Tracking and Mobilization of Vulnerable Social High Risk Groups
A Primer for district level functionaries

I. Background

Since the 2006 P1 outbreak, the polio eradication programme has undergone many shifts in both the terms i.e. Communication and operation. Occurrence of low number. of cases among majority of underserved communities and doses intake by 6mnth to <5 children has also risen substantially. Shift in epid also leads to exploring new areas and shifting of focus on vaccination, in other vulnerable social groups from polio infection perspective. The current epidemiological profile of Polio is characterised by diverse reservoir-based patterns of relatively small-scale, local circulation. While SIA [supplemental immunisation activity] coverage, averages are increasing in most cases (and in many instances reaching 95+%) the epidemiological data show a persistent coverage 'gap' of up to 15% (and in some instances more). It is this gap that supports continuing WPV transmission and on which social mobilisation and communication should concentrate.

What do we mean by 'Vulnerable social groups'?

Vulnerable social groups are groups with specific conditions determined by physical, social, economic and environmental factor or process, which increase the susceptibility of a community to the impact of infection in public health programme. Past experiences and based upon field observations three major social groups identified as part of vulnerable social groups in broader spectrum *1) Nomads 2) Slum population 3) Migrant population in a given geographic area*. **The level of immunity is determined by social and economic conditions and not by religion, gender and race** ***(reference: Underserved strategy document for district level functionaries)***

As in the case of Muslim community, the children were get infacted by the wild polio virus not because they are Muslim *(by en large Muslim population in the state belongs to underserved community:ref USS document)*, but because of their poor social and economic conditions, They live in unhygienic conditions, and have not received the services that are essential to protect them against infectious diseases like polio. Such conditions in the Urban slums, temporary settlements*(deras)* of Nomads and migrant settlements provides breeding grounds for WPV thus affecting children between the age group of 0to 5 years..

To know more and for better understanding we further divide these social groups on the bases of there vivid characteristics and traits.

1) Nomads: Those groups of communities who travel place to place for livelihood, usually setting up home whenever and wherever they stop. The mobility of these groups is an essential economic strategy, central to the very nature of their profession.
As occupational groups of hunters, trappers, blacksmiths, basket weavers and entertainers like puppeteers, acrobats, fortune-tellers, singers and dancers, the nomads share a symbiotic relationship with settled people. In return for their services, they squat on the village ground and use resources such as water or pasture lands for grazing their cattle till they move on to the next ***dera*** *(Settlement)*

The total population of Nomads as per censusu of India in Uttar Pradesh is ~.7% of the total population but continuously giving cases from 2006 onwards, though in absolute numbers, the

number of cases were low but dispropotatnetly high as compare to there population. Four major nomadic groups prominent in Uttar Pradesh are as follows –

1.1***Kanjars*** are widely dispersed, and endogamous population of nomadic artisans and entertainers owing to their living pattern, they find it difficult to settle down in a place and to get a proper job. Additionally, due to their nomadic life style the Kanjars are branded as a criminal community.
1.2 ***Gadia Lohars*** are unmistakably Rajasthani. One only has to look at their features, and their upright postures to recognize this fact. Small Lohar groups can be seen on the outskirts of any large city in the north where they live in small settlements centered around their beautiful carts. Low mud walls enclose each cart, demarcating a place of residence but not ownership. Even their name Gadia originates from the bullock carts which are their homes. Gadia Lohar, literally meaning metal workers of the bullock cart.
1.3 ***Nat*** usually known as Acrobat (Badi in West UP), perform feats for overawed audiences in the streets or at religious or social congregations.
1.4 ***Gandhiley*** a very complex group among Nomads, don't have any specific religion or culture (adoptability is high), mostly involved in criminal activities, poaching, prostitution, begging etc.
1.5 ***Banjara*** women would buy goods in bulk and then do door-to-door selling in villages
1.6 ***Traditional/faith healers:*** Again ambiguity is there, no specific religion, involve in selling herbs.

2) Slums: In 2002, the UN operationally defined slums as those communities characterized by: insecure residential status, poor structural quality of housing, overcrowding, and inadequate access to safe water, sanitation, and other infrastructure. Slums are not government recognized units, and that's the basic difference. It lacks in providing health facilities and infrastructure in the denotified area.6.2% of the total population of Uttar Pradesh resides in 7121 ***(SUDA 2003-04)*** Slums, existing due to rapid industrialization and growing urbanization.

The determinants of slum health are too complex to be defined by any single parameter. Yet, they arise from a common physical and legal pedigree that concentrates the ill effects of poverty, unhealthy environments, and marginalization from the formal sector. Western UP with high percentage of slum population poses threat from every sphere in terms of WPV infection. Districts like Meerut, Aligarh and Saharanpur having high concentration of Slum population (44.2%,45.4% and 35.54%) respectively.

Importantly most of the slum units in Meerut urban and Aligarh urban were already mapped out and good blend of communication as well as operational activities are being carried out, but we need to explore more possible sites for strengthening operations and communication.

Key indicators: The level of education particularly that of women directly influences the income of the family, sanitation, hygiene and child healthcare. The low female literacy rate in these vulnerable social groups is one of the major factors contributing to poor healthcare and low immunization levels for children from these communities. Advancing the conditions of these communities is a long term developmental process and the polio eradication campaign cannot wait for it. Hence, underserved communities have to be persuaded to participate in the polio eradication initiative despite poor civic amenities. They can be best persuaded by religious institutions they respect; employers and contractors are other potential allies, which should be invited to join and help persuade communities and individuals not to use polio vaccination as a means of protest and bargaining tool***(reference: Underserved strategy document for district level functionaries)***

3) Migrants: denotes movement by human beings from one locality to another over long distances in large groups. With a case of polio P1 virus in the mid of 2008 the most virulent strain being reported from Delhi, the proximity of the city to the epicenter western Uttar Pradesh and migrant population has been considered cause for the escalating P1 cases.Significant number of cases are being reported from the migrant population in the state. Owing to this, the health

agencies are now geared up to figure out better ways to monitor the immunisation status of the migrant population who frequently keep moving out from Uttar Pradesh.

Vulnerability among Migrants

Migrants are disadvantaged relative to the native population

- They often have a low socio-economic status with no access to either healthcare or social services
- They suffer from mental and emotional vulnerability and low self-esteem
- Lack of provision of social goods, education and health, Impedes the integration of migrants into the local population.

Rather than getting into types of migration, here it is important to know more about different migratory groups from programme point of view, which could be easily identified and tapped.

3.1***Bricklin workers (****Seasonal migration****):*** Quite often chances of being missed during planning and operations, most of the workers at bricklins in UP are from MP, Bihar and handful are from different districts of UP only.

3.2 ***Construction labors(****Continues****):*** With growing urbanization more and more structures are under construction especially in NCR region and huge work force in the form of construction labor migrated from Bihar, MP and eastern UP to theses area and residing near construction sites in temporary settlements

3.3 ***Skilled Labour (****Continues****)*** Skill is a measure of a worker's expertise, specialization, wages, and supervisory capacity. Skilled workers are generally more trained, higher paid, and have more responsibilities than unskilled workers. Most of the workers from Bihar and eastern UP migrated to districts in West UP e.g. Glass industry in Firozabad, Brass industrial work in Moradabad, Zardozi work in Farrukhabad and Bareilly etc

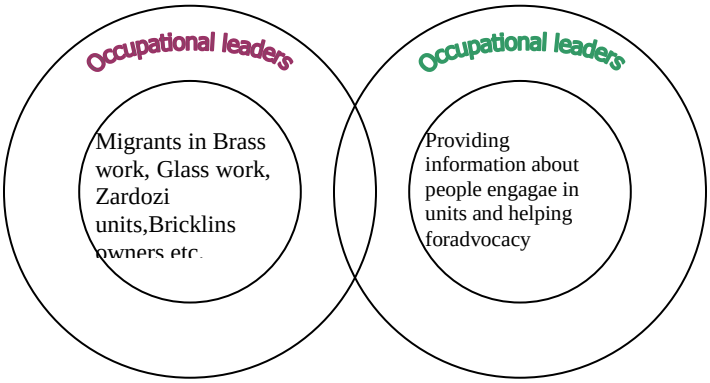
II. *Objective:*

To ensure mapping and vaccination of all the under 5yrs age children belonging to above mentioned social groups. Simultaneously high quality of (I) planning *(Mapping and micro planning)*, (ii) implementation *(effective mobile teams),* and (iii) monitoring of the polio programme with in these vulnerable social groups.

III. A brief overview of geographical spread of Vulnerable social groups:

Nomads	*Slums*	*Migrants*
Geographical spread Evenly spread all over the state in two forms A) Small groups; comprises of 5-15 families B) Large groups; comprises of more 25 & more families **Possible sites**: Peri urban areas,out skirts of a town, along the high ways,rail routes etc	**Geographical spread** Meerut,Aligarh,Ghaziabad,G.B.nagar, Moradabad,Saharanpur,Bareilly,VaranasiAgra,Kanpur urban and all the big cities in the state and district HQs. **Possible sites** Along the big drains, next to Industrial setup	**Geographical spread** Muzaffarnagar, Etah,Firozabad,Kanpur,Moradabad,FarrukhabaGhaziabad,NCR and other prominent districts of West UP. **Possible sites** Constructionsites (Construction workers),Bricklins, rented houses among settled population

IV. Occupation-based leaders within Migrants groups can also be helpful for reaching the unreached children:

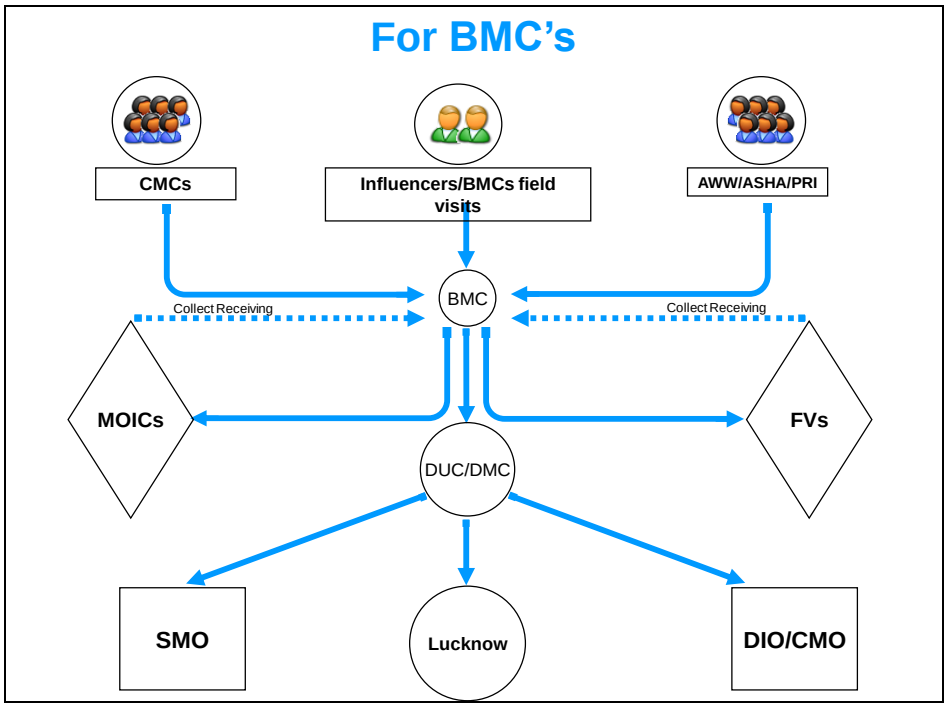


V. Mapping and sharing (SMNet):

With in HRAs CMC and concerned BMCs are responsible to ensure proper mapping and sharing of information with partners and health departments along with reporting the same to DUC and DMCs where DUCs are not designated.

Spl purpose BMCs may be 2 in number per district and would be appointed exclusively for the said purpose with ***specific time bound task*** and clear cut TOR

- Mapping possible sites in the district
- Segregating the different social vulnerable groups in the district , with the help of DUC
- Spl BMC/BMCs should share the data with counter parts at block level
- BMC should ensure incorporation of all the information in micro plans
- DUC in coordination with SSMO (NPSP) and health ensure sufficient teams to be assigned for the vaccination at these sites
- Provide technical inputs to field staff BMCs and CMCs regarding the subject
- DUC should try and find out if any communicatin challenges exist within these vulnerable groups
- DUC should share the compiled and updated list of families (block wise) prior to round and vaccination status of the same after the round to M&E officer in Lucknow
- Over all guidance from USS coordinator and M& E officer in the field staff over the subject.


For BMC's
CMCs
Influencers/BMCs field visits
AWW/ASHA/PRI
Collect Receiving
BMC
Collect Receiving
MOICs
FVs
DUC/DMC
SMO
Lucknow
DIO/CMO