Strategic Communication for Polio Eradication in India
UNICEF 2010-2013 Communication Strategy (Updated August 2011)

Introduction

Almost every month, over 450,000 health workers in India deliver the Oral Polio Vaccine (OPV) to 58 million children under five years of age. This mammoth effort, sustained over several years now, has made the Indian polio programme the largest and one of the most successful public health programmes in the world.

UNICEF has been a longstanding partner in the campaign against polio, both globally and in India. A communication programme for Polio Eradication in India has been implemented for almost a decade by an increasing number of frontline communication workers who go door to door every month mobilizing parents of children under 5 to take OPV each time it is offered. The Social Mobilization Network (SMNet) - now an army of over 6,500 staff across the highest risk areas of Uttar Pradesh (UP) and Bihar - has become a renowned impetus in the polio campaign, and a model for health communication efforts globally.

The SMNet has responded dynamically to the epidemiological analysis provided by the National Polio Surveillance Project (NPSP) of WHO and to the strategic shifts agreed upon by the Government of India, global partners and the India Expert Advisory Group (IEAG). Although the communication strategy has continued to evolve and respond to new priorities as they arise, a comprehensive strategy paper was last conceptualized in 2004. It is time to re-strategize on a broader scale, and to ensure the virus is attacked forcefully, creatively, and irrevocably.

Epidemiological analysis has identified areas and groups where communication efforts must focus; the IEAG and Advisory Committee on Polio Eradication (ACPE) have highlighted critical barriers that must be addressed to succeed.

With India so close to the goal of eradication, 2010-2011 will be vital to securing success in the battle against polio worldwide. Surveillance, operations and communication must all heighten efforts and work even closer together in this critical phase. And although the IEAG has projected interruption of P1 transmission in India by 2010, work cannot end then. Focused effort will still be required to sustain interruption and consolidate hard-won gains until 2013.

This strategy identifies the primary objectives for the communication effort in the next four years. The years 2010-2011 will require intensive implementation, followed by maintenance in 2012 and a phased exit by 2013. Indicators – both for the polio programme and for the communication effort – are outlined to ensure accountability, rigorous monitoring of key milestones and progress, and objective evaluation of success.

The SMnet has reached millions of children, mobilized thousands of local influencers, galvanized hundreds of partners, and collected micro data during each SIA round. We know where to communicate, to whom, and how to do so most effectively. The 2010-2013 strategy will build upon the significant groundwork accomplished to date: proven successful strategies will be applied consistently across UP and Bihar; and lessons learned will be maintained and refined to address the nuanced challenges that pervade the programme at this advanced stage.

With almost a decade of communication expertise and a rigorous evidence base to continue guiding us, UNICEF India is well-equipped to forge ahead into the final phase of battle. This strategy is the roadmap for communication support to push through the “final inch” of the programme in India – and to cross the threshold to eradication

1. Situation Analysis

Where were we in 2010?

Four countries in the world maintain indigenous transmission of wild polio virus (WPV); India, Nigeria, Pakistan and Afghanistan. In 2009, these four countries accounted for approximately 93% of all cases globally, with India accounting for 34% of global cases. In 2010, the four endemic countries account for 14% of all cases globally, with India accounting for only 5% of global cases.

India is poised to eradicate polio first among the four endemic countries. The IEAG and ACPE meetings in 2009 concluded that India has a "very high performing eradication programme and will interrupt poliovirus transmission if current efforts are sustained and contingency plans are rapidly implemented to enhance programme efficacy."

Where are we in 2011?

Polio remains endemic in four countries – Afghanistan, India, Nigeria and Pakistan – with a further four countries known to have (Angola, Chad and Democratic Republic of the Congo) or suspected of having (Sudan) re-established transmission of poliovirus. Several more countries had ongoing outbreaks in 2011 due to importations of poliovirus. India continues to be in a strong position to be the first of the four remaining endemic countries to eradicate polio.

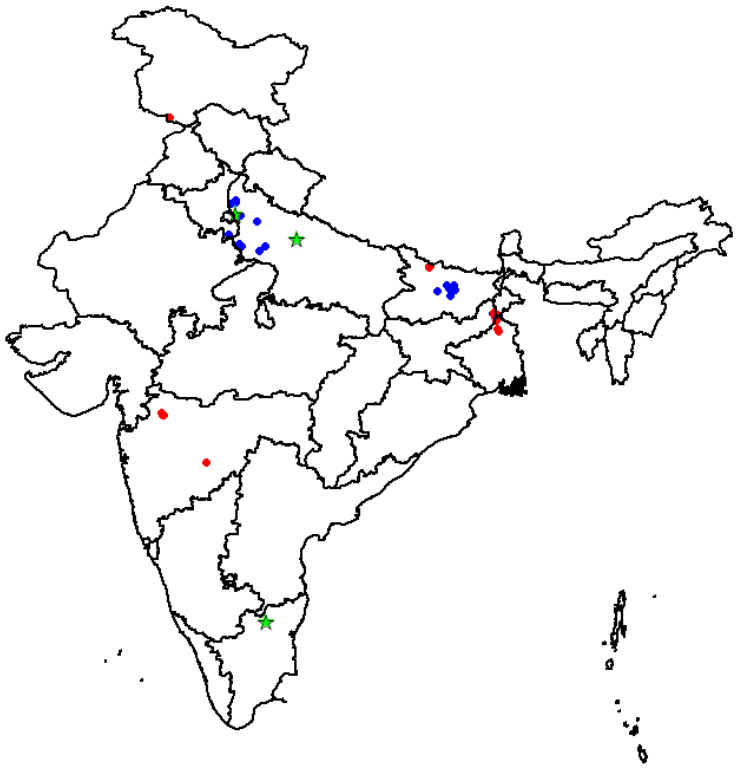
Epidemiology

As of July 2011, India reported only one case of WPV1 in 2011 detected in Howrah, West Bengal in January 2011. The endemic State of UP had not reported a case of WPV since 21 April 2010 and Bihar since 1 September 2010. Environmental sampling has not detected any WPV in 2011, with the last positive environmental sample was taken from Mumbai in November, 2010.

In 2010, 42 WPV cases were reported in India compared to 741 in 2009 and 559 in 2008. Among the 2010 cases, 18 are Type 1 cases, and 24 Type 3 cases. Migrants account for approximately 90% of all 2010 cases, and are the largest risk to polio eradication, and to re-infecting other states, as demonstrated by transmission in West Bengal and Maharashtra in particular, who had not seen a polio case since 2008 before this year. Seventy two percent of all cases in 2010 have been among Muslim children, indicating the need to continue focusing on the Underserved as the most vulnerable children to the WPV.

Polio Cases, 2010 (Data as of February 2011)

WPV Cases 2010			
State	**WPV1**	**WPV3**	**Total**
Bihar	3	6	9
Haryana	0	1	1
Jammu & Kashmir	1	0	1
Jharkhand	3	5	8
Maharashtra	5	0	5
Uttar Pradesh	0	10	10
West Bengal	6	2	8
	18	**24**	**42**



High-risk areas

High-risk area identification, June 2011.

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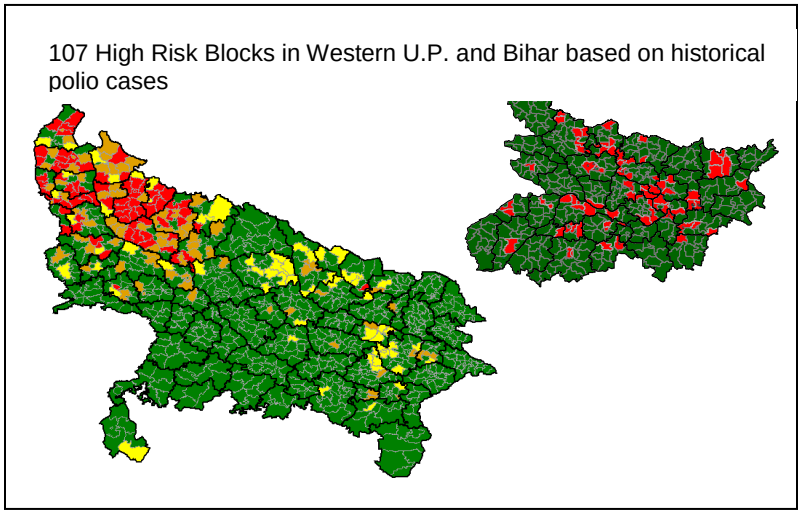
Central Bihar



The IEAG has declared the endemic area with the highest risk for ongoing transmission of WPV1 to be central Bihar. Although Bihar reported only three P1 cases in 2008 and 2010 despite undergoing some of the most destructive flooding in decades throughout this time period, this area has historically remained a reservoir of WPV 1. It is also a major source of outgoing migrant populations who can carry the virus widely throughout the country. The fact that the majority of 2008 cases in UP and 2010 cases in Maharashtra, West Bengal and Jharkand were importations from Bihar is evidence of this.

Western UP

The 2008 outbreak of WPV1 in Western UP makes this area the single greatest risk for persistence of WPV 1 transmission in India. The affected districts had been free of WPV 1 for over one year before the 2008 outbreak, and the entire state has remained polio-free for 10 months in 2010, which proves eradication is possible in this area. However, Western UP has historically remained an endemic area not only for polio, but also for small pox, and this area must be closely observed until WPV1 remains undetected for several years.

Even within Western UP however, there are differences that must be taken into account. Almost 90% of all WPV1 cases in 2008 occurred in six districts of UP, and between 2008-2009, cases have occurred in 18 high-risk districts. This means a limited number of Western UP districts have exceptional polio transmission dynamics, posing a unique risk to eradication in India. It is for this reason that 18 high risk districts in UP have been identified for intensified focus in the Government's 107 Block Plan to eradicate polio from India.

West Bengal

Following the 2011 case of polio in Howrah, 36 blocks in West Bengal have been identified as high-risk, these blocks are found in the districts of Bardhaman, Birbhum, Howrah, Kolkata, Maldah, Murshidibad, Uttar Dinajur and 24 South Parganas. Stopping the residual polio transmission in West Bengal is the biggest priority for polio eradication in India. Intensive and integrated efforts were undertaken in the state to stop transmission immediately through mop-up vaccination rounds implemented each month since February 2011 through to June 2011.

High Risk Groups

While the polio programme has achieved very high coverage in almost all SIA rounds, there is a need to place added emphasis on the groups most at risk for virus transmission in the final stages of the programme. The recent epidemiology and case analysis has identified the following groups as the most vulnerable to polio virus transmission:

Children under two years old

In 2010, 72% of all WPV 1 cases to date have occurred in children under two years of age; in 2009, 66% of cases fell within this age group. Children in this age group are most susceptible to viral infections in general and require greater immunity to beat the polio virus, and OPV is less effective when children have viral or bacterial infections that compromise their gut immunity. Newborns are often born in the maternal grandparents' home, which may be outside the endemic areas, and are sometimes perceived too small to be given OPV when they are newly born. There are therefore specific challenges in reaching children under 2 and newborns in particular.

Underserved Groups - Nomads, seasonal laborers, slum dwellers, minority Muslims

These groups represent the most socially excluded groups, not only in terms of access to OPV, but also in terms of access to healthcare and other social services. Travel for livelihoods and economic opportunities means these groups are often on the move, are susceptible to missing immunizations and are potentially carrying and spreading the poliovirus. Due to the transient nature of these groups, identifying and tracking them is the biggest challenge, particularly when their movement is from high-risk to non high-risk areas (where vaccination rounds are not intensively conducted) and vice versa.

Among the mobile underserved groups such as nomads, seasonal laborers and temporary slum dwellers, there was an increasing trend of polio cases from 2008 - 2010. Monitoring data also shows these high risk groups have fewer immunizations than the rest of the population. Approximately five per cent of mobile and migratory communities are found unimmunized after polio rounds, compared to two per cent of children in non-migrant communities.

Type 1 virus of Bihar origin has been detected in Maharashtra and West Bengal in 2010, and earlier importations detected in Delhi, Punjab, and Assam are genetically related to virus circulating in the high risk areas of central Bihar from 2007. The risk of transmission continuing in mobile populations is one of the most critical for the programme.

The disproportionate number of cases among Muslim populations was reversed for the first time in 2008 when only 33% of all cases were among the Muslim population, compared to 51% in 2007 and 56% in 2006. Nonetheless, in 2010, the trend has picked up again, with 72% of all cases attributed to Muslims.

Cut-off villages in Bihar

Bihar, India's third most populated state, is distinctly rural and poor: 43% population in Bihar lives below the poverty line. The level of chronic malnutrition is the second highest in the country (56%)[1] and reflects inadequate complementary feeding, high prevalence of low birth weight, poor maternal nutrition, low routine immunization coverage and high prevalence of infections diseases.

[1] National Family Health Survey, 2005-2006, Ministry of Health and Family Welfare

The situation of the poor is compounded by the nearly-annual flooding that takes place in the state, leading to continued and large-scale displacement. The floods in 2008 left as many as 10 million people displaced. A geographic analysis of polio cases in Bihar reveals that a significant proportion of the polio cases in the state are located in the Kosi Region. Because these districts belong to an area that is inundated by Kosi and about 36 other rivers, this area is susceptible to flooding. The damage due to such frequent inundations coupled with high population density, frequent displacement and compromised access to services, makes this area at greater risk for virus transmission than other parts of the state. At the same time, vaccinators have less access to these areas, giving the virus an increased opportunity to travel and multiply. Up to 12% of children living in field huts of the Kosi River area have been found unimmunized after SIAs, compared to less than 1% of children in other areas of Bihar. And given that these groups are the most likely to travel outside the state to search for dry land and work, these population groups pose a substantial risk for importation and continued transmission across the country.

Emergency Response

In 2011, every case of WPV will be treated as a public health emergency with a large-scale emergency response. The Government of India has developed and disseminated an Emergency Preparedness and Response Plan to all States of India of which UNICEF plays a crucial role. The plan includes specific guidance on preparedness activities and rapid, large scale and high quality mop up vaccination.

To support the plan, UNICEF is responsible for:

- Developing and disseminating a communications emergency kit with language-appropriate materials including; pre-printed dateless posters for the first round, banners, whistles and other IEC materials.
- Creating awareness, mobilizing the community and advocating with media, elected representatives and celebrities.
- Deploying staff to provide immediate technical assistance and capacity building in the event of a case.
- Providing media training and sensitization in high-risk areas.

Additional challenges to eradication

Sub-optimal vaccine efficacy: The ACPE has classified northern India, and particularly areas of western UP to be the only location in the world where suboptimal efficacy of OPV is the major limiting factor to eradication. The final stronghold areas for the P1 virus in Western UP - Badaun, Moradabad, Bareilly, and Rampur- have very favorable conditions for the virus to survive. Extreme population density, poor sanitation conditions and hygiene practices, and significant malnutrition lead to diarrhea incidence as high as 20% in some areas, which make it difficult for the vaccine to remain in the child's gut long enough to be effective. Sanitation challenges are so extreme that it would take at least a decade to expect improvements here to impact on the polio situation

In these areas, immunity against WPV1 may not be adequate. 87% of P1-infected children in these areas have more than 9 doses of OPV, meaning the vaccine is not as effective in some children as it is in others.

Poor routine immunization status: Routine immunization (RI) coverage in Uttar Pradesh remains low, at 37.2%[2] of children fully immunized. In Bihar, routine immunization coverage has significantly improved, with the latest data showing 53.8% of children fully immunized, compared with 32.8% in 2006.[3] Yet these figures remain a formidable challenge for a programme that requires immunity to be boosted for increased OPV efficacy, particularly in children under 2 years of age. In the long run, the programme will rely almost entirely on the routine immunization system for service delivery of OPV post eradication. Routine Immunization is an area that cannot be ignored to eradicate polio.

Various types of (overt and covert) resistance to OPV: Overt resistance to OPV due to fear of sterility and OPV safety is at record-low levels. In 2009, only an average of 2.65% of households (3,000) openly resisted the vaccine each month, which has been reduced to 1.45% (1,228 households) in 2010, largely thanks to the communication efforts of the last few years. Pockets of resistance still exist in very localized areas of Aligarh, Agra and Ferozabad, for example, and these pockets must continue to be targeted with localized approaches. However, most resistance today comes more often 1) in the guise of "developmental resistance" among underserved groups demanding access to other services such as health care, schools, better sanitation, roads, etc., or 2) claiming that a child is sick (XS) and cannot take the vaccine, or is not at home (XH).

Resisting polio drops for developmental reasons is known to attract the attention of district or higher-level officials, so OPV is politicized and used as a bargaining tool to negotiate additional services felt to be more of a priority in certain communities. These en-mass resistances largely remain confined to a village or block, but their solution is often outside of the scope of the Polio Eradication Programme, and has many times caused a standstill. Resisting polio drops on the ground that the child is either not home or is too sick, is an area that should be intensively monitored by the Social Mobilization Network and addressed through specific messaging around OPV safety and the need for continued doses.

Sustaining Demand for OPV: As cases begin to diminish and progress is sustained, there is greater risk for complacency and fatigue to set in amongst the community, health workers, partners and Government. The 19th IEAG warned against programme fatigue and complacency as a potentially significant threat to the programme. The programme will need to continue reminding people why sustaining the momentum in the final stages is critical to success.

[2] Ibid.
[3] An ongoing Immunization Survey is being carried out by the State Health Society in 10 randomly selected districts.

Knowledge and Attitudes to the WPV

The UNICEF-commissioned 2010 Knowledge, Attitudes and Practices Study conducted by AC Nielson ORG demonstrates an environment of impressive community commitment, participation and engagement with the polio programme across the highest risk blocks of UP and Bihar. Amidst anxiety that programme fatigue may cause a potential threat to community acceptance of OPV, the 2010 study showed 95% of respondents in UP and Bihar think children should receive repeated doses of OPV until they reach five years of age. The number of parents who believe the number of rounds is too frequent has increased from 2008, however, from 18% on average in 2008 to 57% in 2010. This is probably due not only to a real increase in rounds from 2008 to 2010, but also the fact that with a reduced number of polio cases, the perceived urgency for such an intense number of polio rounds naturally decreases. The communication strategy for the next 3 years must reinstate the perceived urgency for increased doses of OPV in order to combat the complacency that often sets in amidst progress and threatens success.

98% of parents in both states think OPV effectively protects their children against polio, compared to 93% who felt this in 2008. 89% of parents in UP think polio could be eradicated forever, compared to 83% of respondents who felt this way in 2008. In Bihar, there is less conviction that polio can be eradicated (68% of respondents agreed, compared to 83% in 2008), though knowledge on polio and practice is generally higher in Bihar.

While knowledge of polio symptoms and awareness of the polio programme is very high – over 90% in both instances across Bihar and UP – there are some misconceptions and knowledge gaps that need to be remedied in order to take the programme into the final stages of eradication. While the vast majority of respondents know repeated doses of OPV are needed, only 35% think it is harmful if a child misses a dose of OPV. Over 50% of parents in both states think polio is curable, therefore the threat severity of getting polio is less than what it should be. Communication messages in 2010-2013 will need to emphasize that there is no second chance with paralysis from polio.

Threat perception of getting the disease is also quite low on a personal level. With fewer and fewer cases being reported nationally, and with most cases recently being reported outside the endemic areas, people in the highest risk areas no longer think polio directly affects their families. While almost all parents thought polio could affect children in India, this percentage almost halved when asked if polio could affect children in their community, and only 10% on average felt that polio could affect children in their household. Therefore, communication messages need to be targeted at personalizing threat perception, so that each parent feels the need for continued doses of OPV for their child until he/she is 5 years old.

Resistance against OPV is extremely low, with SIA data showing resistance levels at an average of 1.5-2.0% in highest risk areas. Approximately 10% of parents surveyed in the KAP study reported ever refusing OPV for their child in the past. Among these parents, 74% cited that they refused OPV because their child was sick, which could indicate a lack of knowledge about OPV safety during sickness, or an emerging trend of covert resistance. The XS generation and remaining data will need to be closely monitored in the next few years to ensure covert resistance is not lingering undetected, and messages will need to focus directly on safety of OPV during sickness.

The attitude to vaccination – both OPV and Routine – is generally very passive. Overt resistance is extremely low, but parents are not actively seeking immunization services. The sentiment is that as long as vaccination is free and it comes to the doorstep, parents are willing to vaccinate their children. However, active health seeking behaviour that involves going to the booth or getting vaccinated when a dose is missed is something that will need to be addressed in new communication messages. Over 50% of parents “wait for the next round” if a dose of OPV is missed, and messaging will need to advice parents on where to go if they’ve missed a dose.

The above knowledge and attitudes are the same for the underserved groups of migrants, nomads, slum dwellers, etc – but exacerbated in intensity. Invoking a more active attitude to vaccination is even more critical for these groups, as they are most likely to miss doses due to their frequent travelling, and they will need increased information on seeking out OPV when they travel. They will also need information on where the polio booths are in their area, as only 50% of respondents in these groups were aware of the booth, compared to 97% awareness among the general population.

In April and May 2011, an additional component of the KAP study was complete reaching 755 brick kiln workers throughout UP and Bihar. Of the respondents, close to 100% of all respondents were employed at the brick kiln site as a brick maker or a brick transporter. The high majority identified their religion as Hindu, with a smaller proportion (33%) in Uttar Pradesh identifying as Muslim. In Uttar Pradesh, 53% of respondents were from scheduled castes, and 33% identified as other backward castes. Alternatively, in Bihar 58% of respondents identified as scheduled castes and 30% as scheduled tribes.

Like the findings from the 2010 study, all respondents had heard of polio and between 71-78% could identify that it was a disease. A very small minority, 1-2% could identify that polio is a viral disease that causes paralysis. Compared to the 2010 findings, the number of mothers and fathers who could recognize the polio poster was fewer; in Uttar Pradesh 85% recognition was measured, and in Bihar with 94% recognition was recorded.

In Uttar Pradesh, 85% of respondents and 79% of respondents from Bihar reported that polio could be prevented. Of these respondents, close the three quarters of them believed polio could be prevented through OPV. Conversely, almost half of the mothers surveyed believed polio could be prevented with medicine.

Consolidating success and shifting gears

All evidence, whether epidemiological or genetic, shows that India has succeeded as never before in severely limiting WPV1 circulation across the country and has established a firm foundation for breaking the remaining chains of type 1 circulation. Success in achieving this goal is dependent on the effective management of the risks and challenges mentioned above.

The communication strategy for 2010-2013 will address each of the challenges above in a focused manner, with intensity in western UP and Bihar. However, to achieve national eradication, effort cannot be confined to these two states, particularly when dealing with such mobile population groups. While the SMnet will remain in Uttar Pradesh and Bihar, support to the Government of India for polio communication messages will be packaged for all states – by high, medium and low-risk susceptibility to the poliovirus.

Partners will continue to be mobilized, but more partners will be brought on board. The media will be engaged with more structured and strategic approaches to target editors, journalists, broadcasters and producers from key media outfits so we can better direct our resources. A concerted effort will go into motivating and training frontline service providers to ensure the face of polio eradication in the field remains positive, consistent, and visible. Intensively focusing on high-risk groups will account for a significant proportion of the strategic shift in 2010. These groups have been and remain the most marginalized group for OPV consumption and other service acquisition. We must work harder to reach these children.

And finally, this strategy is a tool of accountability to stakeholders, partners, and ourselves. With clear objectives and measurable benchmarks, there should be clarity among all stakeholders regarding how to recognize success, and how and where we are veering off the schedule of eradication if this occurs.

It is envisaged that UNICEF's significant comparative advantage in communicating for polio eradication, coupled with clear objectives and increased accountability, will attract consistent resources that will enable us to fulfill our goals with the right staff, in the right place, at the right time.

2. Communication Outcomes 2010-2013: Reaching the goal

Objectives and Indicators of the 2010-2013 Communication Strategy

Based on epidemiological and behavioural analyses, the main objectives of the communication effort for 2010-2013 are the following:

To contribute to the interruption of P1 virus by 2010 and eradicate polio by 2013, the communication effort will:

1. Sustain and increase high levels of community and political ownership of the Polio Eradication Programme.

    Indicators:
    - % of parents who know children require OPV until 5 years
    - % of parents who know multiple doses of OPV are needed
    - % of parents who say their spouse/community leader/community members/support the polio programme
    - % of parents who think polio can be eradicated from India
    - % of parents who know polio is not curable
    - % of parents who refuse OPV to their child
    - % of parents who would give OPV to their child even when sick
    - % of XR, XS, XH remaining households on average annually (SIA data)
    - % of parents who think OPV is an effective method of prevention against Polio
    - % of positive, negative and neutral media coverage
    - % of NIDs/SNIDs launched by a significant political figure

2. Reduce the proportion of missed children in SMnet high-risk areas, particularly those from the highest risk groups of underserved minority Muslims, nomads, slum-dwellers, brick kiln and construction workers

    Indicators:
    - % of parents from high risk groups who know children require OPV until 5 years
    - % of parents high risk groups who know multiple doses of OPV are needed
    - % of parents high risk groups who know they should take OPV even when traveling
    - % of parents high risk groups in UP who know where the booth is
    - % of parents from high risk groups who know polio is not curable
    - % of parents from high risk groups who refuse OPV to their child
    - % of parents from high risk groups who would give OPV to their child even when sick
    - % of parents from high risk groups who think OPV is an effective method of prevention against polio

3. Facilitate interruption of transmission by promoting Routine Immunization, exclusive breastfeeding, water, sanitation and hygiene, and the prevention and management of acute diarrhoea in the highest risk 107 blocks of UP and Bihar

    Indicators:
    - % of parents in 107 blocks who receive 4 key messages on RI during sessions
    - % of children in 107 blocks fully immunized as per RI card
    - % of parents in 107 blocks who know water should not be given when exclusively breastfeeding
    - % of mothers in 107 blocks exclusively breastfeeding their child for 6 months

- % of parents in 107 blocks who understand the link between polio and water, sanitation and hygiene
- % of parents in 107 blocks who can identify 4 critical times for hand washing with soap
- % of parents in 107 blocks who wash their hands with soap at 4 critical times
- % of households in 107 blocks with flushable toilet/latrine
- % of parents in 107 blocks who know zinc can be used to prevent and manage diarrhea
- % of health workers in 107 blocks who know zinc can be used to prevent and manage diarrhea
- % of PHCs with zinc available

3. Communication Interventions: What to Say, to Whom, and How

Behaviour Analysis

The majority of participants within the target audience are vaccinating their children with OPV at every opportunity. Coverage of OPV is over 93%, with missed children in areas where the SMrnet is present at approximately 6% during each SIA.

Social mobilization levels are high, with over 90% of influencers accompanying CMCs to convert resistant households in UP and over 90% of teams with at least one anganwadi worker present in Bihar. An average of 240 children are vaccinated in CMC-area booths in UP This is an 80% achievement rate assessed against a target of 300 children per booth. These indicators, combined with KAP indicators showing 98% of parents think their children should receive OPV at every opportunity and 90% believe in OPV efficacy, demonstrate a very positive attitude to the programme. In the final stage of the programme, where cases are diminishing and the potential for complacency is high, the communication effort must maintain high levels of commitment and interest in the programme at all levels. This will require continued engagement with influencers and community members, and the repackaging of existing messages and materials to make them fresh and combat fatigue.

There is emerging concern and questions from parents about polio occurring in children despite repeated doses of OPV. The 2009 qualitative study on IPV showed parents were confused why polio vaccinations have been continuing for so many rounds, and in some cases, seemed to have little impact on the poliovirus. Messaging in 2010 will need to address the need for continuous vaccination, and explain more clearly the reasons for poliovirus transmission, and the various ways it is transmitted.

Over 60% of people in India openly defecate, and advocacy for defecation-free zones should be a complementary message to the communication programme. Only 34% of parents in UP and Bihar understood the linkage between the poliovirus and water, sanitation and hygiene. Reduced OPV efficacy due to incidence of diarrhea that is over 20% in the highest risk districts of UP and Bihar has been identified as a significant challenge to the interruption of wild poliovirus. While over 70% of parents know ORS is a useful remedy for managing diarrhea, less than 2% know that zinc is a useful prevention and treatment for diarrhea. Exclusive breastfeeding as well must be targeted, as low exclusive breastfeeding rates (just over 25% in UP and Bihar) is a contributing factor to diarrheal diseases and reduced vaccine efficacy.

While demand and attitudes to RI is high (about 80% think their child is at risk of disease if not vaccinated, and 78% and 91% in Bihar and UP respectively would like to have their children vaccinated), service delivery is suboptimal and only 33% of parents in UP and 18% in Bihar are given all 4 critical messages[4] during RI sessions.

These links will need to be explained better in order to reduce the risk factors to polio and explain why polio can still affect children with repeated doses of OPV. “Polio-Plus” messages on topics like hygiene, breastfeeding and complementary feeding, and routine immunization can be targeted to a population that has a higher vulnerability to the poliovirus due to poor knowledge and practices in these areas. A campaign centered around Polio “attacks the weaker” could be an effective angle for communicating this message.

The communication effort must also focus on targeted pockets of people who have been systematically missed by the programme to date – nomads, slum-dwellers, brick kiln and construction workers. With resistance at an all time low, the communication effort should be

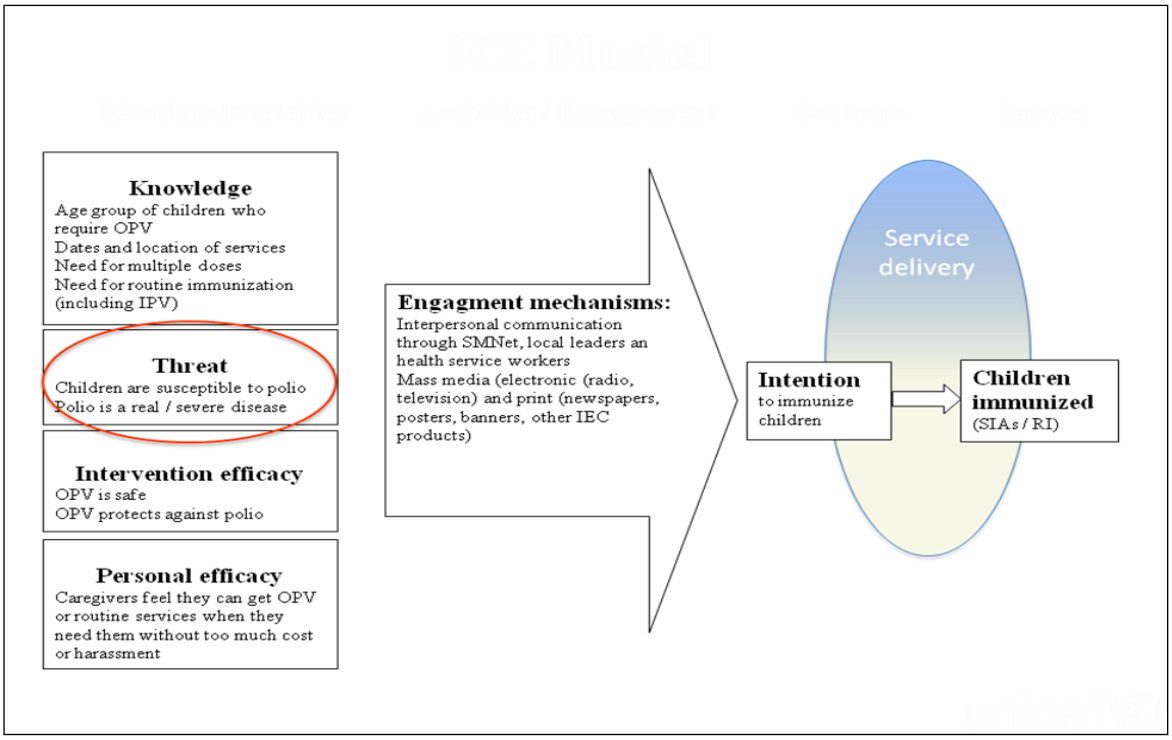
[4] What vaccines to be given, when to come back for immunizing the child, side effects of vaccine, and to bring the RI card at the next visit.

moving more strategically towards the targeting of those families in the XV (out of the village) and XL (house is locked) category – in other words, migrant families who are most likely to miss OPV while traveling for livelihood opportunities. The communication challenge here will be first to locate these groups and continue to track them, particularly when they are coming from non-endemic areas or states without the SMnetwork in place.

These groups will require basic messaging, akin to those at the start of the programme. Special materials and strategies will be required for this group who is largely illiterate, and the communication method will need to move from house to house methodology to transit and mobile communication approaches. Messages and services will need to reach them as they travel.

India Model of Behaviour Change

Messaging and focus for 2010-2013 should focus on maintaining progress within all the areas in the model below, and increasing the level of threat perception and threat severity in all population groups but in particular those in the highest risk 107 blocks.



Participant and Channel Analysis

Posters and health workers are the two leading sources of information on polio for all groups, and the commensurate investment should go into messaging through these mediums.

70% of respondents in high-risk areas report receiving information on polio from their anganwadi worker or CMC. 25% of parents received information about polio from their family members in 2010, compared to 89% in 2008. Where TV is most accessible in UP, 54% of parents cited it as their main source of information on polio; in Bihar, where families have less access, only 13.5% cited this as their main source of information. 97% of parents had seen posters, and could recognize them as polio posters, and 48% of parents in both UP and Bihar cited them as their main source of information.

The expanded underserved groups also cited posters, banners and hoardings as a main source of information, particularly in Bihar (66%). In Bihar, the anganwadi worker is the primary source of information (81%), and in UP, it is the vaccinator with 68% citing this source as their main one. The programme must therefore invest in developing appropriate IEC materials for the underserved (largely illiterate) groups which should be strategically placed in key transit locations. Similarly, investment must be intensified for IPC training among anganwadi workers and mobile vaccinators covering these groups.

Primary audiences are the ultimate beneficiaries of the programme, and those who are the primary targets for behaviour change: mothers and fathers of children under 5 years of age and their potential siblings (youth). Mothers have higher exposure to the CMCs, but have almost universally lower knowledge than fathers on polio and other health related issues. The mother is generally the decision maker in the family regarding whether or not to vaccinate the child, so more intensive and interactive IPC needs to be provided to the mothers, who are more likely illiterate and cannot complement the knowledge they receive from the CMC or AWW with other means, as fathers can.

The secondary target audience are the agents of change who are most likely to reach parents, children and youth with messages for behaviour change: key opinion leaders and influencers (including religious leaders), the Social Mobilization Network, service providers (teachers, health extension workers, physicians), the media, government officials at national, state and district levels, institutions, and private sector companies.

The message matrix in Annex 1 identifies key messages for each target group, which is the basis for implementing the communication interventions in support of polio eradication in India. Key indicators to measure our success will be as follows:

How to deliver our messages

As polio cases reduce, it will be critical to increase and personalize threat perception to polio, severity of the disease, and maintain the demand for continued immunization with OPV each time it is offered. polio, OPV safety particularly during sickness must be emphasized, and direction on where to go if a dose of OPV is missed will be critical messages to deliver in the new campaign.

Mass Media

Mass media remains an effective medium to reach the majority of the public and has successfully generated almost universal knowledge and awareness of the polio programme in India. 74% of parents in UP and 35% of parents in Bihar have been exposed to the polio PSA's with Amitabh Bhachan. 78% of parents in UP and 69% of parents in Bihar could spontaneously recall the polio slogan "*Do boond zindagike" (Two drops of life).* Thus, when transitioning to a new campaign, this slogan should be retained for continuity, but refreshed with another tagline, as only about 10% of respondents could recall the tagline "Har bacha, har bar" (every child, every time). In addition, as there is a need to personalize messages, it should perhaps be revised to say "your child, every time" or something similar.

A target of at least two new PSAs per year should be maintained, however messages can now be expanded beyond encouraging parents to vaccinate their children. More technical messages should be combined with a round announcement, particularly on OPV safety during sickness, on "complete dosage of OPV" to ensure no missed doses. PSAs on these technical messages may also be developed and aired in between rounds. To raise threat perception, testimonials should be used as another mass media intervention, which may include polio-affected people– parents of affected children, youth who contracted polio, doctors and others – speaking about its detrimental effects on various aspects of their lives.

Additional ways to transmit messages on SIA round dates should also be explored. SMS campaigns (in local languages) would be an effective way to reach the majority of the primary target audience, particularly mobile and nomadic groups whose only stable asset is sometimes a mobile phone.

The use of radio announcements and jingles is a medium that has not been fully exploited yet by the programme and will provide a fresh vehicle for message dissemination. Radio PSAs are a cost-effective and efficient way to address specific concerns that may come up in local media. A series of radio PSAs on key issues (e.g. OPV safety, frequency, etc) should be developed and disseminated for needs-based advocacy. Short serials for youth and parents can also be developed.

Given the low access to TV and radio in Bihar and within the migrant and nomadic populations, mass media cannot be relied on as the only medium for these groups, but should still be maintained to generate general public awareness and support for the programme nationally and locally. Mass media materials have not previously been aligned with a campaign approach that repeats the same message through different mediums. For 2010-2013, mass media will be developed following a campaign strategy that introduces a concept and message first through TV and radio for general awareness, and reiterates the message through other medium like IEC materials and IPC.

When media buys are carried out monthly, local channels should be targeted as much as possible to reach the high risk groups, and PSAs carrying local celebrities and spokespersons should be developed (in line with the campaign concept) for enhanced community efficacy.

TV is also an effective method for IPC interaction, and TV programmes using the *Kyunki* FFL messages for polio and other health issues should be used more systematically to engage mothers in particular during community meetings.
Key activities for mass media should include:

- Data-driven media research and planning to place media spots, prior to inserting large TV and radio campaigns before and during NIDs/SNIDs
- Developing at least 2 national TV and radio PSA's per year
- Adapting national PSA concepts to local level mass media; either through testimonials or using local spokespersons; at least 2 local adaptations per state each year
- Implementing SMS messaging or interactive games for health messaging for at least 3 SIAs per year
- Utilizing Kyunki FFL training videos for mother and community meetings

Social Mobilization

Social mobilization refers to a process of bringing together various groups and organizations to support and promote a behaviour change objective. It has been widely proven that the most sustainable behavior change is fostered not only through individual decisions, but also through an active dialogue, debate and engagement with the different social, religious, and cultural foundations of the people and communities engaged in the development process.

Social mobilization has been the cornerstone of the polio communication programme, facilitated by the Social Mobilization Networks of UNICEF and CORE.

70% of parents identify their local health worker or CMC as the primary source of their knowledge about polio. If a spouse does not support giving OPV to their child, 60% of parents in UP reported they consult a community influencer. The social mobilization component of the programme has relied on extensive local knowledge to identify and target those with the most influence, credibility and contact with the primary target groups.

The high knowledge of the programme and support enjoyed today is largely due to the wide-spanning efforts of the social mobilization component of the communication strategy. This focus should continue and expand even further to facilitate continued dialogue on polio eradication.

The SMnet will continue to target influencers (religious leaders, community leaders, PRIs), service providers (teachers, health workers, NGOs) and institutions (Muslim academic institutions, Indian Academy of Pediatrics) as secondary target audiences.

'*Panchayats'* are a particular group that needs special additional engagement as influencers, given their critical link between the government and local community. Popularly elected *Panchayat* representatives act as a strong catalyst for mobilizing and motivating communities and providers and lessons learned have shown that these constituents bring a good deal of strength in the process of connecting the programme with the community. There have been many instances of PRI members actively contributing to the polio programme as mobilizers, members of Block Level Task Force and inaugurating polio rounds etc. PRI members are often listed on micro plans as influencers, and it will be important for the programme to engage them further to ensure they actively support vaccination teams in addressing refusal issues at the community/household level.

Due to the transient nature of the nomadic and migrant populations, their social networks and transmission routes for information are not fully clear. The SMnet has identified approximately 4,000 informers who report on their movement in and out of high-risk areas. These informers are critical "eyes and ears" for these groups, and should be further engaged to serve as influencers for community engagement and support.

Key activities for Social Mobilization will include:

- Ensuring over 90% of influencers in CMC areas accompany vaccination teams for X to P conversion
- Maintain formal engagement (through MOUs etc) with Muslim institutions and universities
- Conduct sensitization workshops for PRI members and ensure their names are included on micro plans and they accompany vaccination teams for X to P conversion
- Increase the number of nomadic informers and engage them as influencers for X to P conversion in migrant and nomadic communities
- Ensure bulawa tolie's (school rallies) and polio classes take place in each CMC area before polio rounds

Interpersonal Communication
Interpersonal communication (IPC) is the core responsibility of a community mobilizer (CMC), and training on IPC skills is the crux of the CMC training course. (See Annex 4: TOR of CMCs) This medium is the most interactive one on one communication with primary beneficiaries. It allows for immediate feedback on ideas, messages, practices and concerns and can be used with literate and illiterate communities.

The CMC will be asked to visit every X house and as many Po[5] houses as possible. The use of child maps should be constantly refined to identify every missed child, every child in a resistant house, and every "concealed" child (false P's). The lists of "X"-marked houses—households where children were missed—in communities covered by the SMnet are analysed after each SIA. Each X house is located and visited and if unvaccinated children under five, especially newborns, are confirmed living there, they are registered. To boost OPV coverage and mitigate the effects of missed children on the eradication effort, SMnet workers are tasked with ensuring that all these children are vaccinated before the next NID through routine immunization sessions facilitated by them. As needed, and particularly in marginalized communities, CMCs will promote and facilitate health camps where routine immunization will also take place. These auxiliary, "localized SIAs" serve to reduce the immunity gap in high risk, high priority communities.

This intervention is the most time-consuming medium with the highest cost per person/contact. Its effectiveness is only as good as the person conducting the IPC, therefore primary importance must continue to be given to the quality training of the SMnet in IPC skills.

To maintain the emphasis on IPC, knowledge, attitudes, and skills included in the training must be reinforced through monitoring and supportive supervision. Indicators for effective IPC should be reviewed by BMCs and DMCs during fieldwork and reported to the SRCs to maintain quality assurance. Key indicators for effective IPC are:

- CMC has established rapport with the mother (e.g. knows the children's names, mother's name, is asking how the family is before entering into polio discussions)
- CMCs are actively listening to concerns of the mother and attempting to address them
- CMC is able to confidently communicate technical aspects of Polio (transmission route, symptoms, where to take the child for R.I.)
- CMC has identified specific communication objectives for each IPC session in communication work plan
- CMC knows which communication tool to use for specific queries and demonstrates familiarity with the material

[5] Houses where there are thought to be no children <5 in the household

Information, Education and Communication (IEC)

IEC materials for the polio programme in India are designed with the support of UNICEF and disseminated by the State Governments, Rotary and within CMC areas - the SMnet. In Bihar, UNICEF is responsible for dissemination of all IEC materials in the State.

Posters and banners have historically been designed to communicate SIA and NID dates. Posters and banners not only provide information on the SIA days, but they also create an enabling environment for the SMnet to approach parents and households. Once IEC materials are visible, parents know a polio round is imminent and are more amenable to CMCs approaching them about vaccination. The heavily branded Polio Booths also help create a sense of community mobilization and enthusiasm for the programme.

IEC materials for the programme have been streamlined to form a set of branded materials that are now universally recognized as unique to the polio programme. 97% of parents in high-risk areas have seen polio posters and banners recognize their content, even if they cannot read the text. The polio brand of yellow and pink, together with the logo, has become very strong and this should be maintained.

Due to the high level of knowledge surrounding the programme, and the fact that over 50% of people cite posters, hoardings and banners as a main source of information on polio, IEC materials will also communicate additional messages beyond the date of the SIA. Messages on polio and R.I., OPV safety, and the need for “complete dosage of OPV” are some messages that will be incorporated into the new IEC strategy and can be placed between rounds since they do not need to be attached to a polio campaign date.

Static messages on hoardings, billboards, etc on and around major transit points will be critical to reach the migrant and underserved populations. Messages for these groups will focus on the importance of vaccinating children while on travel, and should remain at major points throughout the year. These materials should be simple and visual given the majority of these groups are illiterate and have less exposure to the polio programme. Private partnerships with companies who have acquired expansive IEC infrastructure and who may be willing to donate billboard space will be explored

All IEC materials currently in use in the field have all been assessed by an independent agency based on their relevance to the 2010-2013 strategy. The development of new materials should follow the guidance and recommendations in the IEC assessment (with the Polio Unit in Delhi) and should be streamlined with the new campaign approach. CMCs should ideally receive a full kit of IEC materials they are expected to use when they are given orientation.

The following principles will inform all of UNICEF’s work in IEC for polio eradication:

- *Recognizable branding:* Partners producing IEC materials in support of the strategy should work within a common branding framework so that messages are uniform, and recall value is maximized. Branding must also be standardized within States so that migrants and others in transit can recognize the SIA campaign regardless of where they are. A branding toolkit should be developed for uniformity among partners, within the States and across them.

- *Coherent, holistic design:* Color schemes, logo, etc should be streamlined so that one campaign look and feel is maintained IEC materials should be considered as part of a set, and similar branding for the IEC materials should be used for other elements of the campaign – PSAs, leaflets, flipbooks, etc

- *Pre-testing:* Any new messages and materials that are developed should be preceded by pre-testing and formative research if changes are significant, prior to the production and dissemination of materials

Where UNICEF is responsible for the dissemination of IEC materials, they should reach the District level at least one week before the round.

The following targets for IEC should be met:

- IEC materials reach the District at least one week before each SIA, with a clear dissemination plan
- IEC materials should be visible at district, block and village level at least 2 days before the SIA
- Every booth should display a polio banner
- IEC visibility should be monitored during each SIA and reported
- IPC flipbooks and other IEC materials should be standardized according to new campaign objectives and guidelines, in consultation with Delhi
- SMnet staff should be given a comprehensive package of IEC material upon joining and given orientation.

Engaging with the media

Media engagement is a critical strategy in order to generate public interest and awareness for the programme, to create an enabling environment for the programme to operate, and to inform communities on developments and technical issues like rumours and adverse effects that have the capacity to derail or hamper SIAs.

The media environment in India has historically been rather critical of the polio programme, with sensationalist reporting generally dominating news coverage, particularly during outbreaks when the programme – and the deadline to eradicate - is under intense scrutiny from the media. Media monitoring has been established as an approach to guage the media environment for the programme and enable UNICEF and partners to interact more strategically with the media based on data.

Intensified interaction with the media, as well as programme progress in the last year, has yielded substantial declines in negative media coverage. In western UP, the hotbed of negative media reporting, positive media coverage has increased from 18% to 50% from 2009 to 2010, and in Bihar from 8% to 25% across the same time period. However, with diminished “bad news” about the programme, the number of articles on polio has also decreased. Therefore, it will be

Print media monitoring will be continued for the endemic districts of Western UP, the metro’s (Lucknow, Patna, Calcutta, Mumbai, Delhi), and Bihar and will be carried out by a media monitoring agency for standardized monitoring and reporting. (See Annex 2 for media monitoring indicators)

Standard protocols for engaging with the media should be followed, with a Government of India spokesperson always identified and supported with technical guidance by the partners. (See Annex 3 for Media Protocol). Media should be proactively engaged as appropriate during adverse effects and provided with verified data and information in order to quell sensationalist reporting.

Media workshops and sensitization sessions should be conducted with standardized media kits developed by the Polio Section in Delhi and available in Urdu, Hindi and English. Journalists targeted should be based upon analysis of the most influential health journalists and papers in the area, and these lists should be continuously updated on a regular basis. The Polio Section in

Delhi will keep a master file of targeted journalists and editors, which should be updated by the State Media Specialists.

Field visits with journalists will be an additional strategy to engage the media and key journalists from the list mentioned above should be proactively approached for field visits, based on pitching news stories through a monhtly media fact file and close contact with journalists.
Engagement with the National Broadcasting Corporation of India, Prasar Bharti, will continue as a strategic partnership to increase coverage of polio and polio risk factors in TV and radio programming through Doordarshan and All India Radio.

Key activities for media should include:

- Conduct standardized monthly media monitoring on polio news stories and use this for monthly media planning
- Developing efficient response systems for media queries using standard protocols as and when required
- Implementing sensitization and training sessions for mid-level and senior journalists in endemic and re-infected states. Implementing diverse methodologies to sensitize senior editors.
- Implementing capacity development training on polio and polio “plus” messages for TV/radio broadcasters from the Prasar Bharti Corporation
- Well guided field visits of journalists to the endemic states
- Pitching polio news and potential storylines through monthly media fact files
- Developing Video News Reels (VNRs) showcasing various elements of the programme or newsworthy topics, to be hosted on partners’ web portals and shared with TV news channels

Celebrity engagement and support

Celebrity support has proven highly effective for social mobilization and national advocacy. Amitabh Bhachan is widely recognized as the face of the polio eradication programme in India. Despite intermittent propositions that there is fatigue with Mr. Bhachan as the face of polio, 2007 research to gauge his effectiveness demonstrated continued high satisfaction and credibility linked to his dissemination of messages. Furthermore, his status as an “older and knowledgeable” public figure gives him credibility across generations.

Nonetheless, there is a need to diversify the public face of the programme and as we seek to reach mothers as the primary target audience, the programme must try to leverage at least one female celebrity spokesperson in 2011-2013. Mr. Bhachan will need to remain the primary protagonist of the programme given his unwavering popularity and his historical and present commitment to the programme. However, 2008 initiatives to add players from the Indian National Cricket with him on a PSA, for example, proved very successful. More initiatives like this, pairing Mr. Bhachan up with additional celebrities, would achieve the innovation factor that underlies the request for a change in Ambassador.

Players from the Indian National Cricket team have proven highly popular and effective for social mobilization. An MOU should be signed with BCCI in order to standardize UNICEF’s interaction with them for polio, and ensure that their support is more systematic and consistent.

Celebrities should also be brought on for more diverse communication methods beyond TV. For example, Mr. Bhachan’s notorious voice can be used for radio jingles or voice SMS, musicians like AR Rahman should be sought to develop jingles or songs for the programme. Local celebrities should also be identified and used to localize the communication strategy and campaign.

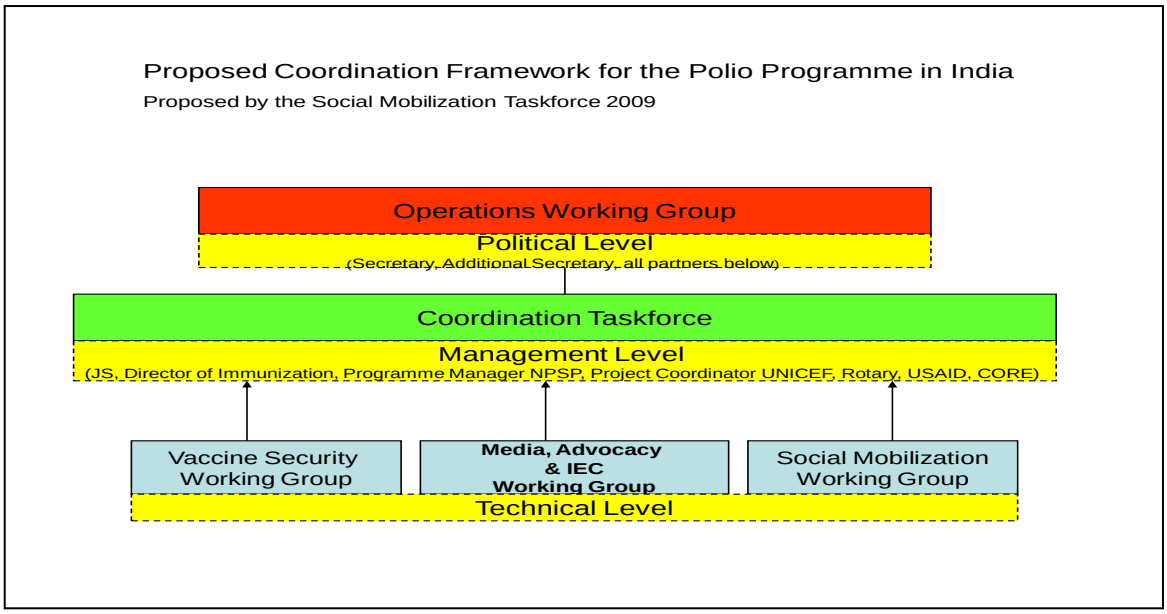
The following targets should be met for celebrity engagement and support:

- Amitabh Bhachan will continue to be engaged for at least 2 TV PSA's each year, and will also be approached for radio spots and/or voice SMS
- An additional female protagonist for the programme will be engaged in 2011, based upon rapid formative research for potential influential celebrities (see 2008 IPV study for suggestions)
- UNICEF's partnership with the BCCI will be formalized by 2011 and cricketers will participate in at least 1 high visibility event per year, and at least 3 field level initiatives per year
- At least 5 local celebrities will be engaged each year at the State and District level to localize the communication strategy

Partnerships

Co-ordination with partners is the key to all models for polio eradication. Polio eradication activities in the states are co-ordinated at three levels: the inter-agency level, the inter-departmental level and the district and block levels. At all these levels, committees have been set up and institutionalised and are now seen as integral parts of the state machinery.

At the national level, inter-agency coordination is critical. Taskforces have been established for Advocacy and Media, Social Mobilization and Vaccine Procurement. (See Annex 3 for TORs) Regular meetings for these taskforces take place between all partners: Government of India, UNICEF, WHO/NPSP, Rotary International, Gates Foundation, CORE and USAID. Issues on IEC



messaging and distribution, SMnet performance, expansion and strategy, as well as communication data are discussed and action points established following the meetings. A coordination mechanism to ensure that technical decisions flow from these taskforces and up to the Operations Work Group, chaired by the Secretary of Health, has been proposed to GOI for their approval:

Coordination meetings take place also at the state level, however technical working groups should be initiated to focus discussions and action points and streamline decision making around key components of the programme.

4. Strategic Shifts: What is different in 2010-2013?

A new campaign for polio and polio "plus"

An overwhelming majority of the populace are in favour of polio immunization. However, the continued pressure of repeated rounds and doses that has reached over 10 per year, has lead to some fatigue among service providers and community members who ask the SMnet why so many repeated doses are required. This fatigue, and sometimes frustration, could lead to an increase in resistance and dropouts.

In addition, based on recent KAP data, there remain misconceptions around the curability of polio, how many doses of OPV are "enough" and what to do if a dose is missed. A new campaign is required to address these emerging knowledge gaps and personalize threat perception and threat severity so that every parent feels compelled to giving their child OPV each time it's offered as a personal commitment to their family.

Furthermore, in order to capitalize on brand recognition and maximize the impact of our communication methods, a streamlined approach to communication is required where all IEC materials, mass media, and IPC messages are standardized with uniform messages. The 2011 campaign will roll out revised flip books, posters, TV PSAs, migrant hoardings, etc under a uniform concept of "Complete Protection Against Polio", whereby protection is equated with love and complete love = complete dosage of OPV.

For the 107 Blocks, a special strategy will be implemented, focused intensively on IPC tools that will promote 4 key behaviours that will provide "additional protection" to children, together with OPV. (See section below on Polio Plus below) The concept here is complete love = complete dosage of OPV+ additional protection against polio.

The principles of the 2011 campaign are as follows:

- **1st Principle:**
  Remind and revive the community's belief in the reason behind OPV and help drive 100% compliance – **Increase threat perception and severity**

- **2nd Principle:**
  Personalise, so protection becomes a personal responsibility for the family, a commitment till the child reaches 5

- **3rd Principle:**
  Refresh the communication to help drive noticeability and impact – **Provide new "news" about the programme**

- **4th Principle exclusively for 107 Blocks:**
  Introduce and promote 4 key behaviours as **extra protection in addition to OPV** to make your child less vulnerable to Polio

2011 campaign materials

The campaign incorporated the original polio messaging, but updated the messages to meet the principles recommended by the IEAG. The key message shifted from; *Every Child, Every Time* to *Your Child, Every Time*, and then to *My Child, Every Time*.

The new campaign logo features both parents, and a child (their child) receiving two drops of OPV.

Posters

Transit hoardings at the India/Nepal border

Materials targeting migrant and mobile populations

Emergency Preparedness and Response Plans (EPRP)

The 2010 IEAG highlighted that as long as virus transmission continues in any part of India or elsewhere in the World, the possibility of virus importation to polio free areas in India remains. In view of these risks, the IEAG recommended that while intensive efforts should continue to stop transmission in areas with recent WPV transmission and the traditionally endemic areas of Uttar Pradesh and Bihar, the programme in India should:

- Make efforts to protect polio free areas from importation of virus from within or outside India.
- Rapidly respond to any WPV detected anywhere in India during 2011 with an aggressive mop up vaccination campaign to stop any further circulation of the virus.

In response to this recommendation, the Emergency Preparedness and Response Plan was developed following the Howrah, West Bengal case in January 2011 at the request of the Honorable Minister of Health & Family Welfare to ensure adequate preparedness and response to an event of importation of poliovirus anywhere in India during 2011. The plan will be implemented in the occurrence of any WPV case in 2011.

The guiding principles of the EPRP are as follows:

- Any wild polio virus from any source will be considered a public health emergency and responded to with urgent mop-ups.
- Government and partners will deploy additional, highly experienced human resources to ensure that mop-up rounds are of the highest quality.
- Mop-ups will target both the area of detection of the virus in a case or in the environment and, if there is a clear genetic link, the area of origin of the virus.

The EPRP plan encompasses seven components at the National, State and District level:

1. Preparedness for virus importation and response
2. Response and actions following the detection of WPV
3. Key actions during the mopping up vaccination campaign
4. Key actions at the end of the activity
5. The role of partners
6. The role of States with a low risk of WPV importation
7. Mop-up strategy

As a partner, UNICEF's key role is to participate in the Central and State Emergency Preparedness and Response Groups by providing staff, technical assistance and support to ensure high-quality communication and social mobilization activities in addition to far-reaching media strategies. UNICEF will support the planning and implementation of these activities and monitor their impact.

Annex 6 shows the detailed EPRP as developed by polio partners in April 2011.

The key steps in emergency preparedness as stipulated by polio partners during the EPRP workshop on 1 August 2011 are highlighted below:

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decompressor
are needed to see this picture.

There are four key stages of emergency preparedness and response:

Emergency Preparedness
Stage 1: before virus identification
Stage 2: from virus identification to mop up

Emergency Response
Stage 3: mop up response
Stage 4: from end of mop up to the beginning of the next campaign

The diagram below highlights the first emergency response in India following a case of WPV1 in Howrah, West Bengal in January 2011.

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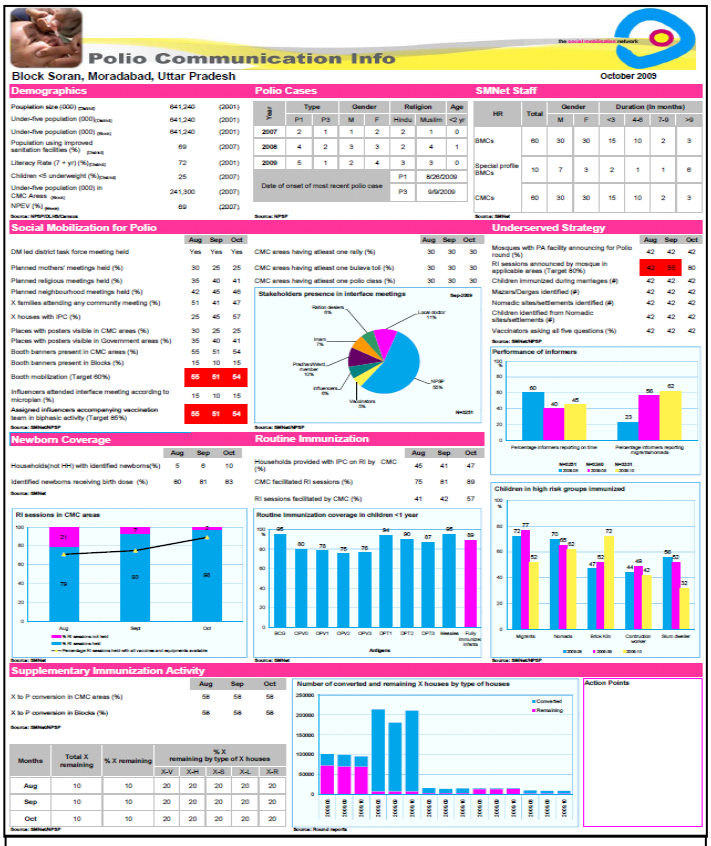
decompressor
are needed to see this picture.

Evidence-based behaviour change

As outlined in Annex 1, optimal behaviours and messages for each target group have been clearly identified and the success of the communication approach will be measured by changes in these behaviours as well as key process indicators to assess intermediate progress.

SMnet staff, Government and other partners should all be aware of the indicators and targets the programme aims to reach. Progress against these indicators should be used at all levels of management within the programme, and shared with partners at regular intervals.



Block communication profile, Uttar Pradesh

The programme has prioritized key management indicators to be reviewed after each round at community, block, district, state and national level. These communication indicators are available in a user-friendly format and reviewed together with key epidemiological and operational data in order to identify communication bottlenecks and plan the most relevant and targeted communication activities for the next round.

The graphic on the right is an example of a block level profile developed using Dev Info technology. Indicators on polio and RI communication efforts, key demographic information, epidemiology and underlying factors of polio (such as hygiene, malnutrition, etc) have been input into the Polio Info database and analyzed together to demonstrate a comprehensive district or block profile on polio.

The database and profiles are available at: http://devinfo.info/polioinfodashboard

All high risk areas of UP are mapped and SIA data entered automatically each month. By 2011, all high risk areas of Bihar should be available, which will make all communication data available for digital presentation and analysis at the block level.

The programme will have the challenge to ensure these profiles are then by key decision makers such as the Ministry of Health and Family Welfare at National and State level, District Magistrates, Chief Medical Officers, Sub-Regional Coordinates and lower level management to ensure decisions are taken based on the data at each administrative level. These profiles should be used in DM-led District Level Taskforce meetings and the basis of SIA communication planning at each level, together with qualitative assessments from the field books and field observations.

Key activities to maintain block level data analysis should include:

- Continuous data transfer from SMnet database to DevInfo software
- Continued training of SMCs and SRCs on using the Devinfo software and profiles for more evidence-based communication planning and advocacy
- Sensitization of profiles to DMs and partners on how to use the data for action

Polio Risk Area Classification for a Standardized Communication Response

The approach to polio communication for the last several years has been to focus on the endemic states of UP and Bihar with a full communications effort, and to contribute posters and mass media support for mop-up campaigns in re-infected states.

As we near closer to eradication, any outbreak must be responded to as though it is an emergency. The increasing threat that migrants play towards transmitting the virus also means that our efforts cannot be limited only to the two endemic states. Thus, while intensive efforts will continue to be made in the polio-endemic areas of UP and Bihar, UNICEF will also ensure an emergency package for polio communication exists for rapid response in all states. All states should be aware of the polio programme's objectives and be well prepared on how to manage adverse effects, negative media and rumours related to the polio programme or R.I.

Based on data, the states with highest in and out migration from Bihar and UP are Haryana, Maharashtra, West Bengal, Punjab and Uttarakhand. Since it is neither possible nor sustainable for the SMnet to expand to these states, UNICEF will contribute to the capacity building of frontline health workers on polio communication so that *anganwadi workers, vaccinators, ANMs and ASHA's* have the skills to communicate to families on the importance of OPV. Training packages will be made available to the National Rural Health Missions at state level, and UNICEF will facilitate Training of Trainers on the contents if this is requested.

An emergency kit of ready-to-use IEC materials is also developed to include:

- Polio flipbook
- RI flipbook
- Green Book for advocacy to Minority muslims
- Deoband appeal for OPV safety
- Media kit and media protocol
- Several poster designs and translations in all languages

A roster of high-performing SMnet staff from UP/Bihar will also be established by Delhi for rapid response to outbreak states.

Engaging the Private Sector

Engaging with the private sector has the capacity to substantially increase visibility of the programme and the reach of polio communication messages, particularly in areas outside SMnet high risk areas where migrants may be traveling through.

The India Unite to End Polio Now! Campaign was initiated in 2010 with the Aid Matrix Foundation and has leveraged approximately $300,000 of in-kind donations and support for the programme from the private sector.

The goals of the campaign are:

- To generate a positive image and increased visibility for the polio eradication effort

- To re-energize the general public, as well as our target groups, tomake the final push to eradicate polio
- To strengthen and sustain awareness and support for GOI's polio vaccination campaigns among high-risk populations.
- To create greater accessibility to Polio eradication efforts among hard-to-reach high risk populations

Engagement with the private sector should continue to be targeted to industries and sectors that can assist the programme in expanding its reach. Key sectors and activities they should be approached to support are as follows:

1. *LCD Producers:* Distribution of LCD screens that can scroll Polio PSA developed at key train stations.
2. *Health commodity producers:* business who can contribute in-kind support like soap, jerry cans, water filters, iodized salt, etc that will function as an incentive product to attract mobile populations to polio booths in train stations and transit sites.
3. *Mobile phone companies and others with successful IEC outreach* in order to establishing promotional campaign space, communication will target adult populations through visual posters, brochures, billboards along transportation corridors, and displayed at transportation areas, where trains, buses, trucks transit.
4. *Media outfits:* who can provide free or subsidized advertising space for polio campaigns in their newspapers or through television broadcast nationally and in UP and Bihar

In order to leverage this private sector support, advocacy messages must speak to the interests of the business community. Key messages that need to be reinforced to the business community are:

- The health of the workforce is the underpinning of a prosperous economy.
- Healthy people strengthens a robust marketplace
- Corporate Social Responsibility is a critical input to strengthening citizens' participation in social priorities and decision making
- Together we can protect health and protect wealth with Polio eradication.

Expanded Underserved Strategy

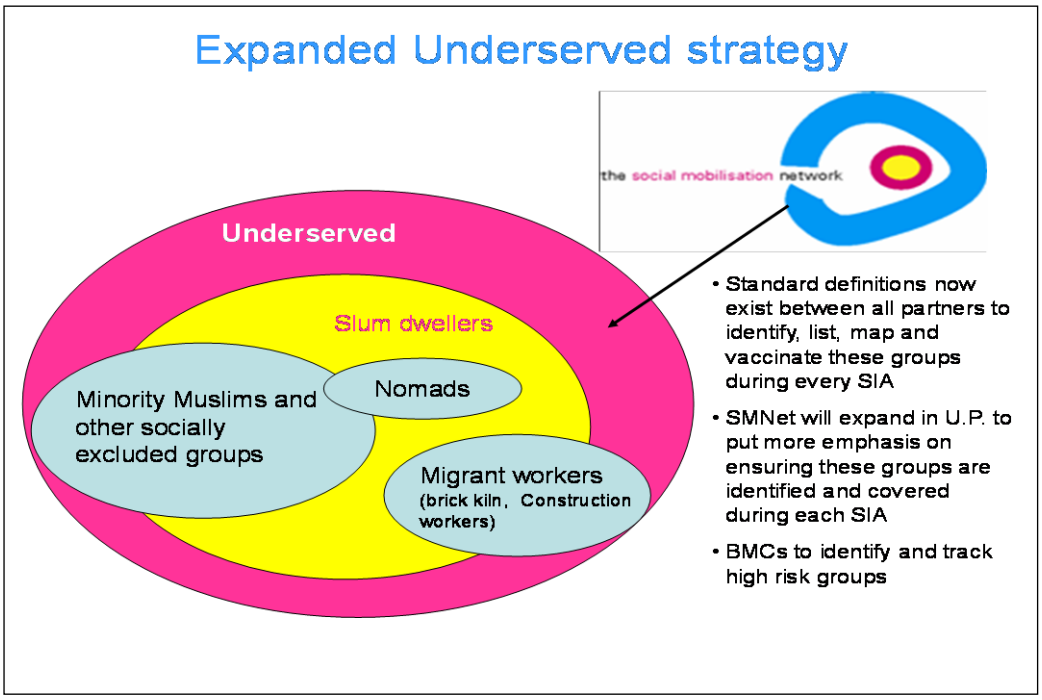
The underserved strategy component remains a key piece of the overall communication strategy to interrupt polio transmission, particularly in UP. To date, the underserved strategy has focused predominantly on minority Muslim groups with the following objectives:

- focus advocacy, partnerships and behaviour change efforts to improve access to basic services to these groups, with a particular, but not exclusive, emphasis on immunization services
- establish strategic partnerships with Muslim institutions who have an impact in Uttar Pradesh;
- advocate for the inclusion of underserved communities in the planning, implementation and monitoring of immunization activities at all levels (state, district and community level);
- provide staff working at community level such as social mobilization agents, vaccination teams, NGOs and others, with skills enabling them to reach to underserved communities.

These activities are being undertaken through a combination of formal and informal relations with Muslim institutions. UNICEF has project cooperation agreements with three universities with strong links to western UP – including Aligarh Muslim University, Jamia Millia Islamia, and Jamia Hamdard universities.

In addition to activating local networks, these institutions will be provided financial support for mobility and IEC activities in the build up to each polio round. Jamia Hamdard, apart from

expanding its work into additional districts, will be used to financially support and coordinate activities with non-formal partners in the western districts, while Shibli College will be used for the same purpose in eastern UP



The performance of vaccinators, mobilisers and others charged with the responsibility for reaching and involving the underserved in all aspects of planning, implementation and monitoring of immunization activities will be measured through:

- Rate of conversion by underserved partners during B Team and after B Team activities
- Number of booths set at mosques and in the premises of Muslim institutions
- Mosque announcements for polio rounds and RI sessions
- Involvement of Muslim leaders at the district and block task force level

The focus on Muslim underserved groups will continue to be emphasized. However, the recent epidemiological and operational data that shows increasing proportions of cases coming from migrant and nomadic groups. This data, together with evidence indicating operational gaps in reaching temporary slum dwellers such as those living in unregistered slums, migrants like those working in brick kilns and construction sites, and nomads has highlighted the need to focus intensively on communicating and reaching these groups as well.

The communication challenge here will be first to locate these groups and continue to track them, particularly when they are coming from non-endemic areas or states without the SMnet in place. These groups will require basic messaging, akin to those at the start of the programme. Special, visually descriptive materials and strategies will be required for this group who is largely illiterate, and the communication method will need to move from house-to-house methodology to transit and mobile communication approaches.

To identify families and children on the move, UNICEF will mobilize all block-level staff to identify and track nomadic and migratory families coming in and out of the blocks. To date, these staff have identified over 3,800 community informers who report to the SMnet each week on the

projected movement of families. These informers must be engaged as influencers, and IEC materials developed specifically for this community.

This will involve additional partnerships, for example with the Ministry of Railways for messaging on train stations and bus stops, and on buses and trains themselves; with construction companies for social mobilization to employees; with brick kiln managers, and other influential people in these communities. Special IEC materials are required to ensure targeted communication to this largely illiterate population group, who has not been exposed to polio messages with the same intensity as the general population.

Key activities will include:

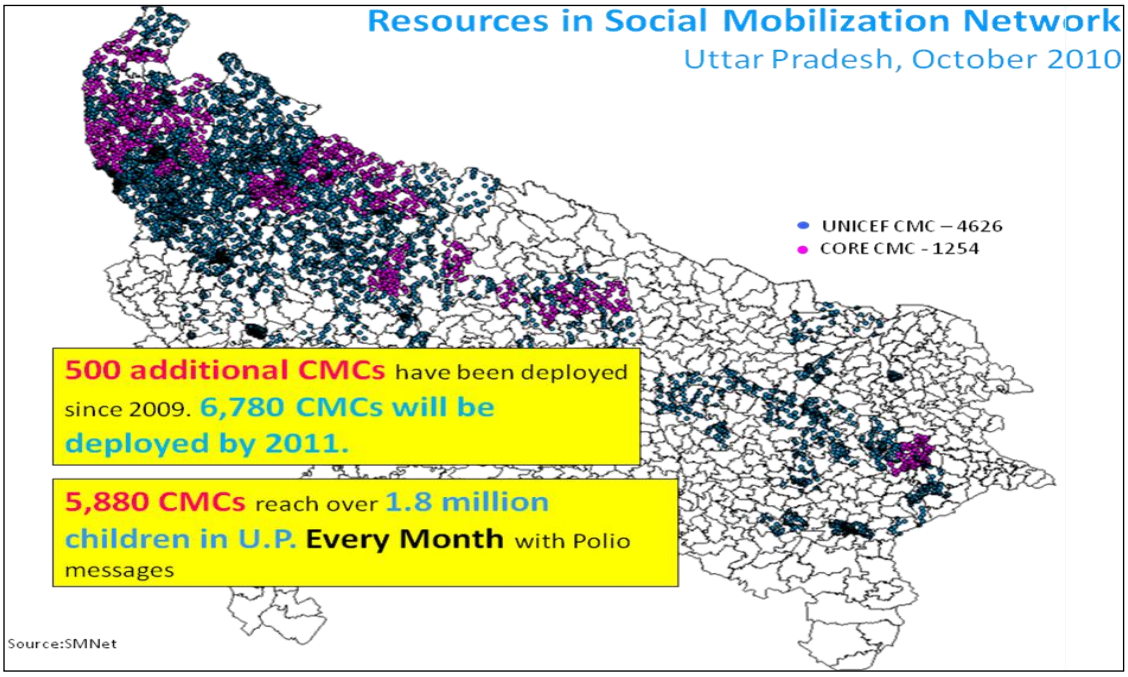
- Orienting block level staff on tasks related to tracking and reporting children from high-risk groups
- Identifying informers and engaging them as influencers and supporters of the programme
- Developing special IEC materials for this illiterate group, which includes flip books, posters and hoardings that can be displayed at key transit locations
- Focusing messaging on taking OPV even when traveling

SMnet Expansion

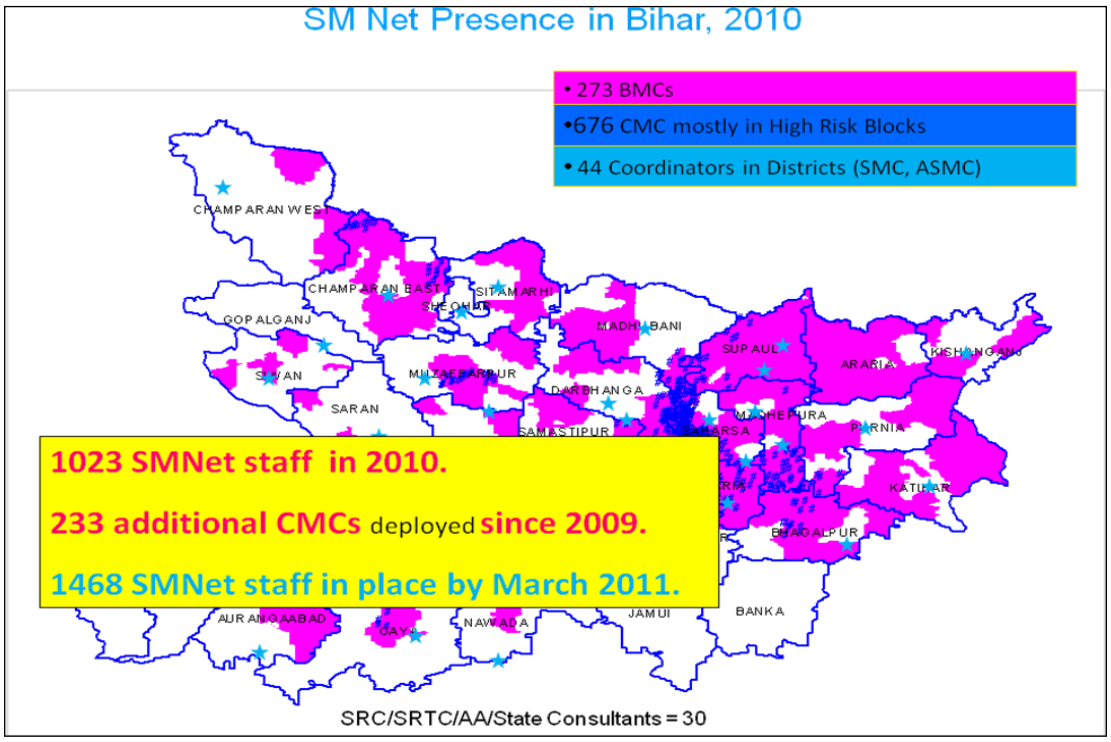
The SMnet begun its expansion in 2009, both in Uttar Pradesh and Bihar. SMnet expansion will continue throughtout 2011, and deployment has been determined based upon weighted criteria developed by the partners which identifies high risk areas requiring CMC support.

Where resistance to OPV is rooted in mythical beliefs or R.I. resistance for example, additional CMCs have been allocated. Where the issue is reaching the expanded underserved groups (mobiles, nomads, etc), a block level coordinator has been allocated.

With UNICEF and CORE expansion, Western UP should be fully covered with SMnet staff by 2011.



In Bihar, the SMnet expansion has taken place largely in the Kosi River area where 1023 SMnet staff exist as of November 2010, which will rise to 1,468 by 2011.

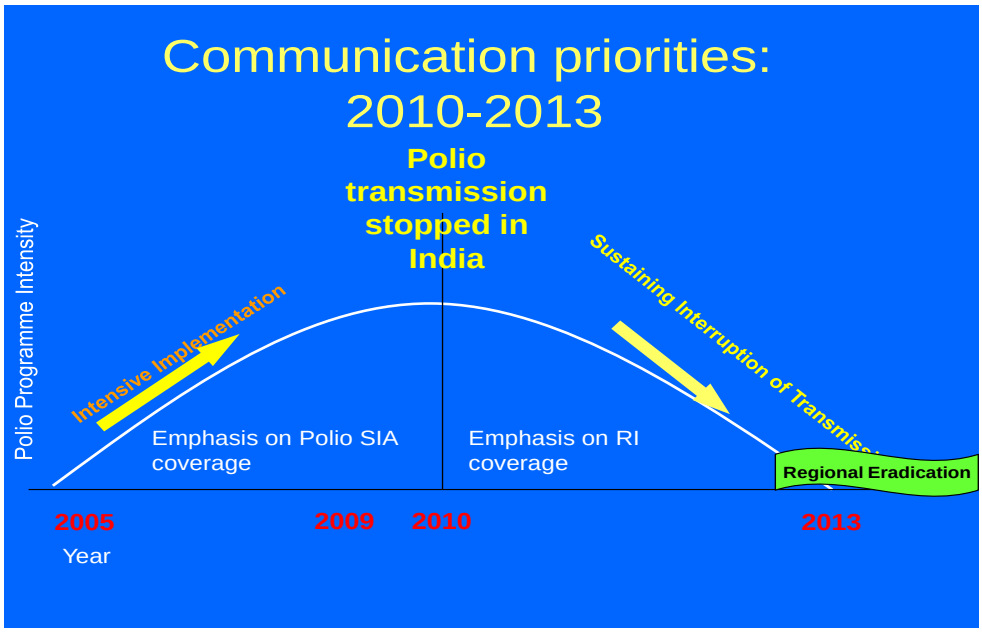


Polio Plus Messaging in the 107 High Risk Blocks

Epidemiological analysis has shown that combinations of factors are likely contributing to the persistence of WPV transmission in the remaining highest risk areas of UP and Bihar. These are:

- High density population
- Poor hygiene practices
- Nearly non-existent sanitation infrastructure
- Compromised water supply
- Inadequate health and routine immunization services
- Diarrhoea

UNICEF will continue to emphasize polio messages as priority until transmission is interrupted, but will more systematically address additional behavior messages that could intensify progress towards eradication, focused on the 107 highest risk blocks. Enhanced messages on routine immunization in particular will be an emphasized component of the strategy. A strengthened Routine Immunization system and increased coverage of R.I. should be the legacy the polio programme leaves behind for sustainability of our results to eradicate polio (See figure below).



Communication materials will be developed to deliver a comprehensive package for polio and its underlying factors. Facts for Life messages will be the basis for the communication approach.

Based on the theme of "polio attacks the weaker" communication messages will be disseminated on each of the 4 additional care practices that make children less vulnerable to polio:

- Exclusive breastfeeding for 6 months
- Routine immunization up to 2 years
- Hand washing with soap at 4 critical times
- ORS and Zinc for prevention and management of diarrhea

One theme should be focused on until it has been agreed to shift focus again and diversify messages. For example, each mothers' meeting should begin with messages on polio, and then switch to R.I., feeding practices, hygiene, etc. for a particular period of time. To achieve impact and ensure mother's hear the message at least six times as recommended by the WHO COMBI model, house to house messages, Ijtema'a meetings, community meetings, polio classes etc should also focus on consistent messages for this period.

Monitoring formats should be modified to monitor the frequency of communication on the priority polio plus themes. Bi-annual KAP surveys will assess periodic knowledge and behavioural change for these 4 key behaviours.

SMnet Capacity Building, Supervision and Management

The Social Mobilization Network is the cornerstone of the polio communication programme. Extensive investment has taken place to build up this army of communicators. But it has not always been clear what constitutes "success" of our capacity building approach. We need to go beyond counting of trainings to look at the outcomes of capacity building efforts and review these against skills and behaviours we want the SMnet to demonstrate.

Learning and Capacity Development Strategies (LCDS) have been developed for the SMnet staff in UP and Bihar that identify minimum standards for training and capacity development for each level in the SMnet. Learning plans should be developed annually against the strategy, and should be monitored through independent assessments, reviews and a KAP Study for CMCs.

The Learning and Capacity Development Strategy also highlights the need to create a mentoring system for newcomers to the system, a coaching system for those who have demonstrated potential – particularly female CMCs who may rise to management positions and remedy the gender imbalance currently in place in the senior ranks of the SMnet, and building a networking system to share best practices and lessons learned across districts.

The key principles of the LCDS are as follows:

- Terms of Reference for each SMnet function should be followed and updated as required.
- Competency profiles have been established for each level of SMnet staff so there are objective criteria and behavioral indicators against which staff can be assessed and can assess themselves. Supervision and coaching discussions should be based around these profiles. See Annex 5 for a sample SMnet competency profile.
- A field-based learning/training needs assessment should be conducted once every 18 months to ensure learning activities and trainings are targeted appropriately.
- Training standards to ensure the quality of SMnet workers should be maintained as per identified learning tracks for each level of the SMnet. These learning tracks should be translated into annual learning plans for each SMnet staff
- Training courses should be professionalized and implemented by a professional training institute and assessed objectively
- Training should only be carried out by certified SMnet Training Coordinators or trainers from a professional institute
- Mechanisms to encourage and support the promotion of women in management roles should be developed. This may include structured mentorship programmes, continuous development discussions, and on-the-job coaching for those with promising potential.
- All managers should receive focused management training, with particular emphasis on training district and sub-regional managers.
- Motivation and commitment of frontline workers is an area that should be fostered not only through one-time motivational events like jamborees, but also through continued support and effective day to day management

5. Monitoring and Evaluation: Are we there yet?

As we inch towards the final stages of eradication, an intensified focus on data will be critical to identify bottlenecks or successes as early as possible. All data generated at this stage of the programme must be geared towards impacting programmatic correction or action.

Monitoring

Monitoring data will continue to be collected for SMnet activities through various forms at community, block and district level. Key indicators identified for communication management and planning will be incorporated into block and district communication profiles and uploaded each month online at http://www.devinfo.info/polioinfodashboard

District level staff and above should continue to be oriented on how to use monitoring data for programmatic action.

Research

KAP studies covering polio and polio "plus" behaviours will continue to be implemented on at least an annual basis, covering the high-risk areas and high risk groups for the programme. These studies should be used to monitor progress against the strategic objectives and indicators identified above. A qualitative component to the KAP should be included as and when more in-depth information is needed to explain certain behaviours or attitudes.

KAP studies should also be implemented at least once every two years to measure the quality of the SMnet, as they are the critical intermediary between the programme strategy and community knowledge, attitudes and behaviours.

Pre-test research should be undertaken to test all communication materials and messages before they are rolled out to the field.

Communication Reviews

Qualitative communication reviews will take place at least once per year and will include a panel of independent experts – national and international- invited to assess the programme on key themes identified by UNICEF and partners. Reviews should incorporate intensive field visits and meetings with local officials, communities and SMnet staff. Recommendations from the reviews should inform updates and revisions to the strategy.

Evaluation

The communication programme has not been evaluated since its inception in 2001. With clear objectives and behavioural indicators established for the first time, the programme is at a stage of evaluability and an evaluation should be planned in 2011-2012 in order to assess the impact of the SMnet and draw future lessons for the India programme, as well as other eradication and communication programmes.

Annex 1: Behaviour and Message Matrix for 2011 Communication Campaign

Polio Messages

Key Audience	Main Message	Sub-message
Parents with children <5	Give two drops every time till your child is 5 because only complete dosage will ensure complete protection against life- crippling polio.	1.At every polio round, your child must be given 2 OPV drops, till age 5 yrs 2. Take your child to the polio booth at every round to get OPV till age 5 yrs because if doses are missed the chances of getting polio are more, 3.If you miss a dose of OPV, go to the AWC to get another dose. Every OPV dose is critical and if doses are missed, the chances of getting polio are more. 4. OPV is a proven safe vaccine without any side effects and it is not harmful to take it multiple times 5. Vaccinate your newborn child with OPV within the first month of birth. Newborns are most vulnerable to polio. 6. Take your child for RI at least 5 times before his/her first birthday. 7.Even if your child is suffering from minor ailments such as fever, cough, cold, diarrhea or some other illness on the day of polio vaccination, your child should still be vaccinated 8. Encourage olders siblings to take their brother/sister under age 5 for OPV 9. Encourage neighbours to get their children under age 5 vaccinated. 10. Polio infection is primarily spread through oral-feacal transmission, with infected . Therefore you should follow safe hygiene and sanitation practices 11.. The symptoms of polio are floppy limbs or the inability to move. If you notice these symptoms in your child, report it immediately to the nearest health centre

Minority Muslims with children <5	The Quran says that children are the future of tomorrow and parents have a responsibility towards their upbringing and good health . You can demonstrate this by giving complete dosage of OPV drops to your child.	1. Quran says that muslims should take care of their health and not ignore it. Ignoring your health is disrespecting the grace of Allah. 2. Quran says that a muslim should do a good deed in society and if he helps a fellow brother, he is helped by Allah in return. Therefore, you should give your child polio drops so that they are physically and mentally strong . You should also help your brothers and sisters to follow the same advice.
Migrants with children <5	Wherever you are, wherever you go ensure your child gets complete dosage by giving OPV every time till the age of 5 to ensure complete protection against life crippling polio.	1. At every polio round, your child must be given 2 OPV drops, till age 5, even if you are traveling 2. Take your child to the polio booth at every round to get OPV till age 5 yrs because if doses are missed the chances of getting polio are more 3. Keep your child's immunization card with you at all times and inform the heaklth worker/CMC/BMC when you return from travel 4. If you miss a dose of OPV, go to the AWC to get another dose. Every OPV dose is critical and if doses are missed, the chances of getting polio are more. 5. If you are traveling during a polio round, take OPV at train stations, bus stands or other transit sites. Every OPV dose is critical and if doses are missed, the chances of getting polio are more. 6.OPV is a proven safe vaccine without any side effects and it is not harmful to take it multiple times 7. Vaccinate your newborn child with OPV within the first month. Newborns are most vulnerable to polio. 8. Take your child for RI 5 times till his/her first birthday.

		9.Even if your child is suffering from minor ailments such as fever, cough, cold, diarrhea or some other illness on the day of polio vaccination, your child should still be vaccinated 10. Encourage neighbours to get their children under age 5 vaccinated. 11. The symptoms of polio are floppy limbs or the inability to move. If you notice these symptoms in your child, report it immediately to the nearest health centre

4 "EXTRA" CARE PRACTICES/ POLIO PLUS MESSAGES

Key Audience	Main Message	Sub-message
Parents with children <5	Polio attacks the weaker, hence in order to make OPV work better, boost your child's immunity to ensure extra protection against polio by adopting 4 care practices: RI, exclusive breast feeding, good hygiene, diarrhoea management.	1. Polio is more likely to affect children who are weaker, so give your child OPV every time it is offered and do the following behaviours to make your child strong: 2. vaccinate against other deadly diseases to boost your child's immunity to make OPV more effective. 3. breastfeed your child exclusively for 6 months to build your child's natural ability to fight any disease and infection 4. you and your family members should wash hands with soap at 4 critical times to prevent the spread of diseases including polio 5. give your child immediate ORS and zinc supplement for 14 days to control diarrhea, as OPV given during an episode of diarrhoea can make the vaccine less effective
	Polio attacks the weaker hence **vaccinate against other 6 deadly diseases to boost your child's immunity to make OPV more effective.**	1.Early protection against 6 deadly diseases is critical. The recommended series of immunizations in the first year and into the second year are especially important 2. You/caregivers should follow the advice of trained health workers on timely immunization schedules to follow 3. If your child is not immunized he/she is very likely to get polio, measles, diphtheria, tetanus, tuberculosis, whooping cough and many other diseases that can kill or leave your child severly weakened resulting in stunted growth or permanent disability 4. Even if your child is given OPV during routine immunization, continue giving him/her every doses of OPV through polio round until he reaches the age of 5 years old.

	Polio attacks the weaker hence **breastfeed your child exclusively for 6 months to build your child's natural ability to fight any disease and infection**	1..Initiate breast feeding within the first hour of your child's birth 2. Your newborn child must be fed colustrum, the thick yellowish milk that the child's mother produces in the first few days after birth, as it is very nutritious and helps build your child's natural immunityy against infections 3. Any other liquid or food for the first 6 months may cause life threatening diarrhoea, which also lessens the efficacy of OPV. Even water should not be given in the first 6 months. 4.Continue exclusive breastfeeding even if the mother is unwell. If your child is unwell , increase the frequency of breastfeeding as the child will need more nutritious and easily digestible food
	Polio attacks the weaker hence you and your family members should **wash hands with soap at 4 critical times to prevent the spread of diseases including polio**	1. Poor and unsafe hygiene and sanitation practices can spread polio including direct contact with infected stool 2. All your family members including children, should wash hands with soap before preparing food and feeding and after defecation and disposal of baby's faeces. Where soap is not available use fresh ash as an alternative. 3.Use sanitary toilet for defecation and safe disposal of faeces of babies and young children 4.Avoid open defecation; where not possible faeces should be buried and everyone should always defecate well away from houses, paths, water sources and places where children play 5.Drink only safe water from identified safe drinking water sources 6.Collect and store drinking water in a safe way so that the water is not contaminated
	Polio attacks the weaker hence **give your child immediate ORS and zinc supplement to control diarrhea, as OPV given during an episode of diarrhoea can make the vaccine less effective**	1. If your child has watery stool for 3 days, the child has diarrhea. 2. A more acute form of diarrhea is when you notice blood in the stool. In such a seek advice from your health worker urgently. 2.Untreated diarrhea may lead to your child's death. It is essential to give your child extra fluids to rehydrate along with foods and fluids 3.During diarrhea, give your child ORS till the diarrhea stops . Additionally, start and

		continue zinc supplementation for 14 days even when diarrhea has stopped, to prevent a relapse.. If you stop the zinc supplement before 14 days the treatment will be less effective. 4. Prepare the correct dosage of ORS solution by mixing the contents of 1 sachet of ORS in a clean container with 1 litre of water. After each episode of diarrhea, give the child half to one glass of ORS solution in small amounts repeatedly. The ORS solution must be freshly prepared after 24hrs. 5.Ask your health worker to provide you with zinc supplement together with ORS, available at PHC 3.During diarrhea, your child needs to continue breastfeeding and eating regularly, while recovering and he/she needs to have more food than usual to replenish the energy and nourishment lost due to the illness. This will make your child stronger and help OPV drops work more effectively

MESSAGES FOR SECONDARY AUDIENCE

Key Audience	Main Message	Sub-message
SM Net workers	In this final battle against polio, your dedication, leadership and field activities for social mobilization of the community will bring us closer to the goal of eradicating polio	1. Your wholehearted participation in the in the programme will play a positive role in ensuring OPV compliance and especially in persuading resistant households to take OPV during each round 2. You should develop and execute Communication Plans including Micro plans that show planned interventions linked to different target audiences within the community including specific plans for resistant households. Fieldbook data should always guide communication planning. 3. You should know all the key messages for the different target audiences including OPV and Polio Plus messages 4. You should identify key influencers within the community and build up a strong and effective influencer-programme 5. 5.You should be aware of all the myths and misconceptions about polio and have the right knowledge to correct them 6. 6. SRCs, SMC, BMC : you should demonstrate good IPC skills and provide supportive supervision to CMCs in IPC skills

Opinion leaders: Influencers including community leaders, religious leaders, PRIs, teachers	As a key opinion leader within the community, your role and influence to encourage OPV compliance will bring us closer to the goal of eradicating polio	1. Your wholehearted participation in the in the influencer-programme will play a positive role in ensuring OPV compliance and especially in persuading resistant households to take OPV during each round 2. You should leverage the trust that the community reposes in you to counter myths, misconceptions and 'developmental reasons' raised by a minority and resistant section of the community
Service providers: AWW, ANMs	Your dedication and service in the polio programme in ensuring OPV compliance and adoption of 4 care practices (in the endemic blocks) will bring us closer to the goal of eradicating polio	1. Your wholehearted participation in the in the programme will play a positive role in ensuring OPV compliance and especially in persuading resistant households to take OPV during each round 2. You should know all the key messages for parents with children under age 5 including OPV and Polio Plus messages 3. You should have good IPC skills in order to convincingly communicate with parents 4. You should participate in polio rounds as per assigned in micro plans 5. You should refer/report parents with AFP children to health facility 6. You should ensure 100% compliance of RI as per schedule 7. If you are working an endemic zone, you should explain and encourage the adoption of 4 care practices
Journalists and media	Your power in creating and moulding public opinion should be leveraged through responsible and positive press reporting of the progress of the polio eradication campaign programme	1. Your role in influencing whether parents allow their children should be vaccinated is very strong. With this responsibility also comes an obligation to report objectively on the polio programme. 2. You should accurately use data for objective reporting

KEY BEHAVIOURS, BARRIERS, OPPORTUNITIES

Key Audience	Key Behaviours	Barriers	Opportunities
Parents of children <5	1. Vaccinate every child at every round till age of 5 2. Vaccinate newborns within first month 3. Encourage neighbours to vaccinate their child <5 4. Encourage older siblings to take children <5 for OPV 5. .Take child for RI 5 times a year and maintain RI card	1. Complacency and fatigue towards OPV compliance with no sense of urgency in continuing with OPV vaccination every round 2. Low personalized threat perception towards polio 3. Poor understanding of need for repeat-doses till age 5 4. Resistance to OPV when child is sick 5. Perception that OPV is unsafe for the	1. Most parents think that children <5 should receive every dose of OPV till age 5 2. Most parents believe that OPV is effective in protecting their children from Polio 3. Strong SM Net and service provider channels for communication delivery 4. Influence of key opinion leaders including muslim religious leaders to counter OPV resistance

	at all times ***In endemic blocks:*** 1.Adopt key care practices a. Routine Immunization - Vaccinate children against 6 vaccine preventable diseases through RI at least 5 times a year b. Exclusively breastfeed children for 6 months	child and has side effects 6. Not always reporting cases of polio to health centre 7. Low knowledge of faeco-oral transmission route of polio virus 8. Low compliance towards RI especially for children <2 9. Resistance to OPV used as a bargaining tool to negotiate better developmental services and infrastructure ***In endemic blocks:*** 1. Lack of knowledge about link between OPV efficacy and poor sanitation and hygiene practices, and malnutrition leading to diarrhea 2. Low awareness and knowledge about criticality of vaccinating newborns in the first year of their life 3. 3.Low awareness and knowledge about criticality of completing full series of immunizations as per schedule 4. Low awareness and knowledge about the 6 deadly diseases that can be prevented through timely immunizations 5. Poor maintenance of RI card 6. Belief that liquids and foods like animal milk, gripe water, honey are nutritious and promotes health of the child. 7. Perception that the child needs water in addition to breastmilk to quench thirst 8. Belief that powder milk being costly is better than breastmilk 9. Perceived inadequacy of breastmilk by the mother leading to early introduction of animal milk and other foods to satisfy	***In endemic blocks:*** 1. Boosting weaker child's immunity through RI, exclusive breastfeeding, safe sanitation and hygiene practices and diarrhea management to enhance efficacy of OPV 2. On-going health awareness programs on RI, EBF, TSC and Diarrhea Management, delivering behavior change messages

	c. Hygiene & Sanitation - Wash hands with soap at 4 critical times - Do not defecate in the open; use sanitary latrine - Differentiate between safe and unsafe water/ Drink only clean water d.Diarrhoea Management - Give children <5 ORS and zinc	hunger of the child 10. Doctors and other health practitioners prescribe infant feeding formulas like *lactogen* etc 11. Low awareness and knowledge of benefits of hand washing with soap 12. Low practice of hand washing with soap after disposal of child's faeces 13. Many things to do in and around the house due to which caregivers prioritise or inadvertently forget to wash their hands 14. Inadequate supply of water for household chores and hence conservation but not using for hand washing. 15. Low awareness and knowledge about how open defecation can be responsible for ill health and diseases. 16. Open defecation is considered a 'social activity' by women; an occasion for free interaction 17. Lack of access to safe drinking water 18. Need to travel far to access safe drinking water 19. Unaware of proper feeding practices during diarrhea and even for some days after the child is better 20. Use of unnecessary antibiotic drugs 21. Low awareness and knowledge about importance of ORT with Zinc	

	supplement for 14 days even after diarrhoea stops		
Minority Muslims with children <5	***As above***	1. Belief that OPV is against Islam 2. Perception that OPV has side effects and giving it to the child will make the child sterile/it's a family planning device	3. Koran provides a religious basis for fighting infections like polio 4. Influential muslim leaders play a critical role within community to counter myths and misconceptions and influence OPV compliance 5. Establishment of several strategic partnerships with muslim social welfare and religious groups for communication and monitoring activities
Migrants with children <5	***As above***	1. Higher risk of polio infection in mobile population 2. Potential of polio virus moving alongwith migrant population 3. Low compliance to RI: fewer immunizations than rest of the population 4. 4.Not maintaing RI card well	5. Strong presence of SM Net and volunteer groups to deliver communication messages and facilitate OPV and RI while on the move

Positive Indicators		
S.No.	**Indicator**	**Description**
1	**Programme success**	Stories which demonstrate that the programme is successful
		Merits/ Benefits/ Advantages of polio eradication
		Highlighting linkages between polio and sanitation, immunization and nutrition
		SMnet and frontline workers success stories
		Reduction in number of cases
2	**Government initiative**	Steps taken by the Govt., directions given by Health Minister, CM & DM to ensure good polio rounds
		Functioning/ review of task force at district level
		Actively monitoring at national and state level
		Funds allocation and utilization
		Stories which talk about strategies adopted by govt. according to expert/ IEAG recommendations
3	**Partner initiative**	Support of programme partners (WHO, Core, Rotary, CDC, USAID, BMGF)
4	**Community support**	Support & participation of communities (Muslims, Migrants, Nomads, slum dwellers) & OPV acceptance
		Meetings and rallies
		Leaders and opinion leaders support & participate in the programme and advocate safety of OPV
		Appeals and support of public figures
		Institutional support (Jamia and Hamdard University)
5	**Celebrity endorsement**	Appeals and support of celebrities/ cricketers to the programme
6	**Vaccine safety**	Stories which cover vaccine potency and safety
		Stories in support of the vaccine
7	**Technical Support**	Stories which cover support of technical/ medical bodies and institutes like IAP, ICMR, NCDC etc.

Negative Indicators		
S.No.	**Indicator**	**Description**
1	**Programme failure/ setbacks**	Programme has failed as the number of cases rise
		Deadlines missed
		Mismatch between input and outlays/Results not commensurate with the funding/ resources
		Lack of community/ leaders' participation & support
		Corruption
2	**Missed children**	Stories on children missed during rounds
3	**Community resistance**	Community opposes OPV, polio programme
		Religious objection
4	**Developmental resistance**	Developmental gains and negotiations as a bargain for the programme
5	**Vaccine efficacy**	Children getting polio despite repeated vaccination saying vaccine has failed
		Stories on ill-effects of vaccine (VDPV)
6	**AEFI**	Significant RI AEFI that could impact on the polio programme
		Inaccurate linkage with the cause of child's illness
7	**Death of child**	Inaccurate linkage with the cause of child's death
8	**Operational failure**	Micro plan failure
		Poor performance of vaccinators/ mobilisers
		Cold chain failure
		Vaccine not reaching on time
		Booths not open or missing

Annex 2: Media Monitoring Indicators

Neutral	Indicators
	Number of cases
	Number of children immunized
	Rational positioning of cases/ technical accuracy
	Polio round info: date notification
	Virus export/ attack/ migration – India/ states spreading polio virus to other countries/states & re-infecting
	Any other factually reported neutral story

Media Visibility Indicators	
Placement of positive stories	Prominent
	Buried
Placement of negative stories	Prominent
	Buried

Journalistic practices	
Headline matches story	Yes/No
Story attributed	Yes/No
Story factual (used evidence and data, named sources, balanced views)	Yes/No

Annex 3: Media Response Protocol

Media Protocols for Polio Eradication Programme: India

(Based on Union Health Secretary's meeting of 5th June 2009 regarding VDPV cases and subsequent media-protocol arrangements discussed with the Govt. of India)

Protocol of response to media: Polio Partners

Section 1: News-media/Print

Possible Situation

1. Polio case reported in area X
2. Media outburst due to death or illness reported during polio round associating them with polio vaccine
3. Reports of programme failure

Field-level protocol (States & Districts):

- Keep the detailed FAQs on Polio as ready-reckoner and provide them with a copy (in local language);
- No "expert quotes" to be offered by UNICEF and NPSP/WHO;
- Inform State office/UNICEF Polio Coordinator and/or NPSP RTL and appraise her/him of the developing situation (State office to request designated State Govt.'s designated spokesperson to connect with the journalist/editor);
- Immediately connect the specific media representative with the CMO or DIO (or the designated spokesperson);
- Arrange relevant data through NPSP/RTL or SMO;
- Request the media representative to access NPSP website (if net facility available)

National level media report(s) reflecting failure or deficiencies in the Programme

- Share evidence/s & technical data that is contrary to the filed negative story with media, including the dealing journalist/editor to enable them file accurate report.
- Arrange Govt. Spokesperson (Deputy Commissioner – Immunization) to speak with the journalist/s (provide relevant and most current technical data and ready-to-use FAQs to the designated spokesperson);
- Encourage access to NPSP web portal (latest data)
- If required, arrange a study-visit to the "location" and organize field-based interaction (clarifying doubts and myths). Such a media study visit should be organized after obtaining concurrence through the designated media spokesperson and/or NPSP/National Office or UNICEF/ICO – Delhi.

Section 2: Electronic Media (News & Programming)

(For field/district/State/National)

Possible Situation:

Polio case or an adverse story on polio programme developing or reported

Electronic - "News media"

- For news stories or clarifications, the above protocol (as in section 1 for news print media) is applicable;
- Only designated Govt. Spokesperson would be in a position to provide sound-byte/quote/interview to the media (including electronic media);
- Encourage access to NPSP web portal for data
- Provide relevant technical data (polio doses/children covered/X houses and success/failure of conversion therein/"polio cases" if any/technical process of surveillance) only through the designated Govt official who is earmarked/deputed as a spokesperson for Polio programme at District/State/National level;

"Non-News"/Programming media – Radio & Television

For promoting good quality and evidence-driven media discussion on Polio Eradication through talk-shows, entertainment shows and jingles/songs:

- Contact (or respond to the request made) the relevant electronic media station/channel with the provided FAQs - as are developed by the technical group in NPSP and UNICEF;
- Encourage access to NPSP web portal for information;
- Only designated Govt. Spokesperson would be in a position to provide sound-byte/quote/interview to the media (including electronic media);
- If ready-made visual/audio programmes are requested by the local/national TV/Radio producers/channels for broadcast/telecast, please provide the programmes as are prepared by the Govt./NRHM/NPSP and UNICEF (Generated also through Prasar Bharti training workshops/Polio Video News stories produced by UNICEF).

Media facilitation through the Govt:

NPSP supports the Government of India with the relevant talking points for new cases, especially those reported outside the endemic states; situations like VDPV cases or any other technical issue which is likely to attract media attention and require technical clarification. These talking points are shared with the designated spokesperson of the Government for the polio programme. Same tech clarifications/update is also shared with the concerned state and district surveillance medical officer to further reach the State/Local government counterparts. This ensures consistency in messages from national to district level and communication support to government counterparts to respond to media.

** Above protocol guidelines are applicable to all field staff/volunteers/officials working with/under the National Polio Programme of the Govt of India, which is in partnership with the leading Polio Eradication partners (WHO, UNICEF, CORE, Rotary & CDC)

Annex 4: TOR of CMC

Roles and Profile – Community Mobilization Coordinator (CMC)
Major Tasks

Communication

- Perform interpersonal communication (IPC) and counseling with families having pregnant women, children vulnerable to polio and susceptible to other communicable disease, capacitate them for caring pregnant women and newborn baby.
- Accompany with house-to-house team, facilitating entry in all houses allowing team to initiate queries on immunization and providing information on all <5 years children if missed by team.
- Involve in pre-round activities by making booth mobilization plan, informing beneficiaries, organize rallies, conduct polio class, constitute bulawa toli, make mosque elan, 1or 2 days before the round.

Relating and Networking

- Identify and seek support from influencers, school teachers, religious leaders, gram pradhan etc in convincing resistant families to get child immunized with OPV.
- Conduct meeting with neighborhood people (padosi baithak), mothers (Mata baithak), resistant family members, influences, AWW/ASHA/ANM to dispel misconception about the vaccine and to encourage resistant families to immunize their children and influence others to do so.
- Facilitate linkage and partnership with stalk holders and front line service providers like –ASHA, AWW, and ANM, private practitioners or quacks in her HRA for identifying all likely non-acceptors and counsel and motivate them by addressing misconceptions and fear for OPV.

Data Collection

- Conduct survey of high risk area(HRA) to list all eligible children under five years of age, pregnant women, and available resources like-school, madarsa, health post, aganwadi centre etc in that area.
- Update field book on regular basis with information of newborn, pregnant women, families leaving or coming to that area, immunization status especially in SIA and routine immunization

Profile

- Female, over 21 of years of age.
- Reside in key village or HRA to be covered by her.
- Must belong to the underserved community in that area.
- Able to read and write.
- Some formal education preferred.
- 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.

Annex 5: Competency Framework for District Level SMnet worker

DISTRICT MOBILIZATION COORDINATOR (DMC)

Functional Competencies	**Level**	**Behavioral Indicators**
Communication	2	Elaborates and presents information, verbally or through written reports, in formal contexts. Elaborates own arguments. Uses appropriate documentation and presentation tools such as PowerPoint.
Leading and Supervising	2	Directly supervises, supports and coaches BMCs at district level. Supports BMCs in supervising CMCs. Encourages harmonious and professional work culture. Motivates the team, identifying and rewarding outstanding performers.
Relating and Networking	1	Has a good understanding of the role of the various partners and stakeholders of the programme at district level, taking the lead in coordinating with and mobilizing them. Liaises with local press and government media.
Planning and Organizing	2	Participates in programme management at district level through planning interventions, ensuring deployment of human resources and keeping track of the progress of the team against set objectives. Manages own time effectively; completes tasks on time.

Technical Competencies	**Behavioral Indicators**
Data-based Planning of Interventions	Interprets the data received from BMCs and attains a broad vision of the programme progress at district level. Supports BMCs in identifying underlying causes and planning intervention activities accordingly.
Key Behaviour Change Messages	Has a good understanding of Key Behaviour Change Messages, including Routine Immunization, Polio, Breastfeeding, Safe Motherhood, Hygiene and Diarrhea. Trains and assesses the knowledge of supervisees on these subjects.
Understanding Role of Partners	Knows and understands the role and responsibilities of Government and non-Government partners and counterparts in the development of the polio programme at district level. Uses this knowledge for effective coordination with them.
Underserved Strategy	Has a good knowledge and understanding of Underserved Strategy and effectively applies it in planning activities for supporting social mobilization of the underserved communities at District level.

Annex 6: Emergency Preparedness and Response Plans (EPRP)

The 2010 IEAG highlighted that as long as virus transmission continues in any part of India or elsewhere in the World, the possibility of virus importation to polio free areas in India remains. In view of these risks, the IEAG recommended that while intensive efforts should continue to stop transmission in areas with recent WPV transmission and the traditionally endemic areas of Uttar Pradesh and Bihar, the programme in India should:

- Make efforts to protect polio free areas from importation of virus from within or outside India.
- Rapidly respond to any WPV detected anywhere in India during 2011 with an aggressive mop up vaccination campaign to stop any further circulation of the virus.

In response to this recommendation the Emergency Preparedness and Response Plan was developed following the Howrah, West Bengal case in January 2011 at the request of the Honorable Minister of Health & Family Welfare to ensure adequate preparedness and response to an event of importation of poliovirus anywhere in India during 2011.

The EPRP plan encompasses six components:

8. Preparedness for virus importation and response
9. Response and actions following the detection of WPV
10. Key actions during the mopping up vaccination campaign
11. Key actions at the end of the activity
12. The role of partners
13. The of States with a low risk of WPV importation
14. Mop up strategy

1. Preparedness for virus importation and response

National Level Actions: The Government of India will have a Central Emergency Preparedness and Response Group to ensure adequate preparedness for a rapid response and manage the response following the detection of WPV in India in 2011.

The key responsibilities of the group will include:

- Identification and training of Rapid Response Team (RRT) members at the national level.
- State Government engagement to ensure a Rapid Response Team, headed by an Officer of the rank of a Principal Secretary, is constituted in each state.
- Ensure RRT members receive training from the MoHFW, GoI with assistance from WHO, NPSP and UNICEF.
- Assigning RRT members with full time duties to support the mop up vaccination campaigns in the event of a confirmed case of WPV.
- Develop a media response plan to be used in the event of detection of WPV.
- Review the availability of buffer stocks of OPV to manage mop-up vaccination campaigns.

State Level Actions: The following states have been identified at a high or medium risk of importation based on past epidemiology of polio: Haryana, Delhi, Uttarakhand, Maharashtra, Punjab, Rajasthan, West Bengal, Gujarat, Jharkhand, Madhya Pradesh, Assam, Orissa, Andhra Pradesh, Himachal Pradesh, Jammu & Kashmir and Karnataka.

Each identified State should undertake the following actions in preparation for the emergency response:

- Constitute a State Emergency Preparedness and Response Group chaired by the Secretary (Health & Family Welfare) and comprised of senior officials from the State Government such as the Director Health Services, State EPI Officer and other nominated

senior government officials. State representatives of WHO- NPSP, UNICEF and Rotary should also be a part of the group.

- Undertake a risk analysis, in coordination with WHO and NPSP officials, to identify districts/ blocks/urban areas at high risk of importation and spread of poliovirus.
- Undertake a communication risk analysis in coordination with UNICEF/ WHO and NPSP and based on the analysis develop a communication plan for issues related to non-compliance/resistance to administration of polio vaccines.
- Develop a media response plan to be used following the detection of WPV.
- Develop and implement a plan to increase polio SIA coverage and RI coverage in these high-risk areas/ populations to achieve high immunity against polioviruses in these areas.
- Identify and nominate 2-4 experienced medical officers to be a part of the Rapid Response Teams (RRTs).
- Review the surveillance quality in these areas with the district and block officials in coordination with NPSP officials to identify actions to strengthen surveillance sensitivity in these areas.
- Assign Senior State Government officials to visit high-risk districts and blocks to review progress in updating and implementation of micro plans for improving immunization coverage and surveillance sensitivity.

2. Response and actions following the detection of WPV

National Level Actions

- The Central Emergency Preparedness and Response Group will meet within 24 hours of confirmation of the case and receipt of information to review and analyze the epidemiological investigation findings pertaining to the polio case and determine the areas and populations at risk of WPV circulation.
- The group will make specific recommendations on: the timing of the response; areas to be covered during the response; type of vaccine to be used during the response; the number of proposed rounds; and the additional investigations and analyses to be conducted
- Members from the Central Emergency Preparedness and Response Group will visit the concerned state to meet the state health secretary and other state officials. The members of the National and State Emergency Preparedness and Response groups will subsequently visit the concerned districts accompanied by the state RRT members to review planning for an emergency response.
- The Central Emergency Preparedness and Response Group will meet on a weekly basis to review the planning and implementation of the response and provide recommendations to the immunization division and state authorities to make improvements.
- Vaccine will be mobilized to reach the State/Districts undertaking the mop up at least three days before the start of the campaign.
- MoHFW will seek support from other Government departments such as Social Welfare, Railways, Panchayati Raj, Urban Development, Education, for the emergency mop up operation.

State level actions

- The State Emergency Preparedness and Response Group should be activated within 24 hours of receipt of information to; inform the Divisional Commissioners and the District Magistrates of the areas undertaking the mop-up within 24 hours of receipt of information; allocate geographical areas and operational responsibilities to all RRT members ensuring an appropriate distribution of human resource within 72 hours of receipt of information; assign senior state officials to the districts and members of the State Emergency Preparedness and Response Group to visit and mobilize the districts within 72 hours of confirmation of case.
- The currently existing State level Steering/Coordination Committee for polio eradication should be requested to organize a meeting within 5 days of case confirmation to seek support and coordinate activities with other Government departments and NGOs.

District level actions:

- The district level officials from health and administration should begin mobilizing the block officials to start preparations within 48 hours of identification of importation.
- District Task Force (DTF) meetings should be organized in the district with RRT members, NPSP, UNICEF staff and key government officials to allocate specific responsibilities within the district and ensure participation of all sectors for a successful implementation of the mop up. The first DTF to be conducted within 5 days of confirmation of the case. Subsequently there should be a weekly DTF to take stock of the situation and address requirements of the response activities.
- Divisional Commissioners should review the preparedness through participation in DTFs and field visits.
- Tehsil/ Block Task force meetings should be organized at sub-district level in all urban and rural areas within 7 days of the confirmation of the case.
- All existing micro plans should be reviewed as per operational guide for mop up with special emphasis to ensure no areas are missed, there is high coverage of high risk areas and migratory populations. All micro plans should be reviewed and modified within 10 days of confirmation of the case.
- All vaccinators should be retrained on operational and IPC skills in the week before the start of the mop up.
- The district and block in consultation with UNICEF and other social mobilization partners should plan and initiate IEC and social mobilization measures based on solid data collected through standardized data tools.
- Develop a media response plan to be used in the event of detection of a virus.
- In consultation with government NPSP should develop a monitoring plan for intensive monitoring and mid course corrections during the activity. Additional independent monitors should be deployed by NPSP in addition to the existing NPSP and UNICEF staff present in the district.

Key actions during the mopping up vaccination campaign

National level actions

- Members from the Central Emergency Preparedness and Response Group will monitor the activity in the highest risk blocks.
- Central Emergency Preparedness and Response Group will meet to review the feedback from its members, States, RRTs and provide directions for corrective actions.

State level actions

- Members of the State Emergency Preparedness and Response Group and the State monitors should visit high risk blocks to monitor the activity and provide feedback to the State Principal Secretary (H & FW)
- The State Emergency Preparedness and Response Group should meet daily to review feedback from the districts and plan corrections.

District/ Sub District level actions:

- The district should implement the SIA activity under the direct oversight of the District Magistrate (DM) and supervision of the Chief Medical Officer/Civil Surgeon. The DMs should report on the quality of the activity to the State Principal Secy (H & FW).
- Daily monitoring and review of activity to plan for corrective actions over subsequent days.
- Senior District level officials from health and administration (Divisional Commissioner/ DM/ADM/CMO/DPO/Dy CMO/BDOs) should monitor the implementation of the activity and attend evening meetings at the high risk blocks.
- A daily evening review meeting should be organized at the district under the chairmanship of the District Magistrate.

4. Key Actions at the end of the activity

- The District Magistrate should send a report of the completed activity to the State Emergency Preparedness and Response Group for review and corrective actions.
- The State Emergency Preparedness and Response Group should meet to review this and forward the report to the Central Emergency Preparedness and Response Group
- The Central Emergency Preparedness and Response Group will review the activity and inform the Union Minister who, at his discretion, will inform the Chief Minister of the concerned state about the quality of response activities and ongoing risk assessment.

5. Role of partners

Partners should participate in the Central and State Emergency Preparedness and Response Groups. The key role of the partners will be as follows:

- NPSP: provide surveillance data, epidemiologic analysis and strategic planning and other technical support to the group as well as support monitoring of the preparedness and response at the district, State and National levels.
- UNICEF: provide support to the communication/ social mobilization and media strategies and their implementation and monitor their impact
- Rotary International: provide support to the advocacy at the state and district levels and to the communication strategy and social mobilization activities

6. States with a low risk of importation of poliovirus

- Undertake a risk analysis, in coordination with WHO- NPSP officials, to identify districts/ blocks/urban areas at higher risk of importation and spread of poliovirus.
- The risk analysis should include identification of areas that have had importations of polio viruses during previous years or a recent clustering of compatibles in time and space, or are hard-to-reach areas or have demographic/ environmental factors that would facilitate the spread of wild poliovirus following an introduction (such as low routine immunization coverage, high population density, migrant sites, poor sanitation etc). Special focus should be on the identification of areas with migratory/ mobile populations in each state as per guidelines issued by GOI in 2010. This risk analysis should be completed at the earliest and the lists of all high risk areas and populations shared by each state with GOI.
- The state should assign Senior State Govt officials to visit high risk districts and blocks to review progress in updating and implementation of micro plans prior to the 2011 NIDs for improving immunization coverage and surveillance sensitivity.

7. Mop-up strategy

- The basic aim of the mop up would be to vaccinate all under children five years of age in the mop up area. Each household in the mop up area will be visited by vaccination teams to vaccinate all under 5 children. The duration of the house-to-house (h-t-h) search and vaccination would be decided by the number of available vaccination teams in the area. In principle, there would be a minimum of 2-5-day h-t-h activity in all areas to ensure a rational workload for each vaccination team. Additional 1 to 2 days of h-t-h activity will be undertaken in special areas with lesser number of available teams e.g. in large urban areas. B team activity will continue in UP and Bihar. Transit teams and Mobile teams will be deployed to cover migrant and mobile populations.
- In areas that have used booths during the SNID/NID, booths will also be setup on day 1 of the mop up campaign because of their IEC/SM value.
- The mop ups shall be implemented as per the Operational Guide for SIAs published by Government of India in 2006.
- General principles for mopping up operations The following guidelines as recommended by

the WHA & IEAG should be followed:

- Speed of response: as early as possible but no later than 2 weeks from confirmation of the case.
- Extent of mop ups: The response should consist of at least 3 large scale, house- to-house rounds of immunization. The World Health Assembly Resolution (59.1) calls for coverage of 2-5 million children in each round. Mop-ups should cover at a minimum the infected district and all districts contiguous with it, across state boundaries if necessary. Where there is a clear genetic link of the virus to the strains in another area, the area of origin should also be included. In the demographic context of India and considering that this is the final stage of polio eradication, the 18th IEAG has recommended the appropriate target population for mop-ups around 5 million children per round.
- In high risk areas: SNID rounds may constitute one or more of the 3 rounds, but in principle at least one additional round should be carried out in an appropriate area using a short interval approach.
- In non-high risk areas: mop-ups should consist of a minimum of 3 high quality rounds, using a short interval approach (minimum interval of 2 weeks but within 4 weeks)
- Vaccine of choice for mop-ups is mOPV appropriate to the local epidemiology or bOPV; a rolling stockpile of 30 million doses of bOPV and 10 million doses of mOPV1 should be maintained to allow for rapid implementation of mopping up vaccination with the appropriate vaccine.

UNICEF's EPRP actions

Stage 1: Preparedness

- Analysis of local-level social data, social mapping for communication risk assessment in high-risk districts - low RI pockets, migrants, underserved, resistant pockets, vulnerable & hard-to-reach populations most likely to be missed in SIAs etc
- Understand information seeking & sharing patterns particularly of the most vulnerable/hard to reach communities
- Map health worker e.g. ASHA, AWW and effective and operational NGO networks in the identified high risk areas & among the high risk population
- Map influential groups, community and religious leaders, institutions & medical fraternity (IAP, IMA), Panchayat leaders and other elected representatives who can be engaged in mobilizing and reaching out to the population at risk
- Identify members to coordinate media response – to finalise talking points, press releases etc.
- List media outlets and persons to be approached at the state and district level.
- Identify and designate spokespersons at the state & district levels to address and respond to media
- Assign funds for emergency response, set mechanisms in place for timely release of funds and have contracts ready for rapid response
- Prepare communication plan with details and timelines – who, what, where and by when

Stage 2: WPV confirmed

Day 1 – Operationalise state plan (EPRG)
IEC: Assess IEC requirement, give print order & get pasting agencies in place
Plan radio and TV spots on local channels, print advertisements in local papers from day 7 to booth day
MEDIA: Finalise talking points, call media conference to announce case and emergency response in the coming weeks

Day 2 - (RRT members arrive in the districts)
•Media conference by District Magistrates to announce emergency response (coordinated by DM/

CMO office)
•Get communication plan from EPRG, contact details of all identified stakeholders - non-governmental organizations (NGOs/CBOs), women's organizations, religious organizations
•Get details of IEC material delivery
•Get media talking points
•Get polio media monitoring initiated

Day 3

- Operationalize communication plan Contact identified NGOs/ CBOs/groups/ organizations
- Plan trainings for health workers/ NGOs/ women's groups in polio IPC and deployment in highest risk areas with underserved population, resistance, refusals etc

Day 4

- Identifying local community, religious and influential leaders to inaugurate polio campaign and support during immunization
- Plan sensitization meetings with the identified influencers

Day 5

- Orientation in IPC of NGOs, health workers begin
- Finalise IEC distribution plan– posters and banners
- Plan PA announcements – fixed and mobile

Day 6

- Orientation of NGOs, health workers continues
- Finalise micro plan and list mobilisers along with vaccination teams in highest risk areas
- Distribute IEC – poster pasting starts
- Mike announcements (PA) begins from mobile and fixed sites

Day 7

- Posters pasted
- Advertisements on TV/radio/local cable channels begin
- Mike announcements continue
- Deploy mobilisers to counsel families in highest risk areas
- Hold influencers, community meetings in underserved populations, resistant and tough pockets

Day 8

- Mike announcements from mobile & fixed sites continue
- Ads on TV/radio/local cable channels continue
- Get updated media messages and develop press note for release on eve of the vaccination round
- Plan booth inauguration by DM, CMO, DIO, community & religious, elected representatives, doctors etc

Day 9

- Mike announcements continue
- Ads on TV/radio/local cable channels continue
- Issue press release before noon for the next day's polio mop-up round
- Invite media to cover key inaugurals by DM, religious leaders etc

Stage 3: Mop up begins

Day 10

- Polio booth inaugurated by DM, CMO, DIO, community, religious and influential leaders,

elected representatives, doctors etc
- Print advertisement appear in local media
- Mike announcements, TV and radio spots continue till noon
- Review day's activity & identify communication issues, if any, to alert mobilisers for house-to-house activity

Day 11 – 15
- Organize intense and close monitoring of the activity
- Review day's activity & identify communication issues, if any
- Relocate mobilisers as per issues
- Engage and respond to media in case of AEFI/ other issues
- Review entire activity – share information with local media

Stage 4: Before next mop up

Day 16 onwards till the next round

Scale up IEC
- More posters and banners for the next round
- Print advertisements, TV & radio spots and mike announcements on a wider scale - to start 5 days ahead of the round till noon of the last house-to-house immunisation day

Scale up IPC
- Assess existing social mobilization & communication resources and partners
- Update and expand list of implementing partners NGOs/CBOs, theatre groups, youth groups etc
- Organise IPC trainings for new and existing mobilisers
- Draw up detailed plan & deploy mobilisers in all high risk areas to counsel families ahead of the next round
- Monitor and evaluate mobilisation activities to fill in gaps and improvise

Scale up media & advocacy efforts
- Intense engagement with media
- Organise media orientation workshops focusing on addressing knowledge gaps identified in media analysis, community concerns and other issues
- Organise events before the next round with local, regional or national leaders/celebrities to enthuse community & polio workers
- Identify, advocate and engage with more and more local groups & individuals for polio advocacy