



ERADICATING POLIO

Building social capital and empowering women



unite for children



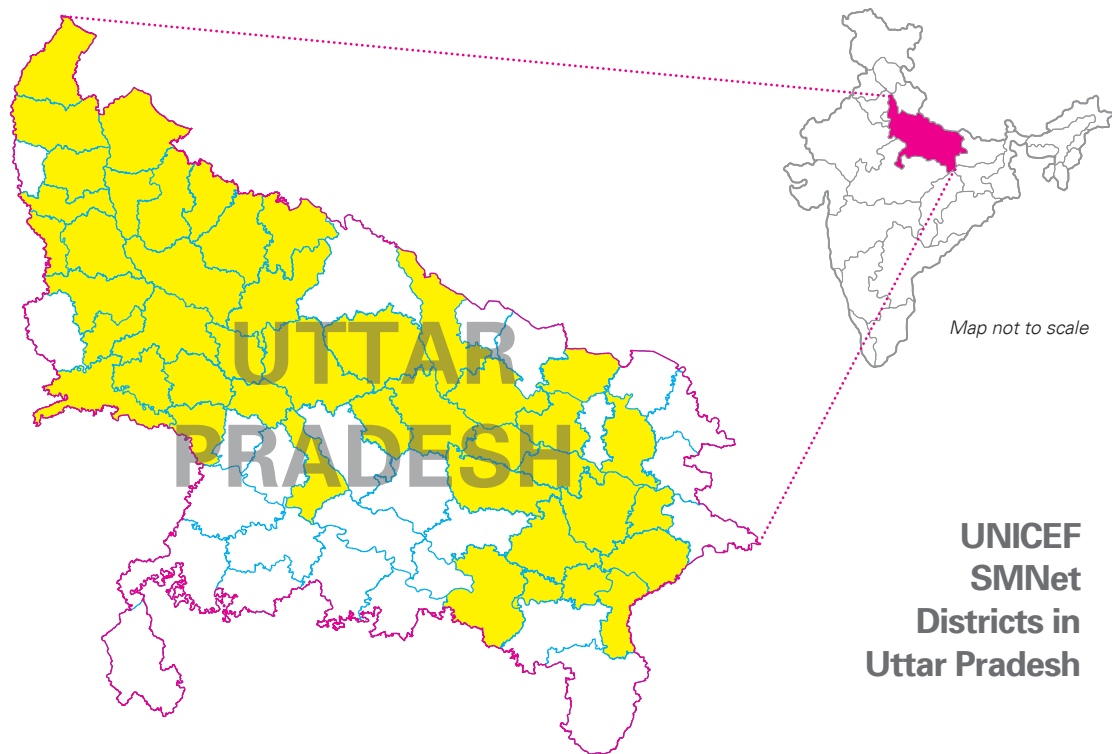
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ABOUT THE DOCUMENT

Uttar Pradesh was a hotbed for the polio virus with many of its western districts reporting a high number of polio cases. This was mainly because the minority community was ill-informed about the Polio Eradication Programme and therefore, resisted Oral Polio Virus (OPV) drops for their children.

To increase knowledge and create awareness about the safety of OPV, United Nation's Children Fund (UNICEF) established the Social Mobilization Network (SMNet) in 2001, to engage with the community and build trust. This involved large scale community participation at the village level. To ensure a credible information source, Community Mobilization Coordinators (CMCs) were selected from the same milieu. CMCs were armed with good interpersonal skills through exhaustive capacity building and mentoring support. They worked tirelessly and selflessly to educate their communities and change attitudes. As they achieved their target of reaching every child with OPV, their efforts empowered them personally as individuals. Many had never stepped outside their homes before. As CMCs, they had now transformed into assertive and confident field workers crossing several social and economic barriers and becoming role models for other women.

It was a commendable achievement for India to be taken off from the Polio-endemic list by the World Health Organization in 2012. In this fight against polio, the dedication and commitment of every CMC as a contributor towards eradication is laudable. This document highlights the journey of CMCs and their role in changing the environment while enriching their own lives.

ACRONYMS

AWW	Anganwadi Worker	IPC	Inter-Personal Communication
ASHA	Accredited Social Health Activist	WHO-NPSP	World Health Organisation - National Polio Surveillance Project
BMC	Block Mobilization Coordinator	OPV	Oral Polio Vaccine
AFP	Acute Flaccid Paralysis	PPI	Pulse Polio Immunization
CMC	Community Mobilization Coordinator	RI	Routine Immunization
DMC	District Mobilization Coordinator	SIA	Supplementary Immunization Activity
DUC	District Underserved Coordinator	SMNet	Social Mobilization Network
GPEI	Global Polio Eradication Initiative	SRC	Sub-Regional Coordinator
HRA	High Risk Area	SRTC	Sub-Regional Training Coordinator
HRG	High Risk Group	ToT	Training of Trainers
IEAG	India Expert Advisory Group	UNICEF	United Nation Children's Fund
IEC	Information Education Communication	UP	Uttar Pradesh
		WHO	World Health Organization



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INTRODUCTION

Polio was endemic in more than 125 countries before 1988, when the World Health Assembly resolved to eradicate the disease¹. The Global Polio Eradication Initiative (GPEI), a public-private partnership led by national governments and spearheaded by the World Health Organization (WHO), Rotary International, the US Centers for Disease Control and Prevention (CDC), and the United Nations Children's Fund (UNICEF) was launched with the objective to eradicate polio worldwide. Since then there has been enormous progress in the global scenario. The number of cases reduced from 350,000 in 1988 to fewer than 700 in 2003. It was estimated that 75 per cent of all cases globally are linked to a handful of polio "hot spots" in Nigeria, Pakistan and India².

1 World Health Assembly - Global eradication Poliomyelitis by the year 2000, 'Resolution and Decisions 1'

2 World Health Organisation - Polio eradication, now more than ever, stop polio forever, 2004



Preceding the formation of GPEI, India accounted for an estimated 200,000 cases³, 50 per cent of the total number of cases worldwide. Since the Pulse Polio Programme was launched in India in 1995, an estimated 172 million children have been immunized on every National Immunization Day (NID). Despite high levels of immunity, among the majority of children across the country, the virus continued to circulate in the northern states of Uttar Pradesh and Bihar, where populations were resistant to accepting the vaccine.

Between 1993 and 2001, Uttar Pradesh consistently reported more cases of paralytic polio than any other state in India. In 2002, 1,271 (80 per cent) of India's 1,599 polio cases were reported from Uttar Pradesh.

3 From 200,000 to Zero, The journey to a polio-free India, UNICEF

Surveillance data from this outbreak showed disproportionate disease burden amongst minorities and in the 13 districts of western Uttar Pradesh. The state has remained highly vulnerable to polio due to several factors such as poor sanitation, low nutritional status of children, and high resistance among certain communities. A critical barrier for the polio eradication programme was intense resistance to the Oral Polio Vaccine (OPV), particularly amongst minority communities in Uttar Pradesh. There were several myths and misconceptions commonly echoed by people to justify their resistance. The magnitude of the resistance was very high and deeply rooted, creating enormous difficulties for polio eradication teams.

The 2002 outbreak also brought into focus the importance of the vaccine acceptance amongst the resistant and migratory communities.

The India Expert Advisory Group (IEAG) for polio eradication provided technical guidance for the eradication efforts. It also focused on the need to create acceptance and demand for OPV in the communities. It was evident that social acceptance of the programme and the vaccine would be important for making the polio eradication programme successful.

A focused strategy was needed to address reasons for resistance in the community. To identify these specific communities, UNICEF and the World Health Organisation - National Polio Surveillance Project (WHO-NPSP) mapped the areas with high number of polio cases in Uttar Pradesh and categorized them as High Risk Areas (HRAs) and called the *Underserved* population. The 11 mapping indicators reflecting the community's participation level in polio vaccination were as given in Table 1.

Table 1: High Risk Area identification criteria

HRA Selection Criteria - Uttar Pradesh		HRA => 14 points
S.No.	Criteria for Selection	Weightage Points
1	Area with HRG group (HR Group: N = Nomads, S = Slums only)	8
2	Area with P1 Wild Polio virus for three or more years from 2003 to 2009 in low season (Feb, Mar, Apr & May)	14
3	Area with P1 Wild Polio virus for two years from 2003 to 2009	14
4	Area with P1 Wild Polio virus once from period 2003 to 2005	14
5	Area with P1 Wild Polio virus once from period 2007 to 2009	14
6	Muslim community > 40% (Y/N)	8
7	Area with Compatible cases for two years (2007 to 2009)	4
8	Area with Compatible cases once in (2007 to 2009)	2
9	PO Houses more than 50%	0
10	Total X generation is > 20% of the total houses	6
11	Convertible X remaining is > 14% of the total remaining X houses	12

To address the concerns of the underserved and migrating communities, UNICEF and partners designed strategic interventions. The clear mandate was to reach every child in every round, despite the underserved conditions. Increase in the cases of polio, lack of faith in the public health system and the health seeking behavior of the families, demanded a communication strategy that would improve community participation in the Polio Eradication Programme. Positive change in behavior can be developed only by regular counseling and provision of information from a trusted source. The understanding of the requirement of community mobilization efforts through counseling and other communication techniques led to the genesis of the Social Mobilization Network (SMNet).

The SMNet evolved as the nerve centre of the polio eradication effort in the state. A prominent part of the polio eradication effort in Uttar Pradesh lay in socially mobilizing community elders and leaders who support the work of the vaccinators and motivate parents to get their children immunized. As Figure 1 shows, the SMNet is a well-defined network having coordinators at sub-region, district, block, and community levels who interact directly with the parents/caregivers of children under the age of five.

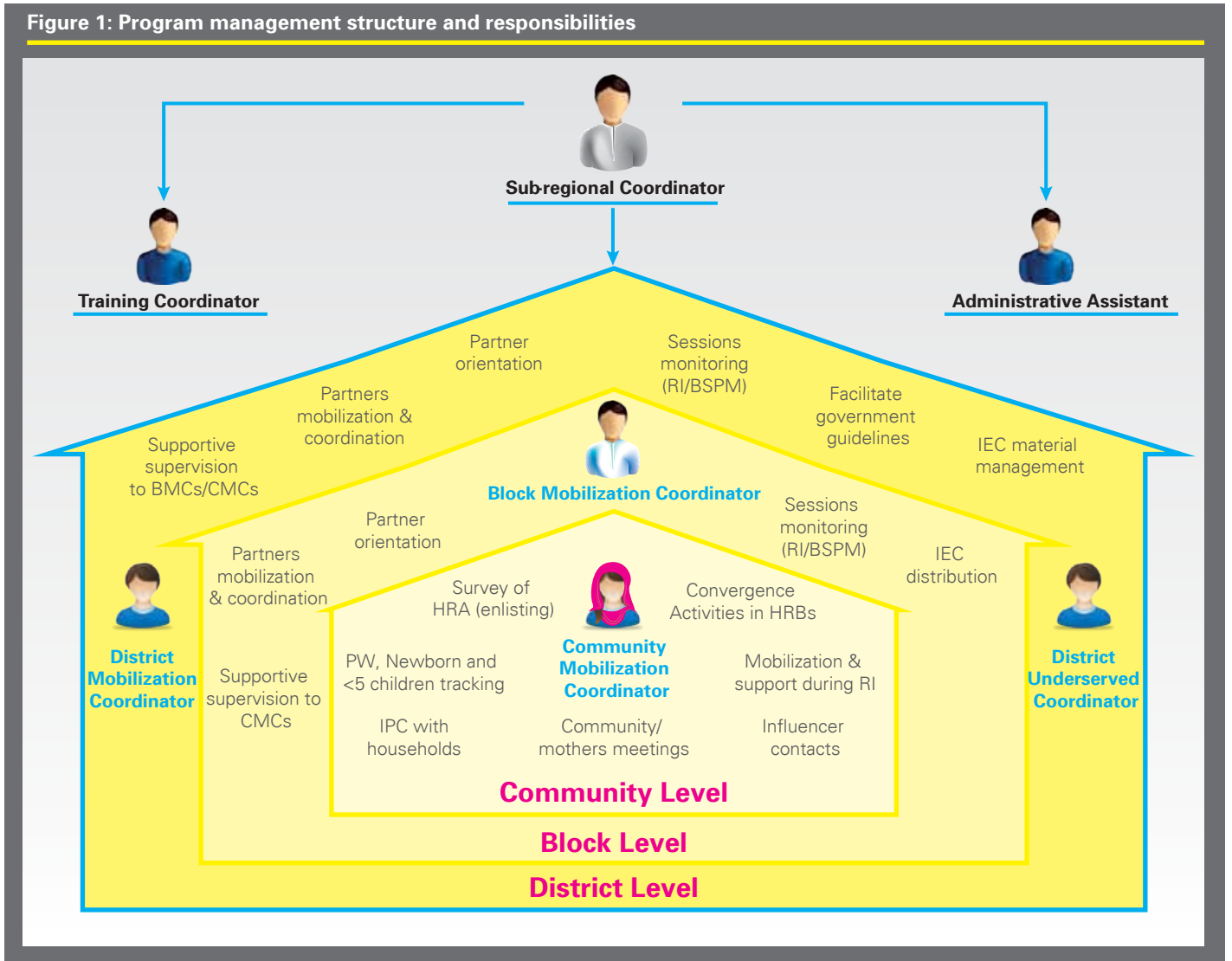
Different types of forums are used to interact with the stakeholders in the community. As mothers are primary caregivers, meetings are organized. Pregnant women and those with eligible children upto 5 years are counseled on the polio vaccine and various child health practices like routine immunization and nutrition during pregnancy. These meetings convey critical messages and create a positive peer group that helps in changing community health behaviour. In certain cases, where the entire family is resistant, neighborhood meetings are

organized in their vicinity to create a platform for discussions. It creates a positive peer pressure and helps CMCs to form a support group that can then convince the resistant families. In minority dominated HRAs, Istama and Milad (religious meetings) are held in which polio related messages are shared with mothers/caregivers keeping the religious perspective in mind. According to Sameena Begum in Budaun district, everyone in her village knows the CMC Shahnoor. Through the CMC's counseling sessions and community meetings, Sameena learnt a lot about Polio and other health related matters.

Sometimes the entire village needs to be addressed to encourage community participation and ownership of the polio eradication program. Community meetings are organized with representatives of the Panchayati Raj Institutions, prominent religious leaders, school teachers and other influential stakeholders to keep them abreast of and engaged with the programme. These meetings create a sense of ownership amongst the stakeholders to be actively involved in the process of the polio rounds. Prior to the round, interface meetings are held between the vaccination team supervisor and community influencers. The BMC, along with the CMC, updates the influencers and provides the list of resistant houses with eligible children to be immunized in the upcoming round. They are also given date-wise responsibility to accompany the vaccination teams.

At the field level, it is the CMC who engages regularly with the community during these meetings. To address concerns of individuals, the CMC is involved in one-to-one discussions with mothers and caregivers through which she provides information about polio and vaccination through counseling.

Figure 1: Program management structure and responsibilities



two

HARNESSING THE POWER OF WOMEN

It was important to reach out to the mothers but the circumstances in high risk areas were complex and it was not easy to establish contact with them. The conservative social norms made it difficult for male vaccinators to enter homes or even communicate with women. It was equally difficult to engage local women as vaccinators and mobilizers. The women in these areas of Uttar Pradesh are among the least educated from India.

Mr. Mohammad is a resident of Jamalpur block in Aligarh. He notes that because interaction between men and women is restricted, men cannot deliver services or messages about health to a woman.



In this context, it was anticipated that although recruiting women as CMCs would be difficult, only they could access other women in the community and engage with them. Selecting candidates was difficult and critical for the success of the programme. The BMCs, familiar with their blocks, were responsible for identifying the appropriate candidate. Informal discussions with some of the villagers, ANMs and AWWs facilitated the identification of potential candidates. Anita Vishwakarma, a BMC from Banna Devi Block was required to identify CMCs from her catchment area. None of the women from the villages in her area were allowed to engage in activities which involved interaction with outsiders. She had identified a young girl as a potential candidate but was refused permission by her family. Anita used the rapport she had developed with the elders in village to convince the family after a few rounds of discussions and persuasion.



CMC interacting with a mother and children in Bareilly, Uttar Pradesh, India

As Anita Vishwakarma recalls, *“Identifying and selecting a CMC was one of the most challenging tasks I have ever done in the polio eradication programme. I used my network with elders in the villages to convince the family to allow the girls to become CMC.”*

Anita Vishwakarma, BMC, Banna Devi Block, Aligarh district, Uttar Pradesh

The entire communication strategy was focused on building trust within the community and encouraging them to regularly participate in the polio vaccination drives. This involved providing information and addressing the mistrust. CMCs are front line workers of the SMNet, who are involved in one-to-one interpersonal counseling while dealing with the women and their families, and one-to-group communication while organizing meetings. They need persuasive

communication skills to convince resistant families and change behaviour. During their interaction with mothers they require basic communication and counseling skills to inform mothers about polio and the importance of vaccination. They also address misconceptions in these interactions. CMCs develop and hone their analytical skills when they collect data and enter it into survey formats and registers. They engage with the families by informing them about polio and the need for repeated doses of OPV, and/or counseling them to address the mistrust and misconceptions surrounding OPV. In dealing with resistant families, negotiating skills play an important role as CMC interacts with women folk, men and elders in the family. Her role as a polio class teacher, rally and booth organizer requires that she possess planning and decision making skills as well. These requirements were kept in mind while designing the training curriculum.

UNICEF conducts Training of Trainers (ToTs) to train BMCs, who further orient CMCs. The trainings are planned, coordinated by Sub Regional Training Coordinators (SRTC). Induction trainings are meant for new CMCs to orient them on their work while refresher trainings are meant for CMCs who have completed two polio rounds but need to enhance their IPC skills and resolve problems they may face at the local level.

The trainings have two objectives: a) to instill confidence in the CMC to communicate

with the families b) to equip her with skills to influence the community. Interactive and participatory principles of adult learning and life experiences are used for this. Concepts like social mobilization, transmission of polio, understanding the field book and data collection methods, the need for customized strategies are taught.

Emphasis is given on developing their communication skills with importance on how to handle queries, myths and misconceptions.



CMCs attending a training in Meerut, Uttar Pradesh, India

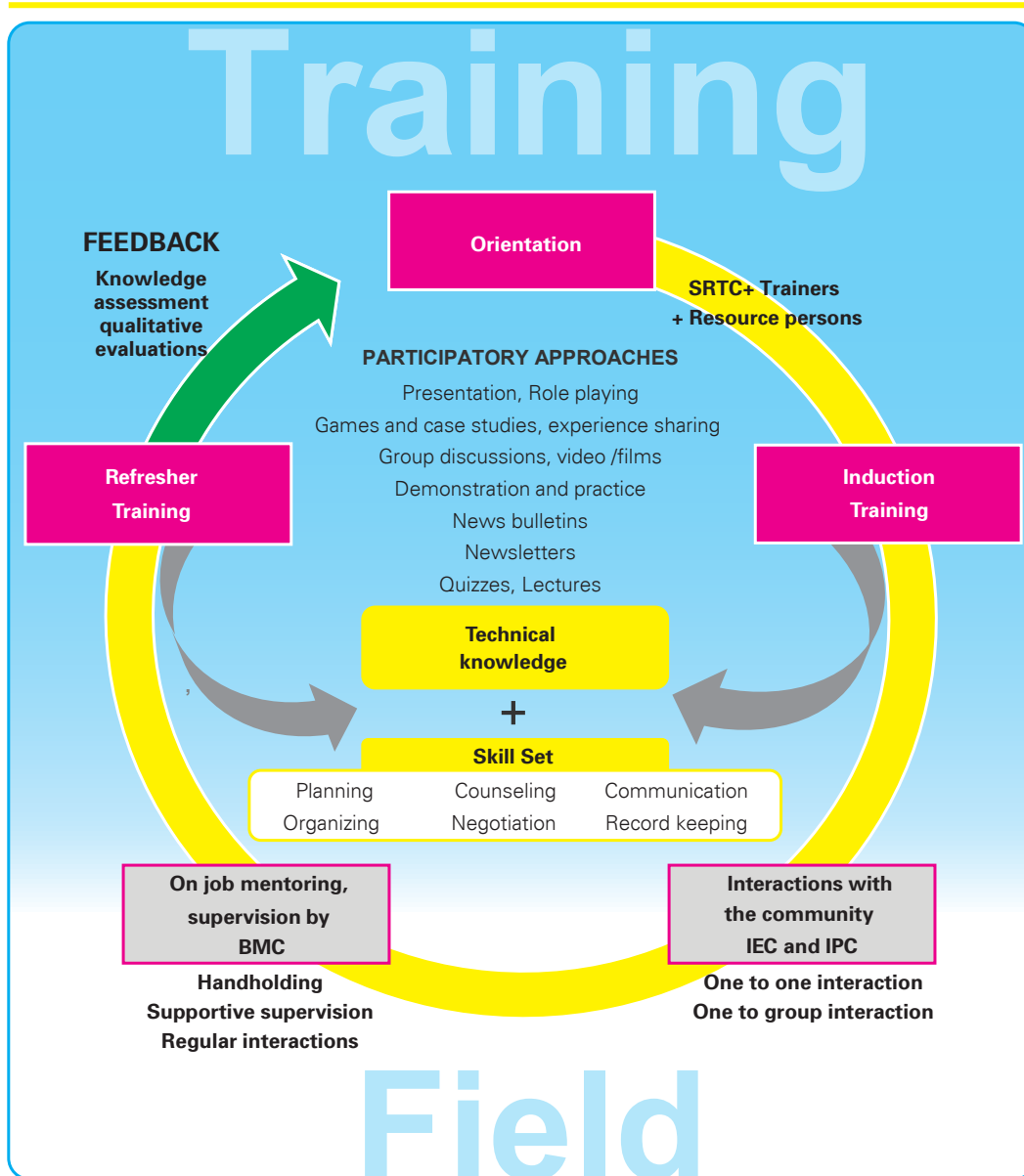
"I was so shy that even during the training, I hardly spoke. I was very nervous and hesitated whenever I was asked to get up and speak. I had never done anything like that before. After receiving training and initial support from BMC now I feel confident of interacting with anyone."

Shabhana Wahib , CMC from, Aligarh district, Uttar Pradesh

The flowchart (Figure 2) best represents the participatory methodologies used in the trainings and it is a continuous process of imparting technical information and skill sets. The CMC goes back to the community and betters her communication with the community and use of IEC to support her. At this stage, she

is also given a refresher training and the BMC supervisors her work and guides her to excel at rapport building. The feedback from BMCs, CMCs and data is fed back into the system for further improvement in IPC skills and knowledge levels of the CMC.

Figure 2: Trainings provided and skill acquired



three

WOMEN AS CHANGE AGENTS

The knowledge about communication techniques gained during training is then put into practice in the field. Though equipped with relevant knowledge and skills, mobilizing the underserved communities requires the CMC to deal with resistant families and the reasons for resistance. The CMCs initially found it difficult to converse about a sensitive issue in a community that was highly resistant to polio vaccination. Families held strong beliefs against the OPV and there were misconceptions about the medical properties and efficacy of OPV. It was a difficult experience for most of the CMCs. Rukhsana, a CMC from Ghaziabad, initially experienced a lot of difficulties in dealing with resistant families. She understood that resistant families had their own reason for refusing vaccination. Moreover, she realized that she needed to interact with male members of the families, something she was not comfortable with at the beginning. Though she had attended a lot of trainings, she learnt from her experience on the field that convincing people and changing their beliefs and opinion was not easy. The Block Mobilization Coordinator (BMC) provides the support required at this stage.



“Explaining the facts to families was very difficult to begin with as men were decisions makers and I had never interacted with them in our villages. I realized I had to do something to find a way to start the interaction”

Ms. Rukhsana, a CMC Aryanagar, Loni, Ghaziabad, Uttar Pradesh from Uttar Pradesh

They work closely with CMCs to mobilize local religious influencers in areas with a high concentration of underserved families or where a high level of resistance is anticipated. BMCs also play a crucial role in sensitizing block and district level government officials and other stakeholders regarding local social and religious structures. The District Mobilization Coordinator (DMC) provides hand holding support to BMCs on a regular supervisory basis and they do the



Children listening attentively to a CMC during Polio class in a madarassa in Ghaziabad, Uttar Pradesh, India

same for CMCs while monitoring their efforts in the community. Through review meetings and monitoring visits, BMCs inculcated confidence in CMCs. They also accompanied CMCs to provide practical in-field demonstrations on how to start discussions. The BMCs support CMCs in conducting dialogues and discussions with male community members. The gradual involvement of religious leaders and local influencers increased the support base of CMCs.

Ms. Shahana is a CMC in the Bannadevi Block of Aligarh district. According to her, people would close their doors when she went on house visits to talk to mothers and caregivers. She helped the families by taking some children to the hospital when they fell ill. This built the trust and rapport by which she could later convince them about polio vaccinations.

As part of the pre-round activities, the CMC would conduct various community mobilization activities like mother, community and neighbourhood meetings to increase awareness about polio and its prevention in her HRA. Besides this, she would also conduct 'polio classes' for children and organize rallies to create an energetic atmosphere and ensure that people understand the message about booth day. On this day, a group of children called '*Bulawa Tolis*' are allocated a grid of 50 households to bring eligible children for polio vaccination. Children would see this as a fun activity and enjoy running around the village shouting slogans about polio and vaccination. The children saw the CMC as a friend or elder sister who brought fun and games into their lives. Leading the energetic group of children and channelizing their energies for a social cause also helped to develop the leadership skills of CMCs. Through *Bulawa Tolis*, adolescent children have become an integral part of the change process, and developed



CMC using a flip book to explain polio disease as a part of interpersonal communication, Ghaziabad, Uttar Pradesh, India

confidence and new aspirations. Observing the CMC and her activities, these children inspire to be involved for a social good. Many young girls and boys aspire to work like the CMCs when they grow up. Shahana Khan, a CMC in Banna Devi Block has been regularly conducting polio classes, rallies and making *Bulawa Tolis*. She observed that the atmosphere is so contagious that even non-participating children eventually get involved and contribute in spreading the messages.

Sherina Anjum, 12-year-old girl from Budaun district excitedly talks about how the CMC, Shanoor aapa⁴, tells them everything during polio classes. After which they conduct rallies a day before the booth day, take part in the *Bulawa Toli* on the day and make all the efforts to ensure every child is brought to the booth. This young girl is convinced that in this way polio will disappear from their village. All of this inspires her to work like Shanoor aapa one day.

Seeing the rapport between CMCs and the children, the mothers tend to share their concerns about the children with them. Over a period of time, the CMCs and mothers become friends, facilitating a better communication.

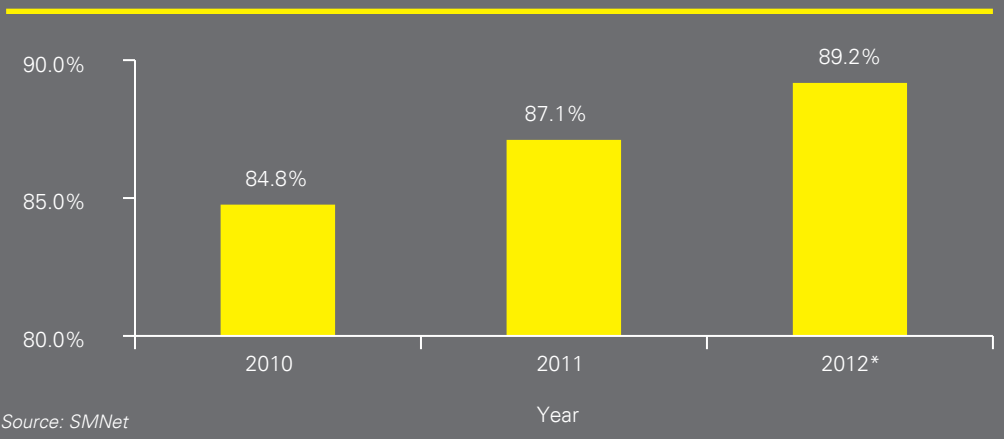
The mothers see the CMCs as individuals they can trust.

Shahana Khan, the CMC of Bannadevi Block in Aligarh district says that the mothers know that their children listen to her. So whenever the child is not well or not obeying, they approach her. If a child is unwell, she takes them to the doctor along with one of the parents. Often, the women even consult her about their own health problems, as they are shy talking to male doctors. The CMC guides her where to access the information from.

The CMCs consider booth day as a test of their efforts. The booth is well decorated with IEC material to ensure its visibility and make it look attractive. The CMC has to ensure the presence of influencers and other community leaders to support the booth activity. She leads the group of children and involves them to bring in eligible children for vaccination. Every possible effort is made to ensure that maximum number of families send their children for the OPV. Some of the resistant families still need to be motivated and convinced by the influencers. The CMCs also receive suggestions from the community about the location of the booth. This is discussed by the CMC in her interactions with government officials.

4 'aapa' means 'elder sister' in Urdu

Figure 3: % Booth inaugurated by influencer

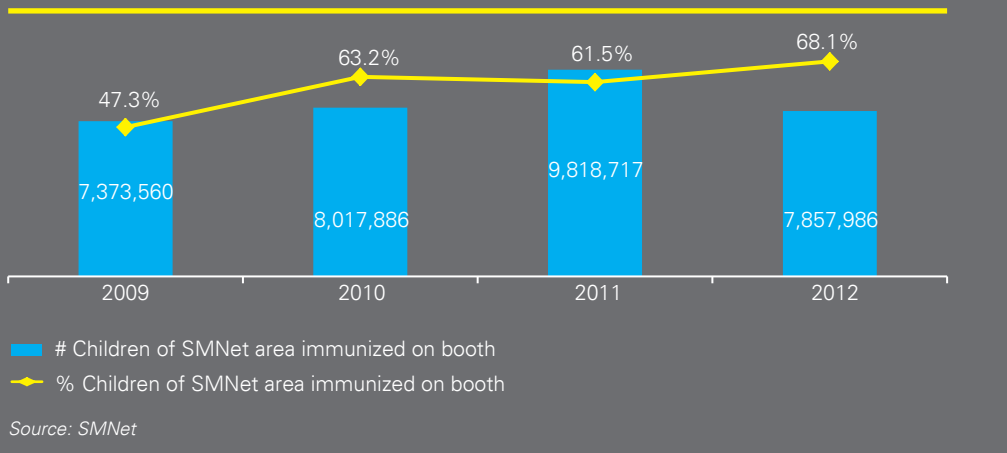


The CMC’s field experience gives her the confidence and conviction to negotiate and suggest changes in the micro-plans through the BMC. The booth is often inaugurated by an influencer or religious leader. The presence of local influencers helps in motivating the communities. There has been a steady increase in the number of booths inaugurated by local influencers (Figure 3). All this is made possible

by the efforts of the CMCs, who develop a rapport with the community and win their confidence.

As a result of the increased community participation in the polio eradication programme, the number of children being vaccinated on booth day has progressively increased over the years (Figure 4).

Figure 4: Children Immunized at booth 2009-2012, CMC Area, Uttar Pradesh



four

POSITIVES CHANGES THROUGH WOMEN



Opportunity to acquire empowering skills

While conducting various activities, the CMCs learn and develop specific skill sets. These skills crystallize over time and become an integral part of their personality. This empowers them and gives them the confidence to face challenges. As part of their training, the CMCs acquire planning and record-keeping skills. They also acquire the organizational and decision-making skills through the various activities and trainings. The trainings on filling field books and similar registers help them to acquire documentation and analytical skills that are useful in conducting and reporting on surveys and data.

Social recognition

The vaccination rounds provide the CMCs with opportunities to interact with health officials and vaccination teams. They accompany the vaccination teams and mobilize children till 5 years of age to take OPV, set up booths and connect with religious leaders to arrange for mosque/temple announcements⁵. In some districts, the CMCs are felicitated at social functions; events such as these have positive influence on their self esteem.

5 William M Weiss, MH Rahman, Roma Solomon, Vibha Singh and Dora Ward : Outcomes of polio eradication activities in Uttar Pradesh, India: the Social Mobilization Network (SMNet) and Core Group Polio Project (CGPP)



CMC using IEC material to counsel a mother with new born, Ferozabad, Uttar Pradesh, India

Kavita, a CMC in Ghaziabad District says that she was like other girls whose aspirations and suggestions had limited value in the family. Convincing her family to allow her to work as a CMC was very difficult. Becoming a CMC has transformed her life and given her an identity.

A platform to learn and express themselves

Social factors of inequity, gender discrimination and cultural norms make the societal framework a complex one. This makes it difficult for a woman to break the existing norms and lead a public health programme in the face of resistance. The SMNet has defied the societal norms laid for women by providing a platform to more than 4, 900 women to gain confidence and realize their potential as leaders. It has facilitated the empowerment of these women by developing their ability to express themselves and giving hope for a brighter future for themselves and their children,

Rukhsana, a CMC from Loni Village, in Ghaziabad district even stood for elections to become a 'Ward member'. Though she lost, she is not discouraged, in the belief that there is always a next time.

Participate in household decision making

In the process of disseminating knowledge, CMCs have been empowered through enhancing their own attitudes and health seeking behavior. Through public interactions, they have become aware about entitlements and rights and the importance of education. Consequently, they have gained the ability and position to take household decisions, like daily expenditure and education of children.

Mohammad Aslam Khan, is a Head Master of a primary school in Budaun. He explained how Noosrat's husband had reservations about her becoming a CMC and finally relented after much counseling.

Now, after training, Noosrat has changed a lot. She ensures the children attend school and then she conducts her survey and maintains the registers. With help of the ANM, she even made sure her sister-in-law breastfed her newborn correctly.



CMC seeing at the resource map with BMC and community influencer, Gautam Buddha Nagar, Uttar Pradesh, India

Developed aspirations for self and children

The CMCs belong to marginalized and underserved sections of society. The exposure through trainings, meetings and interaction with government officials has enhanced their vision and understanding. They aspire and dream for a better future for themselves with promising opportunities for their children. They also see themselves as capable of scaling up their role by becoming teachers, Anganwadi Worker (AWW) or Accredited Social Health Activist (ASHA).

After marriage, Zareena, an ex- CMC from Iqbal Colony, Ghaziabad, now works as an AWW in Chand Masjid village. As an AWW, she has a lot of work and responsibility and believes her experience as a CMC is coming in handy.

Beyond Polio

Over a period of time, the communities developed confidence and trust in the CMCs and approach them for health enquires other than Polio. During initial training, CMCs learnt only about Polio related matters and were not always equipped to answer other queries. However, over the years, they have had several opportunities to attend other training programmes organized by the health department and UNICEF. These trainings have provided an avenue for knowledge on other issues related to health.

Develop into a confident community worker

The development of communication skills has enabled CMCs to strike a conversation with everyone in the community. They have acquired the skills to negotiate and convince people about the benefits of vaccination against polio. They have to deal with all kinds of rationale and arguments and use their communication skills and creative thinking to negotiate.



CMCs attending a meeting at the block level, Meerut, Uttar Pradesh, India

Shabhana Wahib, a CMC from Aligarh district, was from a conservative Muslim family. She used to observe the BMC and was impressed by her confidence. She wanted to know more about the BMC's engagement with the polio work. Around that time, Shabhana's father had an accident and she felt she needed to earn. She approached the BMC who agreed to take her in for training. She found the training very effective and learnt many things. Her life has changed forever. She cannot believe herself that she can now speak confidently to anyone, address people during meetings, convince resistant families, independently organize polio booth days and teach others.

The father of a CMC in Sarai Rehman village in Aligarh, proudly talks of his daughter who is called 'Polio Didi'. Whenever kids fall sick in the village, mothers come to his daughter for support and she takes them to the doctor. She also insists on getting children vaccinated. The father says that his other children also want to be like their sister and that even the village headman sees her as a role model for other girls.

"My other children have all been inspired by her and want to be like her. The village head also appreciates her efforts and sees her as a role model for other girls."

Father of a CMC in Sarai Rehman village,
Aligarh, Uttar Pradesh

Developed into a 'Role model' from the community

The activities of CMCs have improved the health of children and now the mothers feel there is a person in a CMC whom they can trust and approach for guidance. This has made the CMCs into role models for other women in the community.

Increase in mobility of women

As integral members of the SMNet, the mobility of CMCs, which is considered to be a key indicator of women's empowerment,⁶ has increased. The trainings and consequent activities have provided an opportunity for CMCs to travel to nearby towns and interact with known and unknown individuals. This exposure has enhanced their capacity to take on larger roles within the community and their own homes.

6 Suman Kumar Kundu, et al An Empirical Analysis of Women Empowerment within Muslim Community in Murshidabad District of West Bengal, India

Reduction in resistant families

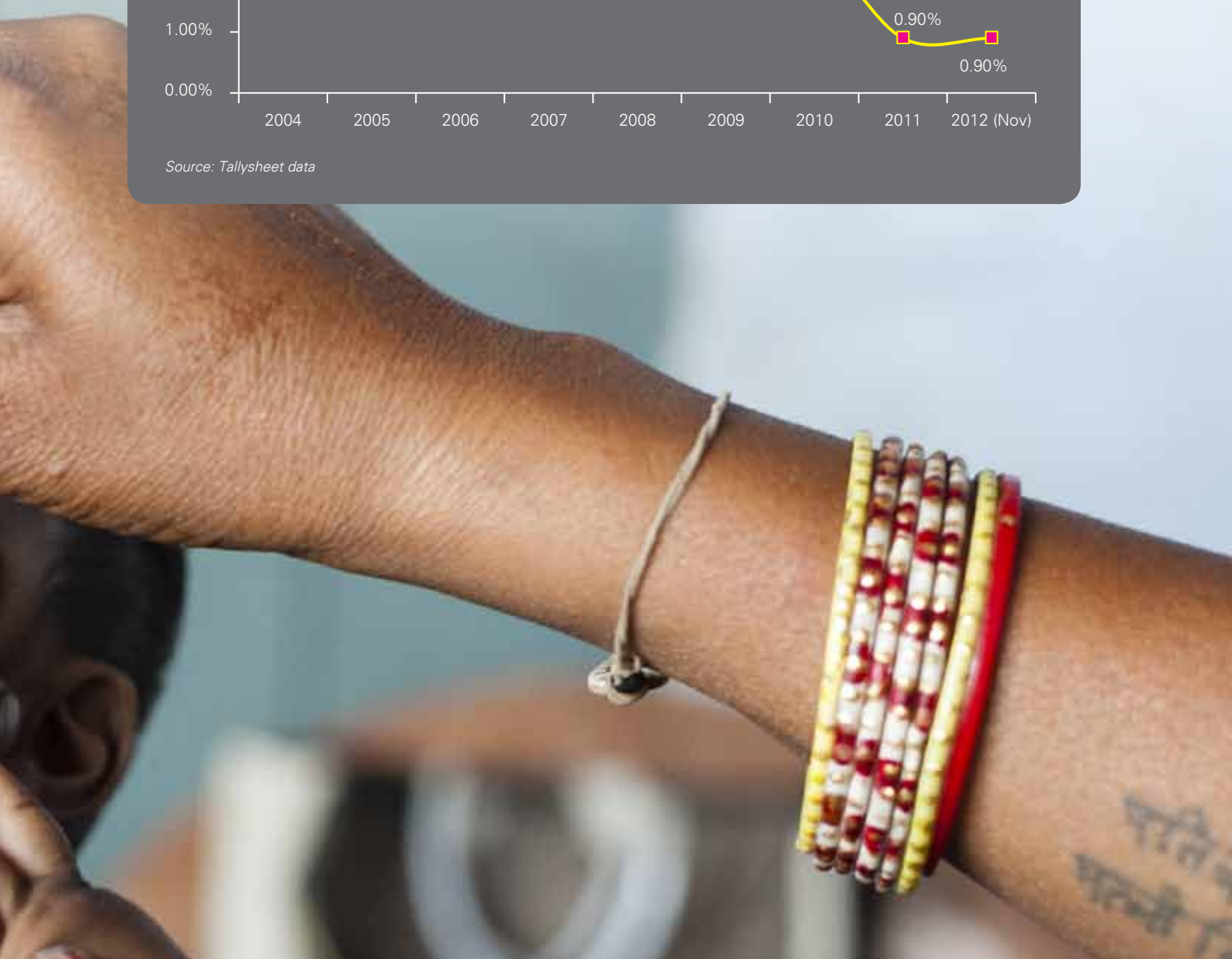
The CMC communication efforts through mother/neighborhood interface meetings have led to only a few resistant families now. The number of resistant families has progressively reduced in areas where CMCs have been working (Figure 5).



Figure 5: % Resistant households in CMC area, Uttar Pradesh, 2007 – 2012 (Nov)



Source: Tallysheet data



five

WAY FORWARD

India is officially off the list of Polio endemic countries. However, further efforts are required to continue the momentum gained by polio eradication programme in order to avoid any reoccurrence of polio cases.

The confident and trained workforce in the form of SMNet with a strong presence at the community level is readily available. This workforce has the conviction and courage to address some of the most challenging



problems. It can be effectively utilized for other public health programmes as well. The CMCs have very good rapport and acceptance at the community level. They enjoy the trust of women in underserved communities. They can be engaged to support initiatives related to maternal and child health.

The experience of social mobilization gained by the SMNet could be effectively used for addressing other difficult social issues.



CMC with Bulawa Toli children in Agra, Uttar Pradesh, India

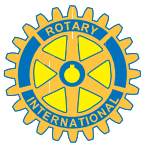


CMC with house to house vaccination team in Badaun, Uttar Pradesh, India



*The Community Mobilization Coordinator -
A credible voice building trust in the community...*





World Health
Organization





unite for children

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