “Now every household knows the date and importance of polio drops,” she smiles demurely.

As the day draws to a close, Suraj takes out a questionnaire, randomly approaches five people for an exit interview. It enables him to gauge whether the villagers have understood polio, who are the target for vaccination, why the need for repeated doses, the date of immunization, the source of information and finally, whether they will go to the booth on NID.

At the end of each day, the 275 teams will have generated the findings of 1,375 respondents, and 10 times the amount (over 10 days) by Booth Day. “I have personally learned a lot about polio and its harm to our children from this job,” Suraj says as he packs up. “I also realize how much people in the village are deprived of health knowledge,” he hoists a bagful of publicity materials on to his shoulder. “If they do not have the proper information, we cannot expect them to do the right thing, such as going to the booth,” Suraj beams, surveying the courtyard to see if he has left anything behind.

He walks to the jeep, which is purring down his way, and hums a tune to end his day.
Thomson Social

Thomson Social applied a slightly different approach. It ran a puppet show (kathputli) at 500 village Haats, a crowded weekly marketplace that drew hordes of buyers, sellers, men, women and children from their homes. A Haat converged in a town that was the hub of six to eight villages, and a team of four promoters, adorning similar, bright yellow uniform, ran the puppet show to attract the crowd. Like the Ogilvy team, the Thomson team also relied on a flip chart, adapted from the SM Network’s training material, to explain the rationale for polio eradication to folks drawn to the sight and sound. The puppet show was scripted based on a number of focus group discussions and qualitative evaluations, and created around the conversation of four people: Jumman, a Muslim, Balwanta, a Sikh, Ramprasad, a Hindu and Dr. Saab, a medical practitioner. Humour was woven into three segments of a continuous dialogue between the four, which served to educate and entertain on:

1. Why repeated doses even though everyone was tired of OPV
2. The “science of eradication”, which was akin to spraying insecticide on the entire potato field. Each child left unvaccinated would expose another child to the risk, and the same applied to one’s own children.
3. OPV would not cause sterility or make children grow a tail, the virus was spreading as fast as rumours, and it would indiscriminately attack children of any caste or creed, of any socio-economic status.

As the team of promoters ran the show and spoke to onlookers, two other teams would move into villages close by to conduct IEC activities. Children were organized and led by the promoters to form a procession around the village, followed by a courtyard meeting with village leaders, influencers and mothers, where they were informed about the NID, along with questions and answers about OPV. Thomson also produced a calendar that carried a routine immunization schedule as well as dates of NID, targeted at school children. The idea was to motivate children to remind parents about vaccination dates for their younger sibling.
They were also given posters to paste on key lanes and village entrances a day before the event.\textsuperscript{44} The intensive outreach enabled UNICEF to cover 2,894 villages and interact with some 600,000 target audience, essentially parents, within 10 days. An entry/exit poll conducted by Thomson showed an improved understanding of the target for OPV vaccination, whether young children could receive polio drops when they were sick, and whether newborns should be vaccinated:

**Graph 24:** Entry/Exit poll of 3,356 respondents, Nov 2002 – Feb 2003 (Source: Thomson Social, India)

![Entry/Exit poll chart](chart)

The intervention also contributed to an increase in booth attendance of children in blocks exposed to the puppet show and IEC activities:

**Graph 25:** Booth coverage increase in districts with Village Contact Drive, Nov 2002 - Feb 2003 (Source: Thomson Social, India, based on tally sheet returns in blocks exposed to VCD intervention)

![Booth coverage chart](chart)

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\textsuperscript{44} Posters pasted on roadside and walls tended to be torn off by people after a day or two. With a short life-span for display, the OPV posters were put out only 1 – 2 days before the NID.
**Lowe, NYKS and Rehman Foundation**

Lowe of Lintaland Advertising, adopted a largely similar approach except for the puppet show. It went around some 500 urban slums and villages in a video van that screened spots of Amitabh Bachchan (described in the next section), and conducted similar IEC activities at schools.

The other two organizations, NYKS and Rehman, however, replicated largely the SM Network’s IEC activities. NYKS, a young people’s network active in 8 districts, staged village miking - megaphone announcement of NID - staged street plays and cultural shows, to draw attention to OPV vaccination. These activities, planned together with UNICEF, GoUP, WHO and Rotary, were substantiated by door-to-door visits to families, meeting with village leaders (Panchayat members), influencers and wall writings. Rehman Foundation, a faith-based organization, made special efforts to meet with Imams and distribute Urdu language appeals with quotations from the Koran. A small NGO, it could only focus on Barabanki district, and within it, 100 high-risk communities where resistance to OPV was reported.

**Amitabh Bachchan to rekindle interest**

The focused, intensive IPC effort, albeit vital, could not replace the pervasive influence of the mass media, especially for the majority of families across India. For them, it was fatigue that nibbled at the edge of their minds after repeated rounds of immunization. And for them, it was the notable disappearance of polio cases in India, with children in calipers now a rare sight, that brought on a disinterest in OPV vaccination. There was no resentment, only a sense of complacency that polio would not affect one’s children; after all, they had been given many, many doses.

Booth attendance had dropped from its heyday of 97% in 1997 – 98 to 81% in 2001 – 02 (see Table 3 and Graph 3). A growing number of parents were no longer interested in taking children to the booth. The trend was worrisome for it signified a more strenuous, extensive house-to-house for every round and escalating costs to track down children and bring vaccines to the door of millions, not only those in endemic states but also those outside. The waning interest further sent an alarming sign of changing health-seeking attitude; it did not bode well for routine immunization, which required families to make a conscious effort to take young children to a fixed location for injection.

Building on its tradition of engaging celebrities worldwide, UNICEF began to look for India’s Bollywood’s icons to motivate families’ return to the booth. A name that jumped up immediately was Amitabh Bachchan, India’s most celebrated actor, who had swayed millions for his heroic defense against injustices on numerous Hindi cinematic masterpieces. A media campaign with Amitabh Bachchan was planned and designed by Ogilvy & Mather, the advertiser. The celebrity agreed to appear in four TV spots, with a similar recording for four radio spots, duplicated into 13 languages, at no cost to UNICEF.
Generations of Indians who followed Amitabh Bachchan’s films understood his indignant disposition well. The script too cast the star in a mood of aggravation:

Spot 1: “Bring your children to the booth” showed the charismatic father figure walking up to a nearly empty booth. He turned to the camera, asked the audience angrily: “Why have you stopped coming?”, and roared about the need for repeated doses.

Spot 2: “Why polio keeps coming back” – Amitabh Bachchan looked at a wall plastered with polio posters, and pointed to the audience disapprovingly. “Polio keeps coming back because you don’t vaccinate your children anymore,” and raged about why people chose to listen to rumours.

Spot 3: “Pulse Polio Immunization is for everyone.” – opened with Amitabh Bachchan reading a newspaper. He threw it away in disgust and talked to the camera: “The poliovirus knows no bounds, does not discriminate between caste, creed and race. It hurts a Hindi child as much as it hurts a Muslim child. No children should be excluded from polio vaccination, every child in India has the right to be protected from polio disease.”

Spot 4: “Applauding the people who get their children immunized” – opened with the tall, bearded Bachchan standing by a booth, facing the camera. “They are doing the right thing by coming back,” raising his hand to salute the crowd that was queuing up for polio drops.

Each ad ended with the star raising two fingers with the message: “Pulse Polio Immunization, two drops for life,” followed by the two dates recorded separately on sound.

School children at a rally said they had all seen and heard Amitabh Bachchan’s spots. The boy at the back raised his fingers to repeat the actor’s message: Two Drops for Life

The TV spots were beamed four thousand times to over 80 million homes on Doordarshan, India’s national television network, as well as to 40 million homes with access to cable and satellite channels. The radio spots were transmitted another thousand times to 54 million homes, including 30 million in rural areas. Audio cassettes were made and sent off to Uttar Pradesh and the SM Network to arrange for publicity on megaphones mounted atop rickshaws.

Amitabh Bachchan’s sonorous voice was

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45 National Readership Survey (NRS) 2002
46 Broadcasting networks in India do not have the practice of providing free airtime for a social cause. For the Jan & Feb rounds, the MOHFW purchased prime time slot for these spots on Doordarshan; UNICEF covered the ads buy-in on satellite and private channels with good penetration in UP, and co-sponsored the radio airtime buy-in with MOHFW on All India Radio and FM services, the latter targeting at urban centers in UP and Bihar.
heard everywhere 10 days before the January and February rounds in 2003. Complementing media broadcast was a series of print advertisements issued by MOHFW, both before and after the rounds. The latter aimed to remind parents who had missed the booth day to take children to the nearest government health centers or hospitals immediately. The ads were carried on all major national dailies in 18 languages.

The media campaign had paid dividends. An evaluation of 9,370 respondents conducted after the two rounds showed the following results:

1. 54.7% of the people exposed to the Amitabh Bachchan TV spots (n = 5,117) and 49.1% of people exposed to the radio spots (n=2,914) said they learned the importance of booth attendance, and the need to go to the booth whenever an NID took place.

2. 65.7% said the TV spots had been “very influential”, and 26.7% said “influential” in their decision to get their children vaccinated during the current NID. In other words, a total of 92.4% had cited the spots as having an influence on their decision to take children to the booth on current NIDs.

3. 61.1% said the Radio spots had been “very influential”, and 30.6% said “influential” in their decision to get their children vaccinated during the current NID. In other words, a total of 91.7% had cited the spots as having an influence on their decision to take children to the booth on current NIDs.

Graph 26: Amitabh Bachchan media spots’ influence on decision for visit to OPV booth (Source: TNS Mode/Johns Hopkins University, for UNICEF India)

4. 9 out of 10 respondents interviewed at booths said they had come to the booth for OPV largely due to their exposure to the TV and radio spots.

5. Approximately 10% of booth interviewees said they would not have come to the booth if not for their exposure to the Amitabh Bachchan media campaign.
Lessons learnt: When every child counts

The escalated pace of vaccination, concerted actions of the government, international and national partners, and heightened media and interpersonal outreach had contributed to a record 33.9 million children vaccinated in UP, and 166.7 million children in India in February 2003. After eight years of efforts, with a growing number of children born each year, the coverage was a milestone as the nation pressed on with its eradication drive.

The process leading to the goal had been the rejuvenation of a movement that demonstrated what extraordinary measures could be and must be taken to track down the last child in order to protect every child. The tremendous energies, organizational capacities and resources that went into organizing mass campaigns year after year had yielded rich lessons not only for the future but for other development initiatives. The magnitude of the effort was matched by the conglomeration of partners, a full range of governmental, non-governmental organizations and private foundations, bringing financial and technical resources to bear for a common aspiration: a world free of polio. Even the Indian national cricket team – icons for millions around the country – had in 2003 become the defenders of children against polio. Before heading off to South Africa for the World Cup games, the team addressed a press conference urging fans to “bowl out” the disease from the country. Several major cricketers also agreed to become “polio ambassadors”, appearing on media spots to bolster public support for the polio eradication campaign.

As a partner in this process, UNICEF had offered its know-how distilled from a long tradition of communication and social mobilization successes, much of it tested and established from its intimate involvement in Universal Childhood Immunization in the 1980s and early 1990s worldwide. In India, it had put to work a variety of communication interventions, complementing mass media with interpersonal outreach, and assembling a full interpersonal communication channel to reach the underserved, with positive results.

An important lesson – as India built on its current success – was the need to engage the forgotten, the marginalized, now the focus of attention in the battle against time to accomplish a goal they had not come to share. For UNICEF and its major partners, the experience gained from using communication to induce behavioural change among the underserved had brought a new meaning to the task ahead. Resistant communities had responded to the full range
of interventions that addressed their fundamental needs for information, knowledge and services, albeit delivered only for a time, by the SM Network to respond to the polio emergency.

The paucity of support to these communities – for a variety of factors discussed in the paper – was an issue that defied any attempt on quick fixes. Forced vaccination, casual marking of P on houses with unvaccinated children by service providers, were short-cuts proven utterly ineffectual to a technical strategy that demanded a genuine, dedicated search for children, as much as a genuine change of parents’ attitude and behaviour. And the SM Network had come in at a time when these two elements were absent, and when resolving one through a holistic IPC intervention could lessen the risk of reversing the tremendous gains made owing to a relatively small minority whose voices were unheeded, and needs unmet.

The positive results delivered by the SM Network in Uttar Pradesh had demonstrated the soundness of the IPC strategy. Yet it by no means remained static, as the virus’ elusiveness called for vigilance as much as the dynamics of human behaviours required constant re-positioning of communication messages and formats. One round of success would not entail an everlasting change. Resistance could pop up again, here and elsewhere, for economic, social and cultural conditions would always assume a larger influence over parental attitude until there were tangible actions to bring about a paradigm shift.

By working on a paradigm apart from polio vaccination, the Network had made headways in tackling resistance, shown in the increase in booth turnout and reduction of X and false P marked houses. In fact, observations made by Sub-NID monitors in April 2003 pointed to a general reduction of resistance throughout UP, and the phenomenon was now confined to a small number of houses. The trend was improving so much that state partners feared the next round might necessitate a new strategy: to battle fatigue and complacency. Further, in areas where the SM Network was present, booth coverage continued to climb. The answer lied in addressing what was utmost in a parent’s, especially a mother’s mind: the health and well-being of her children. Routine immunization, and sanitation and

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47 The most recent April round showed that 62.7% of children in areas with the SM Network turned up at vaccination booth. This was visibly higher than the rest of the district, at 44.5%, and higher the average of all districts in UP, at 41.5%
hygiene, two practices that underpinned the success of polio eradication, were priority subjects for CMCs’ meeting with mothers, for health camps co-organized with the CORE Group of NGO, for baby shows, which invariably rewarded the top prize to the child who had completed the routine immunization schedule.

The path ahead for this communication effort hinged on whether knowledge, attitude and behaviours were given a place they deserved in an initiative dominated largely by epidemiological imperatives for disease eradication. The underserved communities – putting aside a resistant attitude and factors that shaped it – were by their economic and social conditions, a group that fell on one end of the normal distribution curve. By the terms of Diffusion Theory, they belonged to the laggards in a chained development of behavioural adoption, where no amount of general media outreach, publicity efforts, could induce adoption of a new practice unless extraordinary efforts were made. And the SM Network, through the interpersonal communication approach, had demonstrated that changes were possible.

Graph 27: Normal distribution of behavioural adoption

(Source: Daniel W. Surry, Instructional Technology Research Online adapted from Rogers E. M., Diffusion of Innovation, 1995)

A variety of developmental experiences had proven that communication and social mobilization were not just an option, but rather, a necessary condition for success. Recognition by the technical sector of behavioural change communication as not just an art but a science of equal merit was critical to quality implementation of the strategy on the final road to eradication. And this recognition had to trickle down to the block and village levels where mobilizers were fulfilling an essential function as much as vaccinators, technical professionals, in getting resistant families to open the door.

In the course of bridging the knowledge gap between the scientists and the marginalized communities, UNICEF had, through the initiatives of many SM Network’s members, spawned a number of good practices, built new allies in districts and villages, and left knowledge and capacities behind for other equally pressing child health concerns. The experience had shown that a development objective, however well-meaning, could not be imposed upon supposed

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48 The original graph does not contain arrowed markings of the three approaches. They are added here to elucidate the importance of IPC in reaching and converting the “laggards” or late adopters.
beneficiaries unless their right to information, knowledge and consultative dialogues, and in many instances, their right to basic services, was addressed. Attitude was often shaped by people’s immediate experiences, and when none of these interventions were in place, attitude could hardly change, even on a simple matter as vaccinating a child.

UNICEF had also learned, in the process, the importance of monitoring and evaluating perception barriers at every stage of strategic communication design. The tracking of perception was no less important than surveillance of the disease itself since behaviours of the virus was never too far apart from the behaviours of human beings. The effectiveness of communication approaches, whether through mass media or interpersonal, was largely determined by predominant views of various target audiences and how to motivate a shift in attitude. Communication research, both qualitative and quantitative, had been a feature of India’s full-scale intervention, guiding the plan from identifying outreach channels, formats, to message design and pre-tests to ensure relevance and the highest degree of audience acceptance.

The progress thus far had proven the vital role of communication and social mobilization in a technical programme. In making that critical leap to the goal, the right to information, knowledge and consultative dialogues of people, be it the general public or the underserved communities, was not an issue to be taken lightly, especially when every child counted in this monumental undertaking to bring the ancient, sprightly virus to an end.
Annex A: TOR District Social Mobilization Coordinator (SMC)

Working in close collaboration with the CMO and SMO (NPSP), the SMC will:

**Major Tasks**
- Support/assist the District Task Force in developing and implementing a district-specific social mobilization plan for polio eradication and routine immunization
- Prepare a district-specific plan of UNICEF-supported activities for HRRI, SNIDs and IPPI, clearly identifying where CMCs are deployed and activities planned
- Prepare a monthly workplan of activities in support of social mobilization for routine immunization
- Supervise and provide feedback to BMCs on planned activities, ensuring quality interventions that focus strongly on interpersonal and group communication in resistant/underserved areas
- Provide supervision and direction to BMCs in ensuring that CMCs are selected along the profile described in the CMC TOR
- Promote and monitor block and community level activities for polio eradication and routine immunization in reluctant and underserved communities using a variety of approaches, including:
  - mobilizing faith/religious leaders, volunteers (especially women) and Panchayat/Nagarpalika members and other informal leaders
  - catalysing a network of NGOs, community-based organizations and existing social networks, and educational institutions - especially catering to underserved & minority communities
- Liaise with DHEIO for timely dissemination of IEC materials for polio eradication and routine immunization
- Liaise with local press/AIR/Doordarshan/Pvt. channels to promote polio eradication and routine immunization
- Ensure quality implementation of IEC activities (especially drum beating, loudspeaker, group meetings) and other persuasive communication techniques for polio eradication and routine immunization
- Liaise with government media units such as Field Publicity Unit, Information and others to cover resistant pockets
- Provide direct, qualitative feedback from service providers and community members to CMOs and UNICEF/WHO/NPSP on efficacy of social mobilization strategy and promptly report/address rumours, adverse events and communication-related issues and concerns

**Output**
- District-level plan of UNICEF-supported activities for HRRI, SNID, NID
- Monthly workplan of activities in support of routine immunization
- Monthly assessment report on activities in support of routine immunization
- Feedback report on HRRI, SNID, NID

**Qualifications**
- Proven management, supervisory and analytical skills
- 5 years experience of community mobilization and/or working with NGOs and NGO networks
- Preferably a University graduate with social sciences/community development background Good language proficiency in Hindi, knowledge of local dialects in district an asset
- Possess good understanding of various stakeholders, especially Health, ICDS, Panchayati Raj, Education Information, Department of Field Publicity, Press
- Familiar with the faiths, beliefs and cultural practices of communities (especially minority community)
Annex B: TOR Block Mobilization Coordinators (BMCs)

The BMC will operate at the block/urban area in close co-ordination with the MOIC, and report to the District Level Social Mobilization Coordinator (SMC).

Major Tasks

- Develop partnership with the Block MO/HEO/Supervisors/health workers to plan and implement social mobilization/IEC activities for the polio rounds and routine immunization
- Plan and implement activities to tackle refusal/reluctance/resistance to OPV in resistant pockets
- Motivate and mobilize panchayats, religious leaders, schools, anganwadis and other local influencers at the block level and in resistant pockets
- Co-ordinate activities with NGOs working at block level for social mobilization
- Identify, provide on-the-job training and supervise activities of community mobilizers (CMCs)
- Support CMCs in creating awareness and educating the community about ongoing activities for polio eradication and routine immunization
- Prepare detailed workplan of CMCs, including an itinerary of activities during vaccination days for the HTH rounds in March/April rounds, SNIDs, and IPPI
- During HtH campaign, supervise CMCs to ensure they are travelling with vaccinator teams in areas where CMCs are stationed
- During B-team activities, BMCs will ensure that CMCs are properly informed about the B-Team schedule and deployed to accompany vaccinators in converting X houses to Ps
- In co-ordination with MOIC, assign CMCs to assist HtH/B teams in areas requiring active social mobilization outside their own village when appropriate.

Output

- weekly feedback to SMC on progress, constraints and performance
- detailed microplan of CMC activities for polio rounds
- detailed plan of monthly activities for promoting routine immunization
- feedback report for HRRI, SNIDs and NIDs

Qualifications

- Must have managerial/organizational, strong interpersonal communication skills with a dynamic and forceful personality
- Must belong to the reluctant community in that area
- Women preferred
- Fully available for the time frame of the contract
- Resident in the block
- Preference to candidates who have completed formal education
Annex C: TOR Community Mobilizers (CMCs)

Major Tasks
- Identify resistant families by name, and become aware of the number of under-5 children in that family
- Meet with resistant families one-on-one prior to the polio rounds to address their concerns and objections
- Identify and seek support of local influencers (teachers, religious leaders, Gram Pradan, etc.) in convincing resistant families to accept polio immunization
- Hold village-level meetings (Mohalla-Tola) and/or establish local volunteer groups ('Bal Senas', etc.) to seek community-wide mobilization for polio immunization
- Arrange drum beating and mosque elan (1-2 days before the round)
- Assist in IEC activities as required, (when requested, identify where to best display materials, where to conduct miking, wall paintings, etc.)
- During house-to-house (HtH) activities, accompany vaccinators to all homes in assigned area and assist vaccinators in overcoming resistance or reluctance
- After HtH activities, visit X-marked houses in the village before the arrival of the B-Team to seek the family’s co-operation in having all children immunized
- The CMC will accompany the B-Team in his/her village to convert X-marked houses to P, and to neighbouring villages if transportation is provided
- The MOIC can request the CMC to be a B-team member to work in areas other than their own village, but this must not interfere with B-team duties in their own village

Profile
- Reside in key village to be covered by him/her
- Must belong to the reluctant community in that area
- Women preferred (aim is that 80% of CMCs will be women)
- Must demonstrate strong interpersonal communication skills, dynamic and forceful personality
- Well respected in their community, although not necessarily the most influential
- Able to give time required for the assignment
- Preference to people who have completed some formal education

Note
- Consult data available with the CMO, MOIC and SMOs in deploying CMCs as follows:
  - Villages with largest cluster of X-marked houses from January round
  - Villages with B-team activities
  - Villages with polio cases (priority first quarter of 2001, followed by recent cases)
- Each CMC is assigned to only 1 village, with responsibility for up to two more adjacent communities if they are nearby and the CMC is well known
- If more than 2 CMCs are assigned to one village, the SMC must seek approval from the SRC or the Delhi/Lucknow office
- All CMCs to be briefed before the activity by HEO/DHEIO/MOPHC/BMC/SMC. They should be provided with leaflet and other support materials
- Name, address & 1 photograph of the Samudaik Prerak should be available with MOPHC & CMO.
- Each CMC is paid Rs. 500/per round
### Annex D: Consolidated District Social Mobilization/IEC Activity Matrix

**District:** ……………………  
**Updated On:** …………………

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<th>Task/Activity</th>
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<th>Week 2</th>
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<th>During NID</th>
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<tr>
<td>• Rotary posters/banners</td>
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<tr>
<td>• GoUP posters etc</td>
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<tr>
<td><strong>IEC Material Distribution</strong></td>
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<tr>
<td><strong>Monitoring and Feedback</strong></td>
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<tr>
<td><strong>Other/Special Activities</strong></td>
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</tbody>
</table>

1. Development/production of new IEC materials:
   - Rampur Radio
   - Wall painting
   - UNICEF Polio Newsletter etc.

2. IEC materials currently available:
   - Vaccinator folder
   - Rotary posters/banners
   - GoUP posters etc

Plan for GoI/GoUP materials distribution
Distribution channels

Finalising indicators
Preparation of form
Distribution of forms
Collation/Analysis

Vaccinator Melas
Village Guides to search out infants/newborns
### Annex E: Partnership in Action: District Mobilization Plan

<table>
<thead>
<tr>
<th>Partner</th>
<th>Key responsibilities</th>
</tr>
</thead>
</table>
| **Goi/GoUP**                 | - Implement communication POA, with inputs from partner agencies  
- Provide overall guidance to multi-agency communication cluster in Lucknow  
- Ensure District Task Forces are fully operationalized, with a sub-committee for communication and social mobilization  
- Implement IEC activities (posters, banners, miking, local media) for SIAs  
- AIR, Yuva, Harshan, Song & Drama division, Field Publicity to publicize SIAs widely in the state, with key inputs from partner agencies in terms of messages, activities, monitoring and evaluation  
- Mobilize headmasters and teachers at the village level, through district and block-level officers, to create awareness and acceptance for SIAs  
- Mobilize all AWWs in the state to promote polio eradication/dispel rumours during regular meetings with clients; take up special activities to promote community acceptance of OPV  
- Field workers mobilized to promote polio eradication during village-level meetings prior to SIAs  
- Women’s self-help groups mobilized to identify resistant families and actively work to ensure no children are missed during polio rounds; conduct information sessions on polio at village level  
- Gram panchayats in high-risk areas given clear direction to mobilize community support for booth day and house-to-house activities  
- Lead agency in coordinating development of overall communication strategy, including social mobilization, IEC, IPC training and advocacy  
- Provide secretariat for communication cluster in Lucknow  
- Technical support for the development of mass media (television and radio) materials and other IEC materials as requested by GoI/GoUP  
- Intensive social mobilization activities in 2000+ high-risk areas of 19 districts (to expand to 25 by March 2003)  
- IEC activities in 4000 villages in a ten-day period before each round of the NIDs through private sector social marketing agencies  
- Support to NGOs conducting IEC/social mobilization activities in selected high-risk blocks  
- Coverage evaluation and media impact evaluation  
- Participate in coordinating bodies at Centre, State and district level to implement communication POA  
- Coordinate data management and information sharing with partner agencies working on communication at national, state and district levels  
- Coordinate IPC training for vaccinator teams through SMO network  
- Technical inputs in the development of IEC materials (posters, banners, miking)  
- SMOs/block monitors to facilitate and monitor implementation of government-led IEC activities, including materials used for booth day; facilitate advocacy and social mobilization activities in high-risk areas as needed  
- Participate in coordinating bodies at Centre, State and district level to implement communication POA  
- National level advocacy to ensure sustained political and social commitment to polio eradication  
- Resource mobilization  
- Direct implementation of IEC activities (video vans, posters, miking) in high-risk areas as requested by GoUP  
- Direct implementation of intensive social mobilization through volunteer network in high-risk areas  
- Participate in coordinating bodies at Centre, State and district level to implement communication POA  
- Direct implementation of intensive social mobilization activities in selected areas of four districts in western UP  
- IEC/social mobilization activities in high-risk blocks prior to SIAs, participate in mobilization activities to bring children to the booth on booth day, advocacy activities with local influencers; shift activities to support for routine immunization following NIDs  
- Identification of resistant families in areas where working and implement IEC activities for awareness generation/social mobilization  
- Mobilization activities to be determined |
## Annex E (continued): Partnership in Action: District Mobilization Plan

**Partner resources at district, block and community level**

(Shaded areas indicate new partners for implementation of the communication strategy and/or increased activities by existing partners for the NIDs/SNIDs)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Main activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government</strong></td>
<td></td>
</tr>
<tr>
<td>IEC Bureau MOH&amp;FW Union level</td>
<td>Mass production of IEC materials; guidelines and funding to state for production and distribution of IEC materials for booth day</td>
</tr>
<tr>
<td>Doordarshan</td>
<td>Broadcast spots and special programs</td>
</tr>
<tr>
<td>AIR</td>
<td>Air spots, special and sponsored programs</td>
</tr>
<tr>
<td>Satellite channels</td>
<td>3770 spots to be aired in two 10 day periods pre round</td>
</tr>
<tr>
<td>Private radio stations</td>
<td>1400 spots to be aired in two 10 day periods pre round</td>
</tr>
<tr>
<td>IEC Bureau State level</td>
<td>Develop and distribute IEC materials</td>
</tr>
<tr>
<td>Song and Drama Division</td>
<td>Deployment of 61 troops for social mobilization based on HRAs identified by WHO/NPSP</td>
</tr>
<tr>
<td>Department of Field Publicity</td>
<td>13</td>
</tr>
<tr>
<td>Education Department</td>
<td>70</td>
</tr>
<tr>
<td>Rural development</td>
<td>Women's self help groups</td>
</tr>
<tr>
<td>ICDS</td>
<td>69</td>
</tr>
<tr>
<td>SIFTSA</td>
<td>33</td>
</tr>
<tr>
<td>UNICEF</td>
<td><strong>Overall coordination for communication strategy</strong></td>
</tr>
<tr>
<td></td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
<tr>
<td>WHO/NPSP</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Surveillance and monitoring</td>
</tr>
<tr>
<td></td>
<td>Ensure operational quality</td>
</tr>
<tr>
<td></td>
<td>Prepare micro-plans for operations</td>
</tr>
<tr>
<td></td>
<td>300 block monitors</td>
</tr>
<tr>
<td></td>
<td>Block monitors facilitate IEC material distribution, placement, monitor IEC activities</td>
</tr>
<tr>
<td>Rotary</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Supply &amp; distribute IEC material</td>
</tr>
<tr>
<td></td>
<td>Advocacy at National and State levels</td>
</tr>
<tr>
<td></td>
<td>Assist in coordination of booth day activities</td>
</tr>
<tr>
<td></td>
<td>Media advocacy - vernacular press</td>
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<td></td>
<td>7</td>
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<td></td>
<td>7</td>
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<td></td>
<td>7 to 15</td>
</tr>
</tbody>
</table>
### Annex E (continued): Partnership in Action: District Mobilization Plan

<table>
<thead>
<tr>
<th>NGOs</th>
<th>Coverage</th>
<th>Main activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Work closely with underserved/urban community; madarsa mobilization, intensive mobilization in Barabanki.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rahman Foundation</td>
<td>10</td>
<td>11 100</td>
</tr>
<tr>
<td>Social mobilization using their volunteer network.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nehru Yuvak Kendra Sangathan</td>
<td>8</td>
<td>27 800</td>
</tr>
<tr>
<td>Social mobilization using their volunteer network.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARE U.P.</td>
<td>12</td>
<td>100 80 staff 500 animators</td>
</tr>
<tr>
<td>Social mobilization using their NGO network. Coordinate activities with other Government departments and programs. Participate in planning activities at district/ block level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Cross</td>
<td></td>
<td></td>
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<tr>
<td>Preliminary assessment to be conducted on field strength of Red Cross and activities the organization is able to carry out.</td>
<td></td>
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</tr>
<tr>
<td>PCDF RFWP</td>
<td>18</td>
<td>200+ 5277</td>
</tr>
<tr>
<td>Identification of resistant families</td>
<td></td>
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<tr>
<td>IEC activities for awareness generation and social mobilization.</td>
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<tr>
<td>Civil society</td>
<td></td>
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</tr>
<tr>
<td>Aligarh Muslim University</td>
<td>500</td>
<td>Students/alumni to be mobilized to promote polio eradication in their home communities; AMU Task Force being created to mobilize various components of the university community (medicine, media, etc.); possible community level activities in key districts, including health camps, bal swastha melas.</td>
</tr>
<tr>
<td>Hindustan Lever, Coke, Cadburys, Pfizer</td>
<td></td>
<td>All companies will possibly be involve though their field sales staff before booth day – company representatives are volunteering to wear polio T-shirts and pay out fliers to clients in the lead up to the NIDs. Activity to be confirmed.</td>
</tr>
</tbody>
</table>
Annex F:  % Booth Coverage in 25 District with CMCs between Sept 2002 – April 2003, Uttar Pradesh (Source: WHO NPSP)
# Annex G: Social Mobilization District Plan (Example)

## Social Mobilization District Plan – J.P. Nagar

**Mond: Sajid Nadvi, S.M.C. (UNICEF) J.P. Nagar**

### 9th February 2003 NID

#### Social Mobilization

**Location**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 January 2003 to 15 February 2003</td>
<td>Planning Meeting</td>
</tr>
<tr>
<td></td>
<td>BMC: Preti Chahal</td>
</tr>
<tr>
<td></td>
<td>1st Week</td>
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<td></td>
<td>26-1-03 and 1st Week</td>
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</tbody>
</table>

#### Behaviour Change

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>21 January 2003 to 15 February 2003</td>
<td>Planning Meeting</td>
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<td></td>
<td>1st Week</td>
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<tr>
<td></td>
<td>26-1-03 and 1st Week</td>
</tr>
</tbody>
</table>

### Social Mobilization

**Block Level Meeting**

- **IPC with Resistant Families**

- **Training**

- **C.M.C. Meeting / Training**

- **School Goshti**

- **Imam Meeting**

- **Saas-Bahu Baithak**

- **Mosque Elan/ Appeal from Religious Leader**

- **Rally**

- **R.L. Session**

- **R.I. Session**

- **Imam Meeting**

- **Eztma-Milad**

- **Health Camp**

- **Healthy Baby Show**

### Immunization

- **Door-to-door**

- **Bulwara Toll**

- **Bulwara Toll**

### Location

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>CMC Area</th>
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<tbody>
<tr>
<td>1</td>
<td>Shabuddin</td>
<td>Bapliad</td>
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<tr>
<td>2</td>
<td>M. Shand</td>
<td>Shehnigan</td>
</tr>
<tr>
<td>3</td>
<td>Momin Khan</td>
<td>Chuchila Kila</td>
</tr>
<tr>
<td>4</td>
<td>Narinder Pratap</td>
<td>Chuchila Kila</td>
</tr>
<tr>
<td>5</td>
<td>Sufiana Khatun</td>
<td>Karra (GHA)</td>
</tr>
<tr>
<td>6</td>
<td>Sudheeran</td>
<td>Pathana B.</td>
</tr>
<tr>
<td>7</td>
<td>Suresh Kumar</td>
<td>Subhan Nagar</td>
</tr>
<tr>
<td>8</td>
<td>Anuradha</td>
<td>Gandhi Nagar</td>
</tr>
</tbody>
</table>
United Nations Children’s Fund
Regional Office for South Asia
P.O. Box 5815
Lekhnath Marg
Kathmandu, Nepal

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Facsimile: 977-1-4418466/4419479
Email: rosa@unicef.org
www.unicef.org