Mid-Level Management Course for EPI Managers

BLOCK I: Introductory modules

Module 3: Communication and community involvement for immunization programmes

World Health Organization
REGIONAL OFFICE FOR Africa

Mid-Level Management Course for EPI Managers

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Module 3: Communication and community involvement for immunization programmes

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Abbreviations and acronyms

AD	auto-disable (syringes)
AEFI	adverse event following immunization
AVW	African Vaccination Week
BMGF	Bill & Melinda Gates Foundation
CBO	community-based organization
CHAI	Clinton Health Access Initiative
CHEW	community health extension worker
CHV	community health volunteer
CHW	community health worker
CSO	civil society organization
C4D	communication for development
DHS	demographic health survey
DTP	diphtheria-tetanus-pertussis-containing vaccine
EPI	Expanded Programme on Immunization
FGD	focus group discussion
GAPPD	Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea
Gavi	Global Alliance for Vaccines and Immunization
GIVS	Global Immunization Vision and Strategy
GVAP	Global Vaccine Action Plan (2011–2020)
Hib	*Haemophilus influenzae* type b vaccine
HMIS	health management information system
HPV	human papilloma virus
HSS	health system strengthening
ICC	interagency coordination committee
ICT	information and communication technology
IEA	immunization equity assessments
IEC	information, education and communication
IPC	interpersonal communication
IPV	inactivated polio vaccine
IVB	Immunization, Vaccines and Biologicals (WHO)
KAP	knowledge, attitudes and practices
KAPB	knowledge, attitudes, practices and beliefs
MCH	maternal and child health
MICS	Multiple Indicator Cluster Survey

MLM	Mid-Level Management Course for EPI Managers
MNCH	maternal, newborn and child health
MNT	maternal and neonatal tetanus
MOH	ministry of health
NGO	nongovernmental organization
NID	national immunization day
NIP	national immunization programme
NV	new vaccine
OPV	oral polio vaccine
PAR	participatory action research
Penta	pentavalent vaccine (vaccine with five antigens combined)
PCV	pneumococcal conjugate vaccine
PPP	public-private partnership
PRSP	poverty reduction strategy papers
RED/REC	Reaching Every District/Reaching Every Community
RI	routine immunization
RSPI	Regional Strategic Plan for Immunization (2014–2020)
SAGE	Strategic Advisory Group of Experts on Immunization (WHO)
SIA	supplementary immunization activity
SMART	specific, measurable, appropriate, realistic, time-bound
TOR	terms of reference
TT	tetanus toxoid
USAID	United States Agency for International Development
VPD	vaccine-preventable disease

Glossary

Advocacy — A process comprised of activities to gain and maintain the support and participation of opinion and decision-makers for a programme.

Communication for behavioural change — An evidence-based, consultative and participatory process consisting of informing and influencing the knowledge, beliefs, attitudes and practices of an individual or a group of individuals directly linked to the programme objectives. Communication for behavioural change uses multiple communication channels in an appropriate manner to promote and sustain behavioural change.

Communication for social change — A process that engages and empowers members of a community that have shared values or characteristics to change behaviour at the collective level. When a pattern of behaviour changes for large numbers and the change is visible and sustained, it results in a social change.

Community surveillance — Continuous process consisting of community members identifying all occurrences of health events (i.e. possible disease cases) in the community and reporting to/by a community worker to the health worker.

Focus group discussion	A research method consisting of gathering together a group (up to 10 individuals) under the guidance of a facilitator to discuss a particular subject of common interest in a free and open manner. Focus group discussions (FGDs) are used primarily to collect qualitative data for communication research and for the community to identify issues of concern for addressing them at their own level.
Interpersonal communication	Process of exchanging information whereby the communicator engages in face-to-face communication with an individual or a group of people to explore their views on and/or promote a change in behaviour or in social norms. Effective interpersonal communication (IPC) takes the form of an interactive dialogue that provides for questions and answers.
Interviews	A format to gather information from individuals verbally with one person or several people simultaneously. Interviews can be structured or semi-structured to gather specific information from stakeholders.
Mass media	Media technologies (including the internet, television, newspapers, film and radio) used for mass communication to provide and/or exchange information.
Participatory action research	A form of research that enables stakeholders to participate with researchers in identifying issues, by gathering data, data analysis, dissemination and making decisions for action.
Proximity media	Media that is closer to the communities in terms of distance, content and possibilities for participation and tools used. It includes both mass, traditional and community media.
Social mobilization	The process of sensitizing and empowering a wide variety of stakeholders to gain and sustain their involvement and take action to attain a common goal.
Social media	Collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration, e.g. Facebook, Twitter, Instagram etc.
Surveys	Survey in communication implies the collection of data designed to gather data on the knowledge, attitude and behaviours of respondents. Survey findings can help to describe the current mindset of the participant groups, and identify information gaps and perceptions that the communication programme should address. Survey data can be used to provide a baseline for assessing the impact of the communication programme.
Traditional media	Media employing vocal, verbal, musical and visual folk art forms familiar to the society and often rooted in local culture (e.g. storytelling, drama, song and puppetry). Fairs and festivals including social, ritual and ceremonial gatherings also create a platform to meet and exchange views among people.
Visualization in participatory programmes	Interactive facilitation method that uses cards to collect individual or group ideas on a topic and is then sorted by categories discussed. It facilitates active brainstorming and participatory learning.

1. Introduction

1.1 Context

The Expanded Programme on Immunization (EPI) is a key global health programme. Its overall goal is to provide effective and quality immunization services to target populations. EPI programme managers and staff need to have sound technical and managerial capacities in order to achieve the programme's goals.

The immunization system comprises five key operations: service delivery, communication, logistics, vaccine supply and quality, and surveillance. It also consists of three support components: management, financing and capacity strengthening.

National immunization systems are constantly undergoing change, notably those related to the introduction of new vaccines and new technologies, and programme expansion to reach broader target populations beyond young children. The EPI programme also faces external changes related to administrative decentralization, health reforms, as well as the evolving context of public-private partnerships (PPPs) for health, among others.

To ensure the smooth implementation of immunization programmes, EPI programme staff have to manage these changes. This requires specific skills in problem-solving, setting priorities, decision-making, planning and managing human, financial and material resources as well as monitoring implementation, supervision and evaluation of services.

National immunization programmes (NIPs) operate within the context of national health systems, in alignment with global and regional strategies. For the current decade, 2011–2020, the key global immunization strategies are conveyed through the Global Vaccine Action Plan (2011–2020) (GVAP) and the African Regional Strategic Plan for Immunization (2014–2020) (RSPI).

These strategic plans call on countries to:

- improve immunization coverage beyond current levels;
- complete interruption of poliovirus transmission and ensure virus containment;[1]
- attain the elimination of measles and make progress in the elimination of rubella and congenital rubella syndrome;[2] and
- attain and maintain elimination/control of other vaccine-preventable diseases (VPDs).

The key approaches for implementation of the GVAP/RSPI include:

- implementation of the Reaching Every District/Reaching Every Community (RED/REC) approach and other locally tailored approaches and move from supply-driven to demand-driven immunization services;
- extending the benefits of new vaccines to all;
- establishing sustainable immunization financing mechanisms;
- integrating immunization into national health policies and plans;
- ensuring that interventions are quantified, costed and incorporated into the various components of national health systems;
- enhancing partnerships for immunization;
- improving monitoring and data quality;
- improving human and institutional capacities;
- improving vaccine safety and regulation; and
- promoting implementation research and innovation.

The RSPI promotes integration using immunization as a platform for a range of priority interventions or as a component of a package of key interventions. Immunization is a central part of initiatives for the elimination and eradication of VPDs, and of the integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) by 2025.

It is understood that while implementing the above strategies, EPI managers will face numerous challenges and constraints that they need to resolve if the 2020 targets are to be met. Building national capacity in immunization service management at all levels of the health system is an essential foundation and key operational approach to achieving the goals of the global and regional strategic plans.

In view of this, the WHO Regional Office for Africa, in collaboration with key immunization partners such as the United Nations Children's Fund (UNICEF), United States Agency for International Development (Maternal and Child Survival Program) (USAID/MCSP), and the Network for Education and Support in Immunisation (NESI), have revised the Mid-Level Management Course for EPI Managers (MLM) training modules. These modules are complementary to other training materials including the Immunization in Practice (IIP) training manuals for health workers and the EPI/Integrated Management of Childhood Illnesses (IMCI) interactive training tool.

1 WHO, CDC and UNICEF (2012). Polio Eradication and Endgame Strategic Plan 2013-2018.
2 WHO (2012). Global Measles and Rubella Strategic Plan 2012-2020.

This module (3) titled *Communication and community involvement for immunization programmes* is part of Block I: Introductory modules.

1.2 Purpose of the module

This module provides EPI programme managers with a general overview of the communication and community involvement components within the immunization programme, as well as the knowledge and skills needed to ensure implementation of the planned communication activities.

It is designed to support EPI managers to coordinate, plan, implement, monitor and evaluate evidence-based communication and community involvement interventions. This module contains case studies and exercises to enhance the skills of immunization staff to develop and use communication strategies and tools related to various aspects of the programme: planning, management interaction with target populations, new vaccine introduction, injection safety etc.

1.3 Target audience

This module is intended primarily for immunization programme managers at national, regional and district levels. It can also be adapted to provide other health-care staff with basic communication knowledge and skills to enhance their effectiveness in immunization programme implementation.

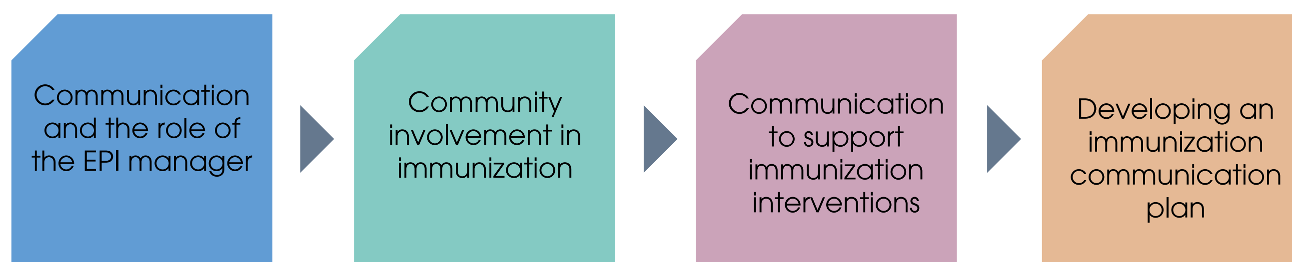
1.4 Learning objectives

At the end of this module, the participants should be able to:

- understand the role of communications and community involvement in supporting EPI;
- describe the role of the EPI manager and immunization programme staff in planning, implementation, monitoring and evaluation of EPI communication and community involvement interventions;
- integrate communication and community involvement into overall EPI plans at all levels;
- guide the effective planning, implementation, monitoring and evaluation of EPI communication and community involvement activities;
- understand the role of formative research in identifying, analysing and addressing challenges related to communication and community involvement and the use of research findings to guide EPI communication planning;
- use the acquired skills for quality communication and community involvement interventions in support of EPI; and
- mobilize resources for effective EPI communication and community involvement interventions.

1.5 Contents of the module

This module contains the following sections:



1.6 How to use this module

This module serves as a reference document for EPI managers at various levels to plan, implement, monitor and evaluate effective communication interventions in support of EPI. Users should first read the narrative content of each section, clarify issues if necessary, and proceed to the exercises and case studies as group work. Trainers can adapt these case studies and examples for role plays or suggest other interactive training methodologies. The output of exercises and group work can then be discussed with colleagues and facilitators.

2. Communication and the role of the EPI manager

2.1 Communication in EPI

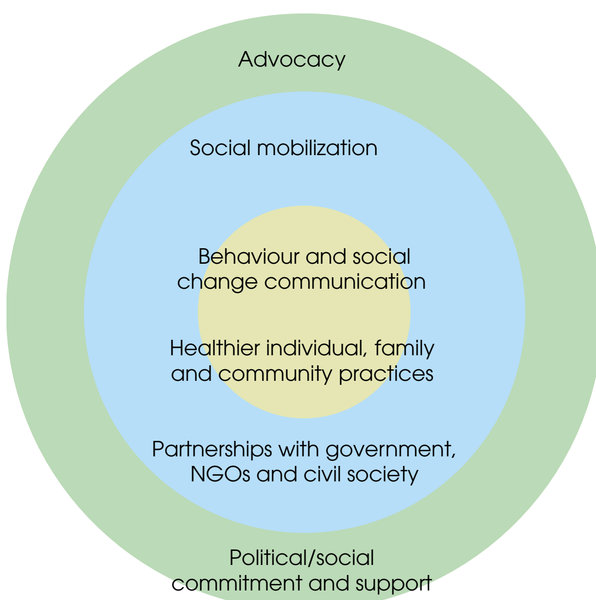
2.1.1 Communication components

There are four major challenges to immunization, which can be effectively addressed through effective communication.

- non-vaccination of children due to caregivers' ignorance on the value of vaccines, when children need to be immunized and where vaccines are administered;
- non-vaccination of children due to exclusion of communities particularly those beyond the reach of immunization services;
- non-vaccination of children due to caregivers' distrust for vaccine safety; and
- non-vaccination of children due to unavailability of vaccines.

Different terms are used to describe activities concerned with informing, educating, enabling and bringing about desired behaviours and subsequent practices in different groups and at different levels in any health programme. In this module, the term "communication" is used as a wideranging descriptive concept encompassing: advocacy, social mobilization and communication for social and behavioural change (Figure 2.1).

Figure 2.1 Communication components



Advocacy aims at developing supportive policies and guidelines, and raising/increasing resources for and commitment to sustainable financing of vaccine. **Social mobilization** aims at ensuring that key actors join efforts to achieve wider community participation and ownership to promote immunization among specific population groups.

Communication for social and behavioural change aims at providing knowledge and promoting positive attitudes for the adoption of immunization practices at both individual and community levels, i.e. by transforming the practices into norms to which individuals accept and conform. Well-planned communication activities can assist immunization programmes to achieve the following:

- high immunization coverage rates and reduction in missed opportunities, drop-out rates and number of unreached children, by mobilizing resources for immunization from national to community level;
- reduction of morbidity and mortality due to VPDs by facilitating community commitment and participation;
- higher awareness, acceptance and demand generation for vaccination by caregivers and communities (including administrative, traditional and religious leaders);
- implementation of immunization policies and action plans through effective communication of facts and data on VPDs as well as intensive lobbying and advocacy to ensure support and increased ownership of leaders and communities;
- stronger understanding between the EPI manager and the interagency coordination committees (ICC), ministries of health (MOH), nongovernmental organizations (NGOs), the community of financial backers, and provincial or district officers;
- improved quality of services to meet demand, ensure good interaction of health workers and communities;
- strengthened health staff capacity to address caregivers concerns about safety of immunizations; and

- development and implementation of relevant policies for an increased sustainability of the immunization programme through resources mobilization, involvement of other sectors encouraging them to support the programme, including support to the introduction of new vaccines.

EPI staff therefore should maintain a continual dialogue with community leaders and caregivers, in order to enhance their understanding and interest in the programme.

Communication for immunization is an integral component of successful EPI programming. It should receive a regular budget and human resources, and be measured through monitoring and evaluation. Demand generation and communication is one of the key components when planning and budgeting immunization programming.

An EPI manager is as responsible for communication as they are for logistics, human resource training and monitoring. Table 2.1 shows the ways communication should be integrated into immunization programming.

2.1.2 Structures and people required at each level

Communication for immunization is an investment. If the following structures are not in place, part of the communication plan should be to assess why they do not exist, whether they are really required, how they can be established and the associated costs. In some cases, these structures may be integrated with those of maternal and child health (MCH). If these, or similar structures do not exist, their establishment requires intensive discussions with government and the ICC. Structures alone are ineffective without quality people to manage and contribute to them.

Table 2.1 Ways to integrate communications into immunization programming

Area	What	How
Planning and resources	National health sector plan	Budgeted as part of the EPI plan
	Comprehensive multi-year plan (cMYP)	Demand generation and communication is one of the key components requiring planning and budgeting
	EPI annual work plan	Communication should be a component in the EPI annual work plan, with objectives, activities, indicators, methods of validation, human and financial resource needs
Management	Interagency coordination committee	Priority communication plans and outcomes should be reported to and endorsed by the ICC
	National immunization operations team	Communication should be directly represented on the team
	National communication committee	Should be a committee or working group of the national operations team
	Regional/provincial/district immunization operations team	Communication should be represented on the team
	Regional/provincial/district communication committee	Should be a committee or working group of the regional/ provincial/district team
	Local immunization operations team	Communication should be represented on the team
	Ward/local development committees	The local community engagement arms
Operations	Communication	Most of the communication programming will be planned and resourced through the communication committee or working group
	Training	Integrate basic communication training for regional and local teams; IPC including adverse event following immunization (AEFI) training for supervisors and health workers
	Monitoring and evaluation	Integrate communication indicators into EPI supervision, monitoring and evaluation

At national level:

- There should be a communication committee or working group reporting to the immunization operations team. This subcommittee/working group will be responsible for the overall communication planning and implementation; and members should be competent in both communication and immunization. They should include representation from the government's EPI team; other government departments (eg. health promotion); key partners including UN partners, partners funding immunization (e.g. Clinton Health Access Initiative – CHAI); key civil society organizations that help with immunization (eg. Lions, Rotary); and active associations.
- One member (usually the chair) of this group should be a member of the national immunization operations group.
- A communication subcommittee or working group at regional/provincial/state/district levels. This subcommittee/working group will be responsible for tailoring the communication planning and implementation in their region. The composition will be roughly the same as at national level – but will also reflect the needs at this lower level – for example, representation from a minority group living in the area.
- Local development committees, ideally for each community, fully involved in decisions about local health and development These could be a group of local people representing community stakeholders including women, minority groups, a local health centre representative, key trades, religious groups, etc. They should make decisions about routine immunization (RI) schedules, including outreach sessions. They should be aware of immunization coverage and gaps; and be supported to identify additional needs.
- Where there are no local development committees, health facility providers should meet with the community to undertake joint micro-planning for session planning including outreach service delivery.
- Community health workers (CHWs), community health extension workers (CHEWs) and/or community health volunteers (CHVs) play a critical role in community health. Some countries have cadres of both CHWs and CHVs. Their roles for immunization can include updating community health registers, new-born tracking and referrals to RI and other health services, defaulter tracing and recovery, maternal RI referral for tetanus, community education, door-to-door mobilization and counselling, and community representation.
- If community health workers and/or volunteers do not exist, countries are encouraged to create the cadre, particularly where poor communities lack access to basic services. Given the resources and management required to create a sustainable cadre of CHWs, this is of course a much larger government decision.

2.2 Role of the EPI manager in managing immunization communication interventions

The EPI manager is responsible for planning and managing all programme components, including communications. The latter includes cooperation with implementing partners, media and civil society organizations in advocacy, social mobilization and communication for social and behavioural change. To support effective communication interventions, EPI managers and programme staff need to collaborate with their colleagues (e.g. cold chain and logistics staff, finance officers, statisticians and other health personnel), government officials, donor agencies and the public. In addition, the EPI manager should work with communication specialists to:

- integrate communication into overall EPI plans;
- ensure that a communication specialist is a member of the ICC to provide technical advice to the committee members on communication issues;
- support staff that are implementing the communication interventions as defined in their job description;
- strengthen the capacity of immunization partners who support communication component in the programme;
- coordinate and supervise implementation of communication activities;
- ensure that adequate educational materials and other tools are available and equitably distributed;
- monitor the process and the outcomes of communication interventions for corrective action when and where needed;
- hold meetings with immunization partners and with the media to communicate progress, constraints, programme developments and needs;
- provide feedback to staff, communities, partners and media;
- involve the community at all levels in planning, implementation and monitoring of immunization activities to ensure demand creation and participation; and
- planning, mobilizing and managing resources for communication.

Effective planning, mobilization and management of resources are needed for communication interventions

in the immunization programme. The role of the EPI manager is to identify and access resources needed to support interventions at national, provincial, district and community levels. The EPI manager must also deploy necessary efforts to mobilize resources for the civil society to join efforts in immunization especially in areas where the RED approach is being implemented.

Communication with staff: EPI managers should keep their staff informed and improve their communication skills by:

- providing timely technical information and feedback on immunization programme challenges and the level of achievement of planned targets;
- assisting staff in liaising with and updating the community, particularly through communication with community leaders and during community meetings;
- conducting supportive supervision and on-the-job capacity building of health staff through onsite training and encouraging dialogue and discussion (see annexes 1 and 2); and
- providing IPC skills training for improving communication skills with the community and amongst other health workers.

EPI staff communication via mass media: There follow some suggestions on how the EPI manager and programme staff can work with mass media to communicate information effectively on the immunization programme and activities:

- develop an informed media network for accurate reporting and to be an ally;
- inform the media in advance about programmed activities, specifying the date, place and participants so that these activities may be given wide media coverage;
- sponsor the media to observe immunization activities and events so that they can cover stories and broadcast information;
- provide the media with human interest and success stories from the programme;
- prepare and issue regular press releases to the media for their use in broadcasts or articles;
- organize regular interviews with the media, involving different advocates of the programme (e.g. leaders, experts, etc.); and
- advocate with the media allies for regular and varied programes on EPI (such as phone-ins, talk shows, panel discussions).

Communication channels: Maximum effort should be made to have free broadcast and press coverage of the improved immunization services. This involves preparing press releases and briefing materials and holding news conferences at national and subnational levels. If affordable, TV and radio can be used to reach health workers and populations. Traditional media can also be used, particularly to reach underserved populations.

The basic strategy for reaching rural populations is to orient local political, social, educational and religious leaders and organizations. Print materials are appropriate for health workers, but many developing country programmes should carefully consider whether they should prepare print materials addressed to the public, given the cost and the public's ability to understand them. Remember that the most important source of information for parents is likely to be local health workers, so be certain that health workers understand the basic messages and are capable of delivering them and responding to questions and concerns.

Information communication technology and social media: Information and communication technology (ICT), particularly mobile phones, are increasingly being successfully used for a variety of development applications. Improved engagement, supervision, monitoring, record keeping, data sharing and information exchange are all possible with specially designed mobile phone and computer applications.

- *The World Bank World Development Report 2015: Mind, Society, and Behavior* summarizes recent findings on the use of mobile text messages and behavioural change. Reviews of evidence "suggest that mobile messages are more likely to be effective when there is follow-up, when the message is personally tailored to the recipient, and when the frequency, wording, and content are highly relevant to the patient. Blasting text messages to large portions of the population reminding them of all the things they can do to improve their health is likely to be a waste of resources: the messages are not salient or tailored."

- Mobile phone SMS messages can serve as reminders to carers to take their babies for health checks and immunization. The system allows CHWs to register birth through SMS messages to a central clinic. The CHWs then receive reminders of post-natal visits from the central clinic, to communicate to the carers. The system asks CHWs to report back when the carer has been reminded about the next visit, and when they attend the clinic. The information is then aggregated into a web-based databank. If reports are not received, the central clinic is asked to follow up with the CHW by phone.

- One of the emerging strengths of the use of mobile phones in development programmes

is the capacity to collect data for monitoring and evaluation purposes, as well as serve as an important advocacy tool to inform decision-makers on the trends, perceptions and knowledge of the population about existing immunization and health services.

- Evidence also shows that SMS and voice calls are efficient and can increase coverage. For example, the K4Health project in Malawi found that "using SMS and voice calls to improve information sharing and communication between community health workers and district-level teams were four times cheaper and 134 times more efficient for receiving feedback than the typical method of traveling to meet with district-level supervisors directly. In fact, worldwide we see that simple text message reminders to mothers have doubled vaccination rates of children." [3]

- As more urban people in Africa use social media, the EPI management team can use social media tools such Facebook, Twitter, Instagram etc, to interact with the urban community. Social media tools have the potential to improve reach, increase engagement and provide tailored experiences for particular individuals and communities.

Barriers to communication programme interventions: Immunization programmes sometimes face barriers and challenges to effective implementation. Barriers that can be addressed by communication can relate to service delivery, demand creation, availability of resources for interaction with communities, appropriateness of channels of communication or adequacy of the content and clarity of the messages. These barriers occur at all levels: central, provincial, district, health facility and community.

They can be institutional, social and/or behavioural. Evidence suggests that the main reasons for un/under-immunized children are related to: immunization system gaps; normative environment; parental knowledge, attitudes, practices and beliefs (KAPB); and/or family sociodemographic, economic and cultural characteristics.

The starting point for planning communication activities for the immunization programme should therefore be a situation analysis using rapid assessment methods and knowledge, attitudes and practices (KAP) qualitative and quantitative research that identify barriers for behaviour change towards immunization. The communication plan must be evidence-based, using existing quantitative immunization coverage data, as well as qualitative data developed from assessements with the participation of actors at all levels. Such a plan will help to define clear objectives.

There are barriers linked to service delivery that have an impact on the motivation of caregivers to immunize their children (Table 2.2). These include distance from the health centre and/or long waits resulting in time lost for income-generating activities, unavailability of vaccines, attitude of health staff and vaccinators, poor implementation of the immunization programme by health staff and vaccinators, health workers charging caregivers for services etc.

Exercise 1

Task 1: In groups, identify barriers to immunization that can be addressed by communication at management level, service delivery points, caregivers, family level and community level.

Task 2: Identify the most suited approach or strategy to address these obstacles (advocacy, social mobilization, communication for behavioural change and communication for social change) and brainstorm on specific communication interventions to address these barriers.

Consolidate the outcome of your group work, using the following format and present it to the plenary.

Areas of obstacles	Type of barriers	Approach/strategy applied	Intervention
Immunization system			
Communication and information			
Family characteristics			
Parental attitude and knowledge			

3 Source: USAID: Integrating Mobiles into Development Projects; August 2014.
This comprehensive guide offers practical steps to build ICTs into development programming (www.usaid.gov/sites/default/files/documents/1861/M4DHandbook_August_2014.pdf).

Table 2.2 Examples of barriers to immunization which communication can address

Immunization systems related reasons/factors	Communication and information related reasons/factors	Family characteristics related reasons/ factors	Parental attitudes and knowledge
• Access/distance to services (rural and/or remote communities with no/irregular outreach) • Unavailability of supplies/vaccines • Poor health worker knowledge and training • Poor service quality and reliability • Lack of antenatal/ perinatal care • Missed opportunities including not having vaccination card at the time of the clinic visit, vaccinator absent at the designated time of immunization services and children receiving curative services only (i.e. the child's immunization status is not assessed) • Lack of referral to services • Cost of vaccinations • Poor timing/ availability of vaccinators • Vaccination schedule • Weak and inadequate supervision at the local and district level	• Lack of health educators • Poor communication from health worker (perceived provider rudeness or a lack of trust in him/her) • Lack of information on vaccination schedule, when child is due, where to receive vaccinations • Inadequate media messages • Dissemination of inadequate or incorrect information by health-care worker • Lack of media exposure • Lack of community involvement • Gender of health worker • Lack of trust or social connections • Lack of home visits by health worker	• Illiterate caregivers • Low education level of caregivers • Low socioeconomic status • Living in a large family/having older siblings • Belonging to minority group • Migrants • Blue collar worker/ occupation • Marital status • Male headed household • Mother's age • Other domestic issues (conflict/ death)	• Caregivers' lack of knowledge about immunizations • Low motivation • No understanding of vaccine importance (caregivers frequently not aware of need to vaccinate their child or threat of disease transmission if child not vaccinated) • No information on when to vaccinate • Misconception of vaccinations (ranging from impression that vaccines do not work to the concerns that vaccination harms the child or causes disease or other adverse events such as sterility) • Fear of side-effects • Fear of vaccination • Being female child • Religious/cultural/ traditional beliefs against vaccines • Lack of family discussions on vaccines • Reject vaccinations (no reason) • Mother's autonomy • Previous bad experience with clinic • Social pressure against vaccinations • Contraindications to vaccinations incorrectly interpreted; and children for whom vaccinations were otherwise appropriate are not vaccinated.

3. Community involvement in immunization

3.1 Community involvement and ownership of immunization programmes

A **community** is often referred to as a group of people who live in a particular geographical location. However, a community can also be defined as a group of people who share other characteristics: cultural, social, economic, political, religious, professional, etc. These communities have the same reference values or social norms.

Community involvement for immunization refers to supportive, coordinated action that can be taken by health workers and community members (a group of people with shared sociocultural and economic characteristics) towards achieving their shared goal of decision-making, providing accessible, reliable and friendly services that are used appropriately by all. It is based on the principle that when communities are involved in planning, implementing and evaluating services, they will develop stronger trust and ownership of those services.

It is important for the EPI manager to recognize that community differences and dynamics interact with all the various sections within the community and determine the extent of community participation and involvement in planning, implementation and monitoring of the programme. Utilization levels are more likely to rise if the community is an active partner andis linked with health services in each phase.

Community involvement and ownership of the immunization programme is a process by which community members voice their opinions about health problems, are involved in the decision-making process to address problems and participate in the actions to resolve them, and also take responsibility for changes. This process, which is one of increasing the control of the community over the resources and decisions affecting their lives, is key to ensuring sustainability and equity. Ultimately, it entails making health services accountable to those they serve.

To ensure community involvement and ownership, EPI managers and health workers need to form a close partnership with communities, while using effective communication skills and tools. While community participation is considered to be a key factor of success, the paradox is that often health staff do not involve communities adequately.

Although knowledge per se is insufficient to create demand, poor knowledge about vaccination is a good predictor of poor compliance. Children do not get vaccinated if caregivers do not know the value of vaccines, when children need to be immunized, where vaccines are available, the appropriate series of vaccines to be followed, or the schedule for immunization. Health workers are encouraged to learn what community leaders and caregivers know and feel about the services.

Define the communication and service delivery needs of communities

- What are the services offered by the programme?
- Are the communities being provided with information related to the EPI?
- Are the communities aware of these services – where/when they are provided?
- How is the information given to the community?
- How do community members perceive the programme?

Define community processes in generating community ownership

- What are the key community processes in delivery of immunization services? (Discuss the process of engaging communities; empowering communities and engaging community health workers.)
- What are the different types of community involvement (discuss marginal, substantive and structural participation).
- What are the elements of community ownership?

Involving "intended beneficiaries" can help maximize the use of services. In most communities, there are resources that can be mobilized and used to improve demand for and access to services. Community involvement often takes the form of health facilities involving community leaders and volunteers to increase demand, particularly for outreach in rural areas, and relying on them for mobilizing the community, providing health education, assisting during outreach sessions and tracking defaulters.

3.2 Participant groups for communication

In the course of performing their work, the EPI manager and immunization staff communicate with individuals and groups at various levels who hold different roles and responsibilities within governmental structures and the community. The type of information that is communicated and the channels used will vary depending on the audience and the purpose (e.g. informational, managerial, awareness building, educational), the level of KAP, the level of resistance to the adoption of the new behaviour. Different communication approaches should be used at different levels in order to support immunization activities and increase demand for immunization services, reduce refusals. Table 3.1 describes key participating groups, their relevance to EPI and some actions that EPI managers should consider to obtain maximum community support and involvement in the immunization activities.

Table 3.1 Participating groups and their relevance in EPI

Participating groups	Relevance in EPI	Possible actions for consideration by EPI manager
Caregivers	First-line participants in ensuring that child is vaccinated	• Ensure effective communication to gain their trust • Provide sufficient information on vaccination schedule, safety, side-effects, protection levels, etc.
Community and religious leaders	Help shape public opinion and can mobilize their communities to support and/or participate in EPI	• Advocate, build trust and partner with leaders to garner their support and participation
Community groups	Influencing community members and can mobilize caregivers and foster behaviour change and support towards EPI	• Inform and involve them in immunization activities to identify and track eligible children and target populations (to support activities and prevent left outs and dropouts)
Health educators/ mobilizers	Assist in planning, implementing and monitoring communication interventions to support EPI	• Ensure that they have basic, factual information on immunization to inform caregivers and communities • Encourage them to assist in reducing dropouts and number of unvaccinated children
Immunization staff	Critical information sources to public on RI during vaccination sessions and supplementary immunization activities (SIAs)	• Develop and monitor staff IPC and counselling skills • Ensure that they are motivated, have proper working conditions and materials • Provide formative supervision
National, district, province, health facility staff	Provide information and implement plans, guidelines and policies Conduct supervision and provide feedback.	• Communicate information on new policies, technical updates, programme status in a timely manner and ensure supportive supervision and feedback
Private sector and NGOs	Provide services to marginalized and hard-to-reach populations. Give technical advice, implement health programmes, monitor and collect data, conduct operational research Can also pressure governments to recognize vaccination as a child right and to provide financing for immunization	• Solicit their assistance with policy and strategy implementation • Provide them with technical updates and coordinate on planning, monitoring, supervision • Encourage private sector to report on their immunization activities and disease surveillance information to MOH statistical services
Statisticians	Collect and analyse data that are useful for the programme and can be shared with communities as feedback for improvements	• Verify that all data collected are analysed, summarized, used in evidence-based planning and presented to the authorities and the public for feedback and action
Mass media	Communicate immunization information to the public, advocate in favour of immunization	• Brief them on immunization issues and achievements with factual information for dissemination • Solicit their support to provide technically correct updates on vaccines to prevent damaging rumours on immunization programme

Community media	Accessible to often underserved populations, it can communicate immunization information in culturally acceptable ways	• Involve them in immunization information dissemination and liaise with them to plan and implement strategies for reaching underserved • Provide them with technically sound scenarios on immunization for adaptation according to their local cultures
Politicians/policy-makers	Support policies/strategies, ensuring financing and other resources from other sectors Advocate in planning and disseminate information	• Advocate with them to guarantee sufficient funding and support to immunization programmes. • Inform them of issues and progress soliciting their involvement in promotion of positive perceptions on immunization among public

3.3 Organizational structures for communication

3.3.1 National communication structures

Interagency coordinating committee: Responsibility for overseeing the quality of communication interventions should be part of the terms of reference of the ICC. The ICC should ensure that there is a communication specialist on the team who participates regularly in ICC meetings and provides technical advice to the committee for integrated planning and coordination of activities at various levels, including (but not limited to) for specific interventions: child health days, African Vaccination Week (AVW), NIDs, polio campaigns, measles campaigns, etc. The ICC should also be involved in monitoring communication interventions (including undertaking corrective measures to address problems) and participate in resource mobilization.

ICC subcommittees: Most African countries have created a separate communication/social mobilization committee to address communication issues and provide input as a subcommittee of the ICC. These committees provide technical support and formulate strategies for advocacy and communication for social and behaviour change.

Focal point for communication: A focal person or organization, preferably a member of the EPI team, should be appointed to coordinate and collaborate with managers of health education and promotion units of MOH and partners. As a member of the ICC, the communication focal point will be responsible for developing specific indicators to measure the impact of communication interventions in cooperation with stakeholders and actors.

Subnational communication structures: The EPI manager should work with these communication structures to be sure that planning and agreements from the national level are communicated to subnational levels. Communication structures at subnational levels should also be engaged in EPI micro-planning. Social mobilization/communication committees and health services at the community and district level should develop EPI interventions, including communication based on their realities.

Case study 1: Support for district-level immunization activities

Although communities in Kulwazi Republic played an active role in previous years' NIDs, the ICC has determined that more financial resources are needed to support district-level RI activities to improve coverage and reduce drop-out rates, particularly with new vaccines being introduced. Only a few district immunization managers have put in place district-level coordinating committees.

Some districts have expressed an interest in mobilizing communities to support an immunization month to focus on low coverage areas and boost attendance for RI sessions. One higher performing district, Matapa, has encouraged support for immunization through information meetings that the district EPI manager and health educator have begun conducting with the district health assembly, mayors, and religious leaders. These meetings have encouraged their support for immunization, evidenced by more finances being budgeted for outreach services, announcements on immunization in mosques and churches, and discussions of health care at district government meetings.

The district is also implementing immunization training for its health staff, including sessions on communication with caregivers and communities as well as on the use of child health records as data management and counselling tools.

A few community leaders are providing information on immunization, but the district-level health staff have requested additional technical information from national level to encourage the support and involvement of community leaders.

Exercise 2

Answer the following questions from the case study:

Task 1: What efforts have already been made to have more information by community members about immunization?

Task 2: Which audiences need to be targeted for additional resource support?

Task 3: What are some other ways that these target audiences can be given information on why/how to support the immunization programme?

3.4 Role of community and community mobilizers/volunteers

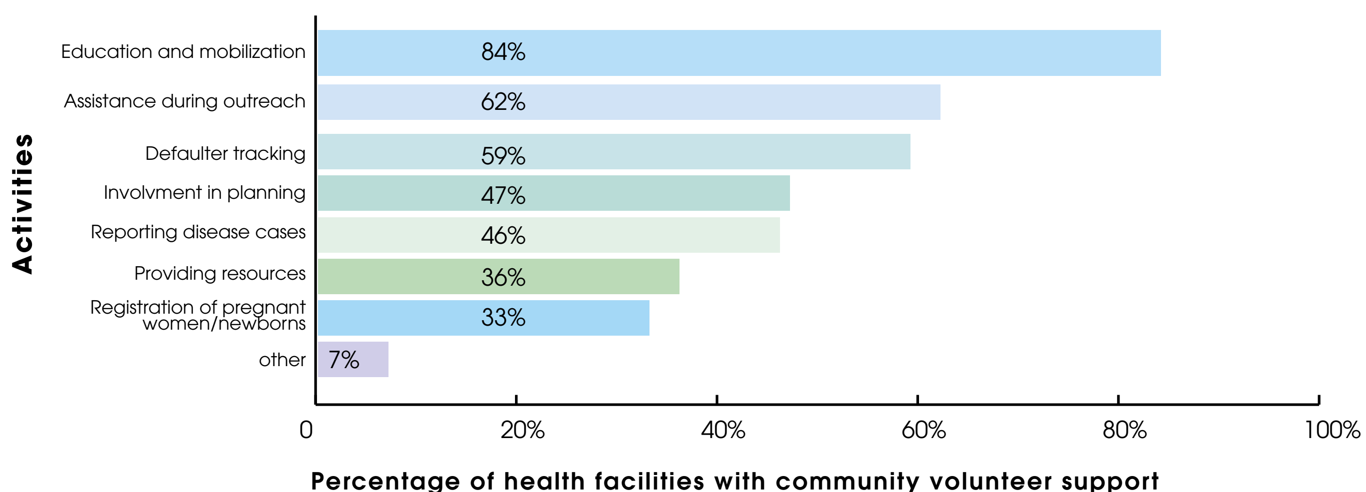
Community volunteers can be involved in planning immunization sessions and/or reporting diseases as well as in registering pregnant mothers and births. Figure 3.1 is taken from the 2007 evaluation of the community component of the RED approach and shows the share in responsibility taken by the community volunteers to improve immunization coverage.

In many countries, members of the community (either paid mobilizers or volunteers) are actively involved in linking their communities with health services. Trained mobilizers can participate in increasing awareness of preventive services like immunization. They can also assist with tracking individual children and women, participate in outreach and mobilize households for health sessions. The coverage area for each mobilizer or volunteer should be based on an analysis of the number and location of households that one mobilizer can feasibly reach.

The following is a typical list of tasks carried out by community mobilizers:

- map target populations and key resources/ services in catchment area;
- assign certain households to various volunteers;
- prepare a list of assigned households with names of infants and mothers (including newborns and pregnant women);
- share lists of names with health workers to include in vaccination registers;
- make home visits to encourage participation in fixed and outreach sessions;
- help mothers to interpret and understand immunization cards (infant cards, women's TT doses, vaccination schedules etc.);
- cooperate with the health worker to keep track of infants and mothers who need to complete the immunization series;
- trace and follow up on defaulters; and
- provide information on the session dates, place and times.

Figure 3.1 Share of responsibility taken by community volunteers



Source: 2007 RED evaluation questionnaires

The following information should be shared with parents and caregivers. Parents should keep a vaccination card detailing:

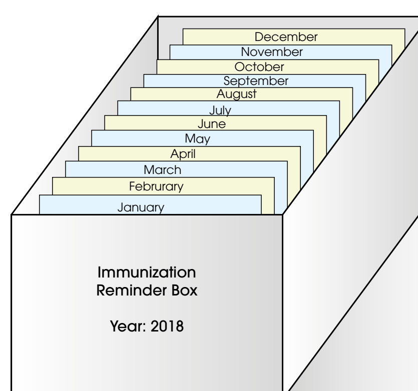
- **when** and **where** they should bring their child for next immunization;
- **the number of contacts** needed for the child to complete his/her vaccination schedule;
- what **common side-effects** might occur; and
- what they should do for **potential side-effects**.

The importance of bringing the **vaccination card** each time the child comes for health care should be stressed.

Health workers should be encouraged to involve key community members to help increase the number of children immunized by tracking defaulters and registering newborns. Mobilizers can also help health workers to identify and list the children under one year of age. In order for this to work most effectively, vaccination registers and tracking systems need to be in place.

Registers that record all children immunized must be well-maintained. Individual child vaccination cards kept in a special "tickler box" or "immunization reminder box" (see Figure 3.2) organized by month, with each card placed in the appropriate month to spot when the next vaccination is due, are useful for individual child tracking (WHO, UNICEF, 2002; MLM Module 5: *Increasing immunization coverage*).

Figure 3.2 Immunization reminder box



Case study 2: Low immunization coverage in Balajani District

Read the following and answer the questions in Exercise 3.

A recent analysis of immunization coverage data in the Republic of Kulwazi showed that several districts had low RI coverage. One district, Balajani, had coverage for BCG at 70% and DPT3 at 57%, which is lower than surrounding districts. Apart from some rural villages within Balajani, where access is difficult during rainy season, outreach activities are conducted quarterly and no vaccine shortages have been reported. However, there have been stock-outs of child health cards to record vaccinations performed.

The new district immunization focal person arrived in Balajani six months ago. Upon arrival, he conducted a short study with the subdistrict health teams and found that most of the health staff had not received immunization training in the last five to six years. The study also found that health workers were not completing the return date on child health cards, when available, and were not informing caregivers when to bring the child back for subsequent vaccinations.

The district manager met with the district health education specialist to discuss Balajani's coverage and drop-out data. He was surprised to learn that the health education specialist had not seen the vaccination coverage figures and monitoring charts. The health education specialist was, however, familiar with polio NIDs coverage data. She explained that during the NIDs in 2014, Balajani had only 80% coverage, but with intensive social mobilization activities and house-to-house strategies, the coverage was reported at 95% in 2016. She noted that some community and religious leaders had been recruited as mobilizers during the NIDs. She also described the visits that she and the previous immunization manager had made to Balajani in 2015 to the local traditional chief's compound before each NID round to provide information on the campaigns. The leader had welcomed them to his home, received the information on the campaigns and informed his community through local criers about the dates for the NIDs. During the meetings with the leader, however, they had not discussed RI; and the only message on RI provided during the subsequent NIDs and other SIAs had been "be sure to bring your child for his or her other vaccinations".

Exercise 3

In your respective groups, discuss and answer the following questions:

Task 1: What type of interpersonal communication occurred in the Balajani District?

Task 2: Are there any barriers or challenges that are similar to those that you noted in Exercise 1? If yes, list them.

Task 3: List at least three participant groups that should be targeted in this example for improved RI planning and community involvement. Name at least one activity that each participant group could support to improve RI coverage in the district.

Task 4: What are some of the communication activities that the new district immunization manager could focus on with their health team and the health education specialist to improve coverage in Balajani?

Task 5: What additional support could the national EPI programme and ICC provide to assist the district with its immunization communication activities?

4. Communication to support immunization interventions

4.1 Reaching Each District/Reaching Every Community

Un/under-vaccinated
Children may be unvaccinated (have never received a vaccine since birth) due to various reasons including geographic distance from facilities or services, refusal or lack of knowledge about vaccination by caregivers, or because they are not part of the system (e.g. refugees). Some research may be needed, such as key informant interviews or focus group discussions with community members, to determine whether facility-based and outreach services are regularly available and held according to schedule or if additional or alternative delivery strategies are needed (refer to MLM Module 5: *Increasing immunization coverage*).

Children who are under-immunized may face some of the same constraints as those that are unvaccinated. However, there are other factors that may contribute to their having "dropped out" of the system. Drop-out problems could be a result of poor quality of service delivery and/or lack of awareness of or demand for vaccination in the community. As these problems are often linked, the programme needs to address both service delivery and demand aspects in order to reduce the drop-out rate and ensure children complete the immunization schedule. In addition to determining drop-out rates by health facility, look at child health registers and cards and determine whether they are available, being kept by caregivers or health staff, and recorded and utilized correctly.

When reviewing the immunization work plan and micro-planning with health facility staff, also ensure that communication activities are included in these plans.

From the communication point of view, the following actions could be helpful to reduce the number of unvaccinated or under-vaccinated children:

- Conducting interviews or focus group discussions with community leaders to determine whether facility-based and outreach services are regularly available, held according to schedule and/or are covering underserved and hard to reach areas.
- Community mapping for identifying households for door-to-door visits, if possible with community leaders; meeting with caregivers of un/under-vaccinated children.

Addressing community participation entails addressing managerial issues, such as bringing immunization closer to communities, improving practices at fixed sites, better monitoring and supervision, increased accountability at community level, etc. Some other strategies may bring desirable outcomes such as exploring with the community innovative methods and practices, involving local people to track defaulters and referring them to services or accompanying caregivers to health centres/outreach points. In some instances, mobilizing traditional healers and other non-health workers to promote participation and peer-training of health workers from well-performing health facilities to poorly-performing centres may proof useful.

Drop-out problems could be a result of poor quality of services delivered and/or lack of awareness of or demand for immunization in the community. As these problems are often linked, the programme needs to address both delivery and demand aspects to reduce the drop-out rate and ensure compliance with the immunization schedule. The following actions are recommended:

- **Assess whether all children in the district/health facility catchment area have access to immunization services**
  Review the coverage rates for BCG and DPT1/Penta1 to determine the access to immunization. Try to determine the proportion of doses being provided through static and outreach service delivery points in the district.
- **Identify priority areas and reasons for low coverage and high drop-out rates related to communication**
  Review drop-out rates by examining health facility reports and immunization monitoring charts to find out drop-out rates: e.g. DTP1 to DTP3, or DTP1 to measles.
- **Identify possible service delivery problems (vaccine shortages, problems in cold chain, lack of outreach services, use of immunization data monitoring tools, etc.)**

In addition, examine possible communication related reasons. Do health workers know the immunization schedule? Do health workers screen properly and use every opportunity to immunize and reduce missed opportunities? Do they complete child health cards correctly? Do health workers meet with community leaders to build awareness about immunization and discuss immunization services and outreach schedules? Are caregivers informed of the number of contacts necessary to complete the vaccination schedule? Are caregivers reminded about the importance of keeping the immunization card safe?

- **Define and implement corrective measures** When reviewing the immunization work plan and micro-planning process with health facility staff, also ensure that communication activities are included. If health worker training is to be conducted, include IPC skills with caregivers as a component of the training. Encourage health staff to negotiate schedule, time, and location with communities during joint planning. All these actions are in line with the RED strategy in which communication is one of the key components. Table 4.1 provides a list of activities in support of the RED approach.

Table 4.1 Communication support for Reaching Every District

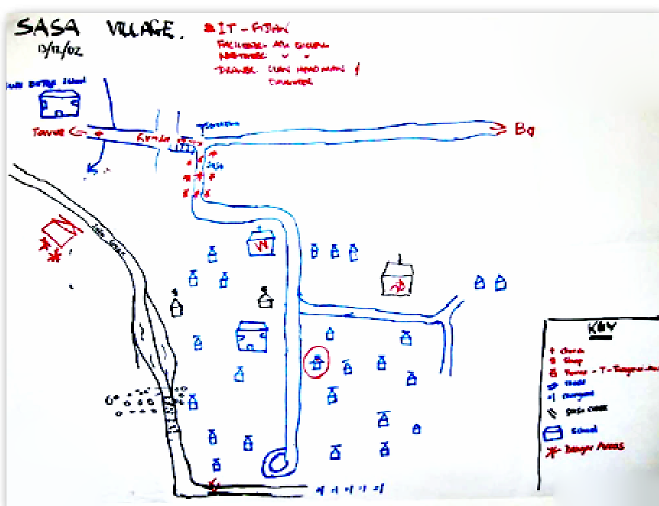
Operational components (RED)	Examples of communication support
Planning and management of resources	Advocate for resources to support training of health educators to improve their skills in support of immunization communication Include key activities for communication in overall EPI work plan and as part of EPI programme activities Include communication line item in EPI budget
Reaching target populations	Engage community in planning of immunization outreach Negotiate with and disseminate information on outreach (e.g. dates, times, location) to communities Encourage health worker to inform communities about services Broadcast outreach schedule through local media and use local contacts to inform community on immunization visit Share reports with decision-makers to show how outreach improves coverage and can reduce disease burden
Supportive supervision	Ensure that health workers are communicating appropriate messages to caregivers Observe that health workers complete child health records correctly during vaccination sessions Include communication questions in supervisory checklists and questionnaires for exit interviews Observe communication between health workers and caregivers during vaccination sessions and provide feedback Discuss key immunization messages and how to improve interaction between the health worker and the community during supervisory visits
Links between community and service	Enhance community ownership by ensuring community involvement in planning and utilization of immunization services (e.g. conduct planning meetings with community, provide community with status on immunization targets) Improve interaction of health workers and clients at every point where services are provided to the public Identify and develop links/partnership with community structures (e.g. religious groups, women's groups, NGOs, traditional leaders) Strengthen capacity of health workers/vaccination teams through training, supervision, to communicate effectively with clients and the community
Monitoring for action	Ensure that data set includes details on communication and behaviour related reasons for dropout and refusals Share immunization data with health educators and involve them in data analysis, micro-planning, work plan development and supervision Include communication component in the monitoring plan with activities strengthening links with community Insert key communication indicators as part of the list of district and facility immunization indicators that are being tracked and reported

4.2 Mapping the community and identifying networks

Many immunization programmes do or should depend on field workers or volunteers to reach people living in remote rural areas or hard-to-reach communities in the country without a good network of health care. These community-based field workers or volunteers need accurate information presented in a simple format. This task could be accomplished through the introduction of a pictorial map known as a "community map" (Figure 4.1). A community map is a simple colour-coded drawing which shows the location of different families in the community who are eligible for or potential users of immunization services as well as key community services (e.g. health centres, government offices, religious institutions, etc.). By using a community map field workers and volunteers can plan communication activities, to distribute and deliver services efficiently, and to improve the quality of service statistics they keep.

Community maps are powerful tools for health programmes that depend heavily on community involvement. Maps are used to help programme managers, supervisors and field workers/volunteers to identify target clients for health services. Supervisors can use the maps to monitor field workers' performance, analysis and making service delivery improvements, estimating commodity needs and planning programme activities. Community maps can also help managers to improve planning and decision-making, improve service delivery and to ensure that the hard-to-reach populations are identified and given special attention

Figure 4.1 Community mapping



4.2.1 Community networks

Communities are made up of a series of social networks characterized by a high level of interaction among their members, strong links of confidence and mutual help. These networks often form group-based or society-based organizations. Quite often, a few members of each network play the role of gatekeepers between two or more networks. Social networks have a crucial role in the diffusion of innovations and acceptance of health interventions (like immunization). Promoting immunization through community networks is a proven means to build trust and acceptance. Caregivers are most likely to trust other community members when they make decisions about the health of their children. A powerful way for change agents to affect the diffusion of the new idea or behaviour is to mobilize "satisfied acceptors", i.e. those whose decision to adopt the new behaviour has resulted in health, social and/or economic benefits, to persuade their peers to adopt the innovation.

It is important that the programme has a system in place at the community level to identify networks and establish the appropriate links between the health system and these groups. The following steps outline the process for community participation and engagement using these networks.

1. Establish contacts with the social networks identified in the community mapping process. Change agents should contact traditional, religious and other opinion leaders, satisfied acceptors, other sectors and organizations within the community. Advocacy should be used to further engage with these individuals/groups in order to stimulate demand creation at community level.
2. Using a participatory approach, define the levels of knowledge and practice on immunization in the community.
3. Using a participatory approach:
    - define the communication interventions that will take place at community level; and
    - chose indicators for monitoring.
4. Collect and analyse data.
5. Provide information and feedback on EPI to communities and to the higher levels (district, region).
6. Re-plan and adjust interventions accordingly.

4.3 Resistance/hesitancy and refusals

4.3.1 Analysing and addressing resistance and building public trust in immunization

Refusal to vaccinate is a common challenge for immunization service providers, both for RI and SIAs. It is important to fully understand the reasons for resistance or hesitancy. This requires careful analysis to determine the extent to which the hesitancy/refusal of services is due to service delivery problems or demand. Table 4.2 can be used as a guide to analyse the issues related to the resistance and some possible actions that could be taken to address this.

Table 4.2 Addressing immunization resistance

Summary of resistance issues	Options for addressing resistance
Source of resistance: Does the resistance represent mainstream thinking? If so, consider options 2, 4 and 6. Are there resistant outcasts or radical elements? If so, consider options 1, 3 and 5.	Option 1: Avoid drawing attention to the source of the resistance. Take action to reduce resistance indirectly by increasing the flow of correct information.
Underlying issues of resistance: Is doctrine represented as opposing immunization? Is opposition used to further a political agenda? If an agenda is broader than objection to immunization, consider options 1, 3 and 5.	Option 2: Develop allies, approach leaders of the same group who are not part of the resistance. Keep the emphasis on the health and survival of children.
What impact does resistance have on the community's use of immunization services? Despite the objections voiced by a religious group, the community's behaviour may be significantly affected. If so, consider options 1 and 5.	Option 3: Send someone appropriate or go to the area affected by the resistance and assess the situation. Talk to community members, local government officials, health professionals as well as religious and traditional leaders, to separate fact from rumour and to ascertain the scope of the problem.
Are people reacting to real or perceived dangers of immunization? If due to an actual negative event (i.e. an AEFI), consider options 3, 5 and 7. If due to perceived or rumoured dangers, consider options 5 and 6.	Option 4: Approach the leader(s) of the resistance. Face-to-face is useful for dealing directly with resistance. Explain the consequences of their resistance on the lives of their children. Help the group separate its personal/political agenda from that of child survival.
Distinguish between the active resistance of a group and an underserved population that happens to belong to that group: Addressing an underserved group will take a different strategy to one where the group is actively resisting immunization.	Option 5: Increase communication on immunization at all levels. Revitalize channels already in use: community groups, health workers, vaccination outreach teams, radio and television broadcasts.
	Option 6: Use the media prudently. While there may be a call for a direct response on the national media – especially if the resistance movement has received similar coverage – use national media first to increase emission of correct messages on immunization. The messages can be shaped to appeal to the resistant group (see option 2), while not mentioning the actual incidents.
	Option 7: Tackle service delivery problems. If the group reacts to a real danger from vaccination (a child gets sick or dies), rather than to a perceived danger (rumour), find ways to bring the group's views to local service providers and the health system in a constructive way. Assess the relationship between the health centre/health workers and members of the resistant group. Address health worker practice concerns.

4.3.2 Interpersonal communication

EPI staff should also master IPC techniques to be applied during communication with colleagues, partners and community members and others. Interpersonal communication is two-way communication, where speakers can exchange information and ideas, listen to one another, ask questions, and provide help and support. It is a key component of communication for immunization, as a tool for health workers, social mobilizers, community leaders and others to engage communities and build confidence and generate demand for immunization. In IPC, heath workers build a rapport with parents and communities by being respectful of culture and social customs, providing information in the appropriate language and level of literacy, and spending the time parents need to ask questions and discuss issues of concern.

Communication can be verbal or nonverbal. Verbal communications are based on speech-tone, volume-speed, quality of the sound, language (mother language, preferred language, slang, dialect, jargon, etc.). The non-verbal type includes gestures, facial expression, muscle tone, eye contact, body language, listening etc. Depending on the occasion, IPC is used during face-to-face communication (dynamic communication), in small group discussions or in public communication. For improved immunization coverage outcomes, IPC must happen at all levels of interaction with the community.

What do health workers, community health workers, social mobilizers and leaders need to practise IPC?

- IPC skills, acquired through training on the reasons and methods for IPC;
- knowledge of the culture they will be working with;
- knowledge of the key messages they are bringing about the basic reasons for vaccination, the vaccines the child will receive, the possible side-effects and the date of the return visit; and
- job aids and information, education and communication (IEC) materials such as simple flipcharts, posters or brochures appropriate to the literacy of the communities they are working with.
- Core IPC skills can be categorized as the "GATHER" approach: greet, ask, tell, help, explain and return.[4]

Greet actions

- when you meet someone in a facility or visit a household, greet everyone according to cultural traditions;
- introduce yourself, what you do, and the purpose of the meeting; and
- when inviting caretakers to meet with you, be sure they can sit in a comfortable place (in the shade for example).

Ask actions

- allow the caregivers to talk and ask questions;
- ask questions in the household about the child's health, age, vaccination status;
- use open-ended questions to elicit more information (e.g. about vaccine hesitancy);
- listen to the caregivers' verbal and non-verbal language, encourage them to talk;
- keep your body language positive and open and keep eye contact;
- give time, don't hurry and stay patient; and
- respect all opinions.

Tell actions

- tell people what they want to know, reinforce what they know already, and provide information about any misconceptions; and
- don't pretend to know everything – if you don't have the answer, tell them you'll return with it (and do!).

Help in the decision-making actions

- help caretakers to overcome personal fears or beliefs;
- help caretakers to overcome religious or social beliefs; and
- explain why children need multiple doses of some vaccines.

Explain actions

- where possible use IEC materials and job aids for higher retention;
- keep language simple using local idioms;
- use local examples, language and personal stories;
- explain what vaccines the child will be receiving, their purpose, what side-effects might be, and when the child should return; and
- explain the purpose and importance of the vaccination card and bringing it to the next visit.

4 The IPC section is adapted from the UNICEF guide (2014), Training curriculum: Increasing interpersonal communication skills for the introduction of inactivated polio vaccine (IPV).

Repeat actions

- repeat visits and discussions wins trust and engagement; and
- repeat the same respectful, open behavior every time you see the caregivers.

IPC training

IPC training should be participatory – an exchange of information, ideas, questions, answers, examples and listening. It should use adult learning principles and methods, including learning-by-doing activities, large and small group discussions, brainstorming, role play and practice in the classroom. The training should aim to build the confidence of the trainees, so that they have a good grasp of both the technical information required to discuss vaccine issues with caregivers, and the IPC skills to engage caregivers in the most productive way possible.

4.4 Coping with rumours

People with varying interests (for example, traditional healers, medical or general press, politicians/political groups, anti-vaccine groups, religious/cultural objectors, media and, sometimes, health workers) may start rumours about vaccination programmes. The spread of rumours may reflect inadequate or inaccurate knowledge, a mistrust of the government or ulterior motives such as greed or a desire for publicity. Examples of rumours include: "OPV, HPV or tetanus vaccines are contraceptives to control population or to limit the size of a certain ethnic group"; "vaccines are contaminated by HIV or mad cow disease"; "children are being experimented on with AIDS vaccines during polio and measles campaigns", etc. Adverse events following immunization can also lead to the spread of rumours about immunization and should be properly examined and responded to.

4.4.1 Responding to rumours

Analyse the situation: Move quickly to respond to rumours, but first:

- Clarify the extent of the rumour or misinformation (type of messages circulating, source, persons or organizations spreading the rumour).
- Determine the motivation behind the rumour (e.g. lack of information, questioning of authority, political or religious opposition, AEFI).
- Turn the rumour around. Go to the source and ask what the solution is. Acknowledge existing shortcomings, if necessary. Offer the source an opportunity to be part of the solution.

Advocate

- Target key opinion leaders for meetings (politicians, traditional and religious leaders, community leaders, and health workers).
- Launch a corrective campaign at the highest level (e.g. the minister of health, governors, district administrators, etc.).
- Meet with local leaders at sites where the individuals/groups are comfortable and can feel at ease to ask questions and have peers present.

Strengthen alliances

- Involve all immunization partners through social mobilization committees, ICCs etc.
- Alert and collaborate with relevant ministries and NGOs.

Conduct training

- Train volunteers and health workers to handle rumours.
- Disseminate tailored information on common misconceptions and guidelines on response.
- Promote positive key messages.

Mobilize communities

- Empower local people to address and take responsibility for the issue.
- "Demystify" immunization through education, taking the initiative to the community via such channels as films, street players, schools, community seminars and discussion groups.

Get assistance from the health community

- Seek collaboration from health professionals in the public and private sectors, including doctors, nurses and vaccinators, NID volunteers and other members of partner organizations.

Contact media

- Contact persons or groups that have already misinformed the public and provide them and other appropriate media (TV, radio, newspapers and street theatre) with credible, factual information on the controversy.
- Call on previously established relationships with the media. Delegate one spokesperson to handle all media questions.
- Arrange for respected authorities to support the programme publicly. For example, a key politician giving oral polio vaccine (OPV) to his/her baby. Use print materials to provide answers to common questions, to correct common misconceptions and to deliver positive messages. Target key opinion leaders.

4.4.2 Preventing rumours

- Be proactive – budget for and implement ongoing activities to prevent and limit rumours.
- Use local NGOs, religious organizations or community groups that command respect as mobilizers and educators.
- Involve community leaders in planning and implementing health activities.
- Approach communities early, and make frequent contact.
- Present health issues as national social, economic and security issues.
- Discuss immunization campaigns with public and private practitioners in advance to obtain their support.
- Make communication and social mobilization a continuous activity. Design strategies that establish continuity between NIDs and RI. Disseminate consistent messages.

Case study 3: Resistance in the Kulwazi community

Based on information on resistance from the Kulwazi community, the EPI manager has proposed that, to improve drop-out rates and address lower coverage districts, there is a need to intensify vaccination services and activities in the poorest performing provinces early next year. Although some districts have conducted RED activities, they have not continued and community involvement was inadequate.

Immunization assessments and NID findings from past years revealed that some of these districts have lower coverage due to nomadic groups that have been difficult to reach and sects that have refused immunization services for religious reasons. In addition, vaccination teams reported resistance to immunization services during outreach sessions and during SIAs in some areas that have traditionally had lower coverage, but did not provide details.

Exercise 4

Divide participants into four groups. Ask them to read the case study about resistance in the Kulwazi community and answer the following questions:

- What communication and mobilization strategies could immunization staff use to reach these target groups?
- What communication approaches could immunization staff use to inform communities and gain the target audiences' acceptance of immunization?
- What communication activities could immunization staff use to dispel rumours?
- What are some possible reasons for "resistance" by these communities? Provide some examples of misconceptions?

4.5 Crisis/risk communication

Every immunization communication plan should include a crisis/risk communication plan. The Global Vaccine Safety Blueprint (WHO, 2012) recommends that every country should develop a vaccine safety communication plan as part of an integrated communication plan, aimed particularly at communities, health-care workers and decision-makers. The Blueprint stresses that any vaccine safety concerns should be investigated and promptly communicated appropriately.

4.5.1 Causes of immunization crises

- The coincidental death of a vaccinated child occurring during a campaign.
- An adverse event with grave consequences that can initiate rumours and vaccine hesitancy with caregivers.
- An outbreak with poor and late response from decision-makers.
- A vaccine stock-out during a campaign or RI causing mistrust in health system.
- Poor communication about changes in immunization schedules – e.g. a perceived sudden introduction of a new vaccine without involving relevant stakeholders (such as consulting religious leaders).
- A new vaccine introduction.
- Misinformation from anti-vaccination campaigns from the internet.
- Groups with their own, possibly unrelated agenda (e.g. political, social, ethnic) spread rumours to destabilize programme or even take violent action against health workers.

Events or public perceptions in other countries – even other continents – can have an impact on people's understanding of and trust in vaccines. A crisis left unmanaged can erode trust in EPI and other health programmes very quickly. An AEFI linked to a cluster of illness and deaths during an SIA, for example, can have

an impact on people's trust in vaccines, health workers and the government, and can result in mistrust of RI in general.

4.5.2 Crisis plan

- Identify and train key spokespersons at central and regional level. This action is aimed to maintain and quickly restore trust in EPI through a plan to provide reliable, transparent, correct information rapidly and regularly, including actions being taken by leaders, and those required by the public.
- Provide standard operating procedures and clear direction on managing a crisis – including a chain of command with clearly articulated roles and responsibilities, rapid processes for agreeing next steps and activities; a process for designating spokespeople. Have an AEFI/ crisis communication group/committee within EPI or health promotion unit. The composition of this committee should be a mix of programme and communication experts.
- Provide continuous briefings with journalists and media agencies. This will greatly reduce the risk of news reporting in favour of any false rumours and simultaneously challenging the safety of vaccines, as many examples in the region have shown.
- Include a contact list:
  - all stakeholders who need regular updates
  - media.
- Consider the same mix of strategies and channels as communication for development (advocacy, social mobilization, social and behaviour change communication).
- Plan methods to listen to the views and concerns of all groups. For example, prepare how to monitor public concerns through community contacts, the media and social media.
- All key stakeholders (e.g. minister, EPI manager, key partners) should be in agreement.

Tailor the strategy to the situation – if, for example, the crisis is not receiving public attention, a local meeting with the community may be adequate. If the crisis is causing nationwide anxiety, the communication plan requires a national scale intervention by the minister of health with the possible involvement of WHO and UNICEF representatives. Be proactive and implement the strategy rapidly. Aim to stop the crisis before it gets larger.

At the start of the crisis

- Designate respected and trained spokespeople – people tend to trust scientists and experts more than politicians. The spokespersons should be identified beforehand – not when the crisis begins.
- Analyse the risk – is this a low-, medium or high-impact event, and respond proportionately.
- Set communication objectives – for example, to provide information, stop a rumour, protect the public, call for collective action.
- Identify your target audiences and understand their concerns and needs; and remember marginalized and high-risk communities.
- Ensure coordination with other relevant parties – such as local health units and schools.
- Ensure each stakeholder knows their role and responsibilities.
- If required, ensure an investigation is carried out rapidly, and results communicated – ideally in coordination with trusted partners such as WHO and UNICEF.

Public announcements and information

- Timing – the public announcement should be timely and partners should know when it's coming so they too are prepared.
- Transparency – the messages should be easy to understand, complete, factually accurate and up to date.
- Prepare and update these materials regularly. Make public information available via a website and/or in social media:
  - key messages appropriate to each audience about health risks, uncertainties and measures to take to protect oneself
  - talking points, updated and circulated regularly to everyone who needs them
  - frequently asked questions
  - news releases and holding statements
  - ensure the information is packaged appropriately for all groups.
- You may not have all the information or answers – it's ok to tell the public that you "don't know", but then find out and follow up with more information.
- Listen to the public and their concerns – and address these through media statements or community meetings.
- Consider setting up a hotline, with trained staff who can listen to public concerns and answer questions.

Audiences

- The minister of health, other relevant ministries and senior government/policy staff should agree with the plan developed together as a team addressing specific concerns. It should be owned by and led by MOH.
- Political and other opposition – appropriate people should proactively meet key leaders and provide them with correct information in a timely manner.

- Health workers – should be regularly briefed with the right information to address and help manage the crisis.
- Partners – there should be a plan to ensure partners receive key information on time to help manage the crisis.
- Media – can help to manage a crisis with correct, timely information, but can also spread rumours quickly if they don't have the right information. Media may have a low understanding of what vaccines are for and how they work. Be proactive to give them the basics of why vaccination is so important. It is always helpful to have a media orientation before the introduction of a new vaccine and before campaigns, with a focus on crisis communication and emphasis on verifying any rumours or news related to vaccines before broadcasting or publishing.
- Traditional or religious leaders – find out what their beliefs are, and respond to their questions or concerns and work effectively with them.
- Communities – find out which communities are concerned with the crisis and work directly to resolve it. Establish channels of communication with them with their trusted sources.
- Subgroups within communities – find out the at-risk population such as the minorities, e.g. women and disabled people and develop ways to reach them.

4.6 Reaching the hard-to-reach populations and areas

Delivery, supply, quality and demand issues influence the use of immunization services, as noted in Module 5: *Increasing immunization coverage*. For a variety of reasons, certain groups remain unreached by immunization services. Some are absent when services are available, some are not in areas reached by services or outreach, some reject them, and others dropout of the immunization programme. Reasons range from lack of information, religious and traditional beliefs, difficulties in access due to infrastructure and terrain, to economic and/or political situations that have caused these populations to migrate, among others.

Table 4.3 identifies some special groups and outlines possible communication strategies to reach them. In all cases, communication planning should begin early. It is important to ensure that communication plans at all levels take into special consideration these particular groups. Communication strategies should be sensitive to people's beliefs, practices and constraints. They should utilize IPC to the extent possible. They should be coordinated with delivery of services.

Difficult terrain and inadequate infrastructure can cause access and communication problems

Table 4.3 Communication strategies for hard-to-reach populations

Group	Proposed communication strategies
Nomadic/migratory groups and families	Determine dates, entry and exit points and locations where large numbers of these groups come together, then plan/implement activities. Utilize members and former members of these communities as mobilizers and vaccinators. Prepare/use mobile teams. In border areas, carry out planning and coordinated actions with the neighbouring jurisdiction.
Ethnic or other minority groups	Brief traditional leaders to encourage their support. Put in place a team of local mobilizers/educators to work with these communities.
Families that fear contact with government (e.g. lack proper documents)	Work with local NGOs providing assistance to these families and use local mobilizers/educators and community groups/leaders to provide information and talks on importance of vaccination.
Groups with difficult physical/geographical access	Ensure transport to reach these groups for service delivery. Put in place a team of local mobilizers/educators to work with these communities.
Religious or traditional sects that refuse vaccination	Identify and brief the leader(s) of the sect or religion to encourage their support and discuss their concerns. With the participation of their leader, meet with members to inform/educate them about the initiative and vaccination. Plan and implement activities with their community groups/leaders at locations and dates that do not conflict with cultural/religious events.
Refugees	Work with local NGOs providing assistance to these families. Identify leaders among the refugee populations and organizations in the camps, and then try to convince them to advocate for and educate on vaccination.
Wealthy/elite groups and their staff	Use high-level political and/or society leaders (local Rotary clubs, diplomatic missions, etc.) as advocates – credible, knowledgeable and respected people in that community. Provide educational materials explaining the initiative and outlining the benefits and public health importance of immunization. Engage private doctors and health officials as advocates, educators and vaccinators. Provide information through mass media and IPC targeted at these individuals.
Homeless families or families in dense urban areas; street children	Use community mobilizers to provide information in the neighbourhood, particularly at common gathering places (e.g. markets, water sources). Identify and engage any leaders, organizations and women's groups that can act as advocates, mobilizers and educators.

4.7 Communication for disease surveillance

The EPI manager and district EPI staff must ensure that data from all levels are received, analysed, and feedback provided for programme improvements between the national structure and the lower levels. Health facilities should also provide feedback to the community in their own and surrounding areas.

Disease surveillance committees that exist at central levels and in some districts can assist with this and should include an epidemiologist, a statistician and a communication expert. The epidemiologist will ensure the collection of relevant data, the statistician will carry out data analysis to facilitate its interpretation by the EPI manager, partners and community members. The communication expert will help the EPI manager present and communicate the data to the community in a participatory and precise way and mobilize community members to support facility-based surveillance by detecting and reporting cases that may go undetected by the health facility. Reports by community members should be incorporated into the overall surveillance data managed by health personnel.

4.7.1 Communication methods for surveillance

- dissemination of disease prevalence and morbidity and mortality data during community meetings and gatherings;
- dissemination of information through newspapers and other publications;
- radio and television news flashes on disease outbreaks and control measures;
- press conferences on diseases/outbreaks to brief the media on what health authorities are doing;
- publication of bulletins or newsletters;
- training members of communities in surveillance activities, including data collection, analysis and reporting (community surveillance);
- electronic dissemination of information (email, internet); and
- dissemination of information on best practices in the country.

4.7.2 Surveillance topics to be included in a communication strategy supporting surveillance activities

- describe the signs and symptoms to look for, using disease names that local people commonly use;
- encourage communities to report similar cases to the nearest health facility;
- highlight the severity of disease outbreaks (e.g. measles or cerebrospinal meningitis epidemics);
- map the regions affected by outbreaks or emergence of diseases;
- note the number of children or adults affected;
- communicate the period of outbreak of diseases (e.g. there is a high incidence of measles that begins at the end of the rainy season and continues during dry season);
- mention the support and contribution made by the community;
- outline the progress made or the successes recorded;
- advise the community on how to prevent their children from getting the disease; and
- advise families and the community on how to manage children or adults with the disease.

4.8 Communication for supplementary immunization activities

This section highlights some of the issues related to planning communication activities for SIAs (e.g. polio, measles, maternal and neonatial tetanus – MNT). As stated earlier, the EPI manager will need to ensure that a communication focal point works with the EPI team to support the development and integration of communication in SIAs plans at all levels.

4.8.1 Planning

Planning for SIAs should begin 9–12 months before the planned SIA. Communication activities should be integrated within SIA plans at all levels and for all aspects, particularly the micro-planning. Plans should be based on an analysis of coverage data from previous rounds, including missed children and on communication related research. Specific communication strategies should be developed for border and conflict areas, migrant groups, resistant groups. Plans should be developed to address potential rumours and/or refusals. In addition, strategies should be in place for reaching un/underserved populations. The planning should include communication activities for before, during and after the SIAs.

4.8.2 Strategies

The communication strategy (advocacy, social mobilization, social and behavioural change communication) will need to be adapted, tested and implemented to suit the type of SIA being conducted, taking into account the following:

- disease being controlled/eradicated
- age group being targeted for the SIA
- SIA strategy being used: fixed, outreach, mobile or house to house
- region(s) being targeted and potential political, cultural and/or religious differences.

4.8.3 Training

- Communication aspects need to be integrated into the training and monitoring of mobilizers, vaccinators and supervisors.

- Training modules for IPC for vaccinators and partners should be developed and staff/partners trained, particularly for house-to-house vaccination, but also to ensure communication on the importance of RI.
- Health workers, vaccinators and mobilizers need to know key messages for the different groups, which should be addressed in training and supervision.

4.8.4 Monitoring and evaluation

The EPI manager should ensure the following key elements are included in the plans, and monitored during the SIA:

- advocacy with political, religious and traditional leaders for SIAs and support for RI;
- resource mobilization (financial, human) to support immunization and SIA activities;
- intersectoral collaboration;
- social mobilization at various levels, including ensuring mobilizers are active in the field before and during the SIA;
- communication activities conducted before, during and after SIAs;
- vaccinators' communication with caregivers/ sources of information/high-risk areas/ awareness level and
- training of vaccinators and mobilizers should include messages for the different groups mentioned above (community leaders, caregivers, etc.).

4.9 Communication for immunization safety

The safety of vaccines requires both sufficient and appropriate tools (supplies and equipment) and management and supervision systems that support the correct use of those tools. Regardless of good systems, negative reactions to the vaccines or adverse events can occur due to chance or through improper injection technique or poor handling or conservation of the vaccine. Adverse events that occur within a few days of the immunization session can clearly be interpreted as resulting from the vaccination. Consequently, it is important to prevent, control, report and carefully examine the causes and effects of AEFI in order to take appropriate measures.

Messages relating to adverse events must be disseminated rapidly to prevent rumours and other wrong interpretations. AEFI can have repercussions on the entire RI programme and campaigns. Where medical interventions are necessary, they should be carried out as rapidly as possible.

Once an AEFI has occurred, the reaction should include the following communication elements:

- Communicate immediately with the MOH, ICC and other high officials.
- Provide the parents with factual information. Remember that some parents may seek information elsewhere and you may lose credibility if you do not provide a trustworthy and technically sound response. The public and the other stakeholders have a right to know exactly what happened.
- Reassure parents, caregivers and adults that necessary measures are being taken so that members of the community and caregivers are kept informed.
- Communicate the results of the investigation to programme managers and to EPI officers at all levels.
- If the AEFI was caused by a programme error, tell the public what steps are being taken to prevent similar events in the future.
- Broadcast an official statement about the event on radio and television and publish a statement in newspapers.
- Repeat the message to dispel all fears.
- Constantly reassure the public of the safety of vaccines.

Injection safety measures to prevent the spread of hepatitis, HIV/AIDS and other viruses via contaminated needles and syringes are also critical. While vaccination injections represent less than 10% of all injections and generally are the safest ones, prevention of disease spread through proper handling of syringes and needles during and after vaccination sessions is critical.

4.10 Communication strategies for introducing new vaccines and technologies

4.10.1 Introducing new vaccines

When introducing new vaccines, communication plays a crucial role to inform parents and caregivers on the the following:

- the new vaccine, its effectiveness and safety
- the diseases that can be prevented by this vaccine
- how the vaccine is administered
- the need for multiple injections
- potential AEFI and their management
- communication for immunization beyond infancy (i.e. life course).

Appropriate basic messages for the public need to be developed and tested, based on target audience analysis (e.g. through KAP or other studies or assessments) to assure them that the immunization service is now improved because it offers protection against more

diseases and that these vaccines are highly effective and have virtually no side-effects.

Introduction of many of the new vaccines is compatible with existing RI schedules thus ensuring that children receive more protection early in life but also minimizing efforts for health workers and caregivers (i.e. by not increasing the number of visits required and/or to enable coordinated logistics and programme management).

The precise type and timing of protection of the new vaccines are somewhat difficult to explain to the public. In the case of hepatitis B, the effects will not be seen for a generation, since the virus is mostly manifested in liver disease in adults. In the case of Hib and pneumococcal conjugate vaccine (PCV), the vaccines protect against more severe strains of pneumonia and meningitis causative agents (but not all). Similarly, rotavirus vaccine protects against severe diarrhoea caused by the rotavirus, but will not prevent diarrhoea caused by other diseases or contaminants, and this is a challenge for communications.

Given these complicated scenarios, it is best to describe the vaccines' benefits in general and familiar terms to the public and the media and avoid going into details that could lead to confusion. Pre-testing of messages is a key strategy! Health workers need to understand the details regarding the new vaccines and corresponding diseases, so that they will be convinced of the importance of the new vaccines and can respond knowledgeably to questions from the public or the media.

The introduction of new vaccines and technologies can provide an opportunity to improve overall services, re-motivate health staff and build public demand for RI. For example, with PCV and rotavirus, there is a need to ensure awareness of the public (and health workers too) that they prevent the most severe strains of the diseases (greatly reducing morbidity and mortality), but not all of the cases caused by other strains of the microbes. As for caregivers, there is a need to ensure that they understand the importance of providing multiple injections during the same visit! The addition of new vaccines and auto-disable (AD) syringes means that a country's immunization service is "improved", since users can now be protected against more diseases (directly through immunization and indirectly through safer injection). This idea needs to be promoted among the public and the health staff.

The bigger issue that countries are facing now is the need for increased capacity of cold chain and the accumulation of additional medical waste due to additional injections, with more used vials and syringes discarded. Special communication messages therefore are needed to address these changes.

As systematic infant immunization programmes became a fixture of the healthy child growth process in all countries, there is need to promote immunization beyond one year of age in children. Countries are encouraged to introduce measles second dose at 18 months for all children, human papilloma virus (HPV) for girls between 9 to 13 years and tetanus toxoid (TT) for women of childbearing age. Where there are outbreaks, vaccines such as yellow fever, meningitis A, OPV have been administered to an older age group where special considerations for communications have to be employed.

Communication for immunization beyond infancy calls for a multi-sectoral approach including other ministries such as education to reach school age children. Behaviour change communication strategies should be planned for and implemented, targeting parents and caregivers to inform them of the benefits of the additional vaccines to the RI schedule. Formative research on KAP toward the targeted diseases should be conducted to inform communication plans and respond to parents' and caregivers' concerns. A crisis communication plan for the targeted vaccine is necessary to manage AEFI for the targeted vaccines. For the vaccines being introduced into the RI programme such as measles second dose, it is necessary to develop some sort of reminder system (i.e. cards, community follow up, or SMS messaging) and make use of a well-maintained defaulter tracking system.

4.10.2 Timetable and outline for communication planning for new vaccines

Ideally, planning should begin at least six months in advance of the introduction of new vaccines. The communication strategy in the plan should be appropriate to the characteristics of the new vaccines or technologies and should comprise new vaccine launch, programme implementation, monitoring of activities as well as the pre- and post-introduction evaluation.

The programme may require the following activities: re-design of the immunization schedule, child health/ immunization cards and recording forms; vaccine and syringe distribution patterns, vaccine storage; training of health workers about vaccines to be able to respond to the public's questions. The latter will require preparation of technical and training materials for health workers. Separate subcommittees may be needed to plan training, logistics and community mobilization activities.

The following outline can be considered a model for communication planning regarding new vaccine (e.g. rotavirus vaccine) introduction:

Examples of immunization objectives

- Reduce under fives morbidity and mortality due to diarrhoea through the introduction of rota vaccine within child immunization schedule linked with other child survival interventions (breast feeding, vitamin A supplementation, growth monitoring, etc.).
- Ensure that every child is immunized on time and completes the recommended routine immunization schedule, including rota vaccine.

Examples of communication objectives

- By 2016 45% of communities in province X achieve individual and community understanding of rota vaccine benefits in protecting children against severe diarrhoea. Use this opportunity to promote other preventive interventions such as personal and environmental hygiene.
- In 2016 launch introduction of new PCV nationally in a way that boosts demand and utilization of routine immunization services.
- Ensure readiness to respond to at least 80% of crisis by 2016 caused by AEFI among children immunized with new vaccines and deal with false rumours about vaccine safety and effectiveness.
- Develop, implement, monitor and evaluate evidence-based communication strategies by June 2016.
- During this planning period (2013–2017) support advocacy efforts in all provinces in the country to increase recognition of, commitment to and resources for pneumonia prevention and control.

Examples of expected results after social and behavioural interventions

- The achievements of the above objectives could result in the following behavioural changes which usually are documented through KAP research or other studies/assessments:
- Increased and sustained demand for RI which includes new vaccines with full and timely completion of the vaccine series according to the updated national immunization schedule.
- Improved skills of health personnel and community health workers, in IPC with caregivers on immunization and the new vaccine(s).
- Additional support of leaders and influencers for promoting RI and healthy behaviours of population and for timely response to crises caused by rumours and allegations about vaccine safety and efficacy.

Possible participants

A strategy will be used to identify key participants and facilitators that could lead to adoption of new behaviours associated with introduction of new vaccines. Based on existing knowledge, key participants will include:

- families
- health workers
- media staff
- advocates/influencers/opinion leaders.

Strategies, channels and messages

- Use KAP or other research findings to formulate key strategies, identify appropriate channels of communication and develop key messages.
- Key messages should be standardized and based on a selected number of behaviours to support priority interventions. They should be field tested in order to exclude multiple or inconsistent messages which can be ineffective and confusing.
- The complexity of the new vaccine introduction plan with multiple communication activities and messages may require phased implementation.
- Strategies related to new vaccine introduction should also include integration of related initiatives such as training, environmental hygiene, nutrition and others, to ensure synergy of key messages to communities and caregivers.
- Other opportunities such as World Pneumonia Day (12 November annually), Global Hand Washing Day (15 October annually), MCH weeks/days, Africa Vaccination Week, etc. should be used to support advocacy for new vaccine introduction.

Case study 4: Introducing new vaccines in Kulwazi

The Republic of Kulwazi has received word from GAVI that its application has been approved to introduce pneumococcal vaccine next year. Although national coverage with DPT3 has increased and is reported at 85%, several districts still have access problems and approximately 40% of districts have drop-out rates higher than 15%. The country has also instituted case-based measles surveillance and is beginning to improve its follow-up investigation on AEFI reports related to measles vaccination. The surveillance system has improved, but a community surveillance component has not been developed, particularly in lower coverage districts. Acceptance of vaccination has been good, but a popular local radio announcer in one of the districts has recently been broadcasting messages about vaccinations being associated with the spread of HIV/AIDS and some health workers have raised concerns about the additional injections that must be given with the new vaccines.

Exercise 5

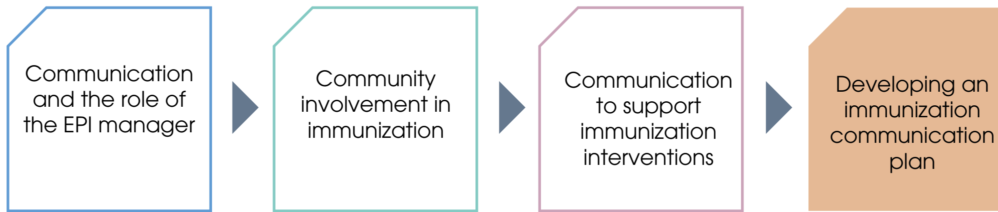
Form four working groups and assign one of the following tasks to each group to discuss and present the results to the plenary.

Task 1: Based on the information above and previous case studies, what are some challenges for the introduction of new vaccine?

Task 2: How can micro-planning be improved (including the use of community mapping, identifying un/under-immunized, and working with the media and private sector)?

Task 3: How could communities be further engaged in surveillance activities?

Task 4: What communication strategies are needed to address injection safety issues?



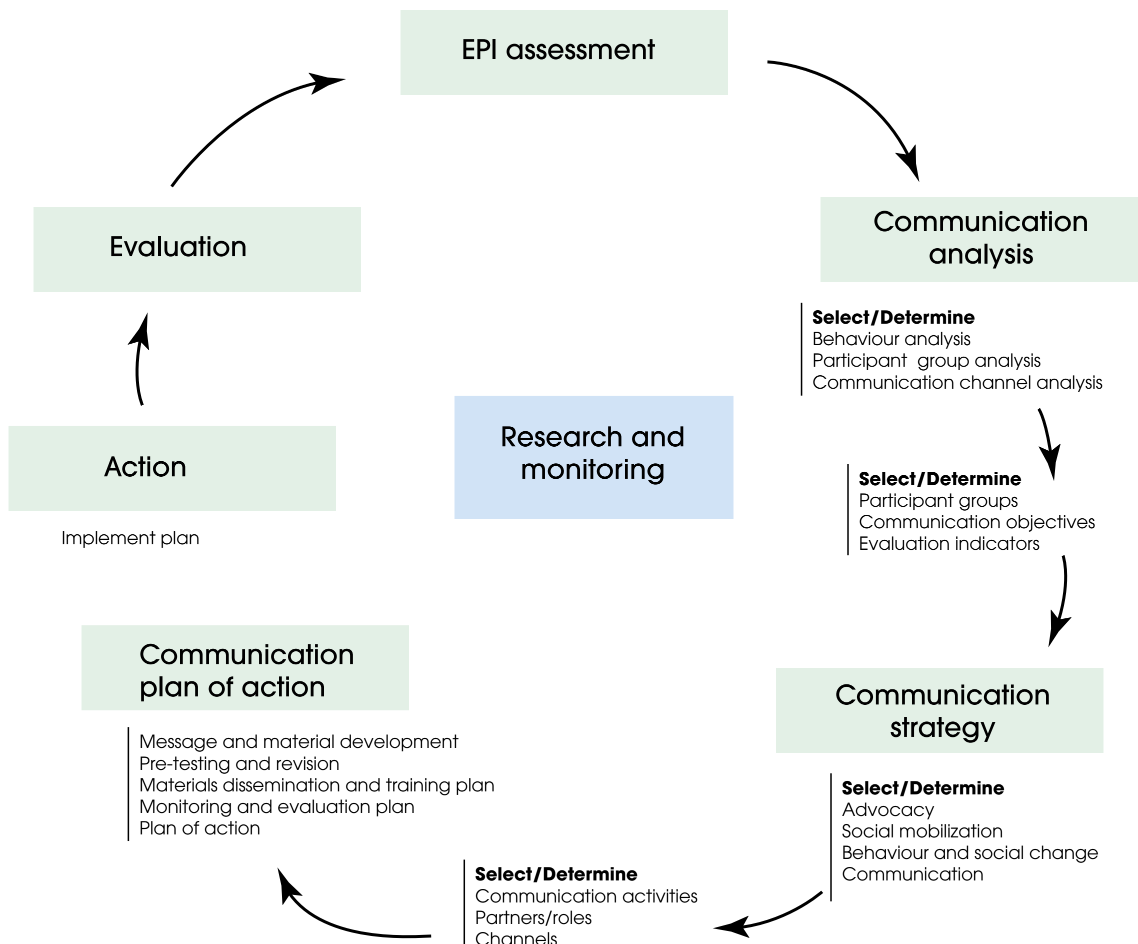
5. Developing an immunization communication plan

5.1 Communication – a key strategic objective of EPI

The planning process for multi-year and annual plans of EPI activities is described in Module 4: *Planning immunization activities.*

The immunization communication plan should be comprehensive, addressing all aspects of EPI (routine, SIA, surveillance, new vaccine introductions, outbreak preparedness, and disease control). Communication needs to be integrated in the planning from the beginning in order to ensure necessary funds for materials, training, monitoring and implementation of other activities, and operations to ensure quality interventions in support of the EPI programme. Figure 5.1 summarizes planning process comprising various elements which should be monitored using communication indicators and behavioural research.

Figure 5.1 Communication planning process



5.1.1 Components of communication programme management

- documenting evidence to guide communication planning;
- developing a training curriculum and material to strengthen the capacity of EPI managers, health staff and vaccinators in the field of communication;
- designing communication interventions for specific groups (with clear objectives, indicators, strategies, activities and risk assessment);
- developing and ensuring that tested communication-related tools are available, accessible and used by teams at various levels (e.g. immunization cards with information for caregivers, counselling cards for health workers, advocacy and media guides, key immunization messages, guidelines for community involvement);
- developing tools to monitor the process and outcome; and
- developing a mechanism for supportive supervision.

5.1.2 Developing the communication plan

The development of the communication plan for EPI is often entrusted to the communication focal point or to a health education unit. The EPI manager is responsible for including this communication plan into the EPI plan and for ensuring that planned communication activities directly support EPI programme objectives. To create and sustain demand for vaccination services, reach participant groups and increase coverage rates, the various components of the immunization programme (logistics, surveillance, programme management, service delivery) need to be combined and supported by well-planned communication strategies and activities.

Strategic communication is evidence-based, measurable, results-oriented, planned and undertaken in consultation with the participant group(s). It is linked to other programme elements, takes into consideration local context and includes a range of communication approaches, to stimulate positive and measurable behaviour and social change. It should include appropriate timeframe, budget and clear responsibilities at all levels for implementation, monitoring and evaluation. In developing a national strategic communication work plan and budget, efforts should be made to encourage the establishment of baseline and change indicators and the use of qualitative and quantitative technical and behavioural data in the planning, implementation and evaluation of the overall national strategic workplan.

Consulting with the community, using participatory planning techniques, will engage key local partners in the programming process from the start. This will allow focus on certain critical activities during the planning phase before the start of the programme.

Communication is not a substitute for effective service delivery. However, if there are significant deficiencies in service delivery, communication can contribute to service improvements. Through advocacy and the strengthening of IPC skills of health staff and vaccinators, communication can help make service delivery effective, i.e. providing services of good quality and active in their outreach to the population. Communication is needed to promote utilization, i.e. reconcile perceived needs of the population that is to benefit from these services with the demand for and acceptance of vaccination services, and to sustain that demand. Communication that promotes services that are not accessible or available and not perceived as a need will have the opposite effect of discouraging the population to use them. In other words, service delivery can be considered as the hardware and communication as the software of an inclusive system.

Steps to be undertaken in developing a communication strategy

1. Conduct a situation analysis

- Review recent RI or SIA communication activities; conduct formative research (e.g. behavioural and sociocultural studies, KAP, etc.), as needed.
- Determine participant groups and priority problem behaviours that will be addressed: refusal/non-compliance/hesitancy resulting in children not being reached during routine services or in SIAs, dropouts, low immunization coverage.
- Review available human, material and financial resources for communication activities at all levels. This exercise may help identify partners from the media and civil society who might need to be mobilized to join efforts in vaccination.

2. Set objectives

- Analyse factors underlying main behavioural problem: immunization systems related reasons/factors, communication and information related reasons/factors, family characteristics related reasons/factors, parental attitudes and knowledge. See examples of barriers to immunization which communication can address (Table 2.2).
- Formulate communication objectives[5] and measurable targets to address factors underlying the main behavioural problems. Identify the individual or groups that communication activities will target with a particular focus, as well as the specific purpose, i.e. what is expected from this individual or group as a result of the communication activities.

3. Determine strategies and activities

- On the basis of results from the previous steps, select key communication strategies (advocacy, social mobilization and behaviour and social change communication) and develop their components for each participant group:
- Communication activities – specifying media to be used, message content and support materials. Message content should be based on formative research and field tested.
- Training and capacity-building plan and community involvement activities.
- Budget.

4. Determine communication indicators

- Outcome indicators would allow measuring the extent to which communication objectives have been met. These indicators may relate to advocacy, social mobilization, behaviour change and social change, depending on the factors underlying the main problems that have been identified as the focus for the communication activity.
- Impact indicators would be defined in terms of reduction in refusal and noncompliance and increases in target children reached by antigens and fully vaccinated prior to first/second birthday.

5. Develop an action plan for implementation and monitoring

- Draw up an implementation plan of action with timeframe (linked with overall immunization plan and for all levels of system).
- Develop monitoring indicators and decide on periodicity for monitoring.
- Develop a format for data collection and identify who is responsible at all levels for the collection, analysis and dissemination of data.

6. Evaluate communication activities

- Use indicators for evaluation.
- Make recommendations based on the results of evaluation.

5 Objectives should be SMART: specific, measurable, appropriate, realistic and time-bound. They should also address: who is called upon to complete the action, what action/change in behaviour is to be promoted, by when the action/behaviour should have been implemented or changed, and how many conditions are to be met (e.g. percentage change, number of individuals influenced, etc.).

Table 5.1 Data types and sources for developing communication plans

	Type	Location	What it tells you	Limitations
Understanding the big picture	Multiple Indicator Cluster Survey (MICS)	National	Information on a broad range of MCH indicators; disaggregated by gender, rural or urban, wealth quintile	National data; disaggregated by state/province but not by district; conducted infrequently
	Demographic health survey (DHS)	National	Information on a broad range of demographic indicators, including employment, education, health	Disaggregated to state level only; conducted infrequently
	National Immunization Coverage Survey	National	Comprehensive immunization coverage by antigen at national and subnational level; may include summary of reasons for non-vaccination	May not include sociocultural/economic factors
	Immunization equity assessments (IEA)	National	Identification and classification of high-risk communities in Gavi-eligible countries	A new tool that may take time to implemented in all countries
	EPI reviews	National	Strengths, weaknesses and recommendations for improving the programme including in communication	Quality of communication-related aspects varies by country
Getting closer to the subject	Knowledge, attitudes and practices surveys (KAP)	Usually national	The KAP of communities on any issue, can be immunization specific	Will be indicative for a broader geographic area; may be disaggregated by lingo-cultural groups, but not for specific communities
	Administrative coverage data	District level	The basic coverage data for routine immunization in a district	May be poor quality
	RI monitoring data	District level	Depends on country, but generally RI planning, supervision, session information	May be poor quality
	SIA monitoring data	Location of SIA	Depends on indicators, but can give coverage and social information (e.g. why child was missed). If well managed, can be disaggregated to a low level	Dependent on types of indicators and quality of data gathering and analysis
	VPD case investigations	Case based	Often the sociocultural/economic characteristics of child affected by VPD; RI coverage sampling within the community; good if there are multiple cases in a small geographic area	Limited to individual cases, not necessarily indicative of communities unless there are investigations of many cases in a large outbreak
	Media reports	Any level	Indicative of community concerns and complexities; can be quite specific	Poor media reporting; bias
	Donor reports	Any level	Often well researched, comprehensive, give insights into communities involved in specific donor projects	May not be relevant for main area of concern
Understanding leaders and communities	In-depth interviews	Any level	Insights from key stakeholders, particularly leaders – whether ministers or local religious leaders; can identify policy, systemic problems	Individual views; subjects may have an agenda
	Focus group discussions (FGDs)	Local	Insights into attitudes and the reasons for behaviours; can be done with local groups – health workers, caretakers, local leaders	Quality FGD results are dependent on adhering to FGD methodology
	Community household surveys	Can be local	Specific information about any desired topic; gets very close to a community	Sampling method and data quality very important
	Social mapping	Local	Identifies sociocultural/economic dynamics, neighbourhoods, gathering places, and other relevant social information	Social mapping requires participation from wide representation of the community for accuracy
	Rapid or "dipstick" surveys	Local	Provides specific, on-time information in many settings (e.g. interviewing parents at a health camp)	Data limited to the place of the survey
	Observational studies	Local	Provides on-time information about human behaviours (e.g. health worker behaviours during RI session)	Requires many sessions to achieve statistically significant findings
	(SWOT) analysis	Any level	Identifies specific SWOTs linked to the priority programme; can be applied to various issues	Data can be subjective, dependent on who is conducting the analysis

5.1.3 Existing data sources – what we know already

In developing communications plans, the initial situation analysis requires analysing information from various data sources in order to understand the whole picture. Table 5.1 shows some of the following types of data and sources of information.

5.1.4 Sample qualitative questions – what we want to know for immunization

In addition to quantitative information from various sources, communication planners may use information from qualitative research – such as FGDs or key informant interviews. These qualitative studies utilize open-ended questions that allow participants to speak openly and provide as much information as they can. Open-ended questions allow the researcher to probe, and ask follow-up questions to responses. The information can be more difficult and time-consuming to code and analyse, but provides deeper insights. There follow some example questions for caregivers.

Knowledge of VPDs

- What are they?
- What causes them?
- What are they called in local language?
- How do you prevent them?
- How do you cure them?
  - Why?
- Has this community been affected by VPD?
  - When?
  - What happened? (illness/deaths)

Knowledge of vaccines and immunization

- What are they for?
- Who are they for?
- When/at what age?
- How many times?
- Where do you go for immunization?
- Who provides immunization?
- How much does immunization cost?

Attitudes towards VPDs

- Do they pose a threat to you and your children?
  - Why/why not?
- How do you feel about them? Worried? Complacent? In control?
  - Why/why not?

Attitudes towards vaccines and immunization

- How effective are vaccines at preventing disease?
- How important is it to have your children immunized? Why/why not?
- How do people in the community feel about vaccines?
  - Important/not important?
  - Why/why not?

Practice towards vaccines and immunization

- Have you taken your children for vaccination?
  - If yes why, if no, why not?
- Have they been fully vaccinated?
  - If yes why, if no why not?
- Where do you go for vaccination?
- What do you think of the quality of the health-care workers?
- What kind of information do they give to you?
- Is it enough information? Why or why not?
- How long do you have to travel to reach the health centre?
- Do you have home-based records/child health cards for each child?
- If you have these records:
  - Who gave them to you?
  - What do you do with them?
  - What did the nurse tell you to do with them?
  - Did the nurse fill them for you each time you went for immunization?
  - Where do you keep them?

Trusted sources of information

- Where do you receive information about health? Name all.
- What media do you use/listen to/engage with most?
- What sources of information do you trust the most?
- What sources of information do you not trust?

5.1.5 Funding EPI communication plans

The communication plan requires buy-in from senior staff and partners. Communication will "sell" if the plan is realistic, rigorously prepared, evidence based and clearly presented with targets, milestones and monitoring plans. Communication may be perceived as an add-on to a programme when it is presented as one – using anecdotes from the field for example, instead of validated data.

If the plan is ambitious, and substantially changes the way of working, it will be critical to present evidence that the plan was based on solid analysis and will produce results. An ambitious project may require a pilot before scaling up to a large geographic area. This means we need data to show evidence – and that will need funds. Selling the plan may also require selling the entire idea of communication for development – ensuring decision-makers understand that communication is much more than news releases and IEC posters. Following the steps in this guide should help in preparing a convincing communication plan that will attract the resources it requires.

Funding sources: Funding sources for immunization will vary from country to country. They can include

government resources, external partner funding and sector-wide basket funds. Consultations with partners including potential donors at the outset of creating the communication plan will help to build support for the plan.

For eligible countries, Gavi health system strengthening (HSS) funding also offers opportunities to fund communication programming. Gavi's "approach to HSS includes support for community mobilization, demand generation, and communication, including the communication for immunization approach."

There are currently two grant categories that provide specific opportunities to strengthen communication-related activities. The first relates to human resources, offering the option to train the workforce, scale up and train volunteer and community health workers. The second category ("empower community and other local actors") includes the opportunity to apply for funding to support a range of communication activities, advocacy to enhance an enabling environment, establish partnerships, and strengthen the capacity of community groups and networks.

Gavi stresses the importance of gender in immunization outcomes, and encourages communication activities that address gender issues that may be a barrier to immunization including lack of health information programming for men; women's lack of access to appropriate information; and addressing literacy and language.

5.1.6 Determining communication activities for the work plan

The EPI manager should ensure that an implementation plan is developed based on information gathered in the planning stages and is harmonized with the overall EPI work plan. Attention should be given to participatory approaches, allowing both beneficiaries and technical partners to jointly decide on the role and accountability of each stakeholder in implementing interventions as well as on feedback and coordination mechanisms.

The communication objective is a statement of the desired outcome. The communication strategy indicates the general approach that will be used to meet the objective. The activities break the strategy into individual units that can be scheduled in an action plan for implementation. The implementation plan must specify, for each activity, responsible units/officials for implementation, timeline and realistic budget.

The national level should encourage the development of provincial/regional level advocacy, communication and social mobilization work plans and budgets targeting sustainable behavioural change. Engaging staff from subnational level in a participatory planning exercise will result in greater ownership of the communication plan of action and generate sustained commitment to its objectives.

It will be expected that these staff encourage communication local catchment area planning at district level, examining local data, reaching consensus on the problems to be overcome, negotiating objectives and targets, determining available human resources and commodities, identifying resource gaps, operationalizing the delivery strategy, engaging communities and local leaders, determining budgetary requirements and identifying a monitoring process. This process should be conducted at district level, information shared with higher levels, and feedback provided to districts. Once approved, work plan budgets should be fully funded.

The communication plan of action should specify the activities for all components of the communication process at all administrative levels in the country. There follow some examples of communication activities.

Advocacy

National level: Commit high-level political leaders and opinion makers to expand funding for and support to revitalized RI services which may include the introduction of a new vaccine into the EPI schedule. Advocate among interagency partners, with the leadership of governmental organizations, to set up a functioning communication committee that works with the immunization ICC; and to establish strong subnational advocacy mechanisms as many budgetary and human resource decisions are now made at this level.

Regional level: Advocate for government to allocate resources to immunization (e.g. funding for RI activities, regional cold room, transport, maintenance, allocate communication staff to district health team). Involve regional based partners, private sector and NGOs in your communication activities to maximize opportunities for supporting the introduction of the new vaccine.

District level: Advocate for local radio to broadcast spots free of charge, advocate with health authorities to garner their commitment to and support for community mobilization.

Community level: Advocate with opinion/traditional/religious leaders for the introduction of new vaccines, acceptance of a specific antigen or support for community surveillance activities.

Social mobilization

National level: Organize national/international NGOs, support civil society organizations (CSOs), encourage private sector to provide mobile phones to health teams during immunization campaigns.

Regional level: Establish technical advisory committees on health which will include local immunization experts.

District level: Reinforce the participative involvement of civil society – NGOs, community-based organizations (CBOs), faith-based organizations – in promoting immunization agendas throughout the district, assisting officials of the involved districts in setting up or reactivating dialogue structures and local social mobilization committees, sign partnership conventions with rural and community radio.

Community level: Initiate case studies on strengthening ownership of the programme with women's groups, CBOs, local social mobilizers, involving authorities and other local leaders as well as NGOs and associations in the sensitization of the population in favour of vaccination; encourage responsibility among traditional leaders, local religious and women's groups regarding local management of known cases of refusals.

Communication for social and behaviour change

Activities include those aimed at changing behaviours and catalysing social change, e.g. shift social barriers to behaviour change. They are concerned with informing the general public, exchanging information with specific participant groups about immunization, empowering people to take action, and creating an environment in which communities, in particular affected ones, can discuss, debate, organize and communicate their own perspectives on immunization.

National level: Develop appropriate tools to better inform, sensitize and help participant groups to adhere to vaccination, guidelines for IPC for vaccinators, multimedia outline for messaging on vaccination, prevent or dispel misinformation and doubts related to immunization through mass media.

Regional level: Communication staff to participate in regional immunization meetings, regional communication workshops to ensure good practices and lessons learned are disseminated, deployment of regional communication officers with the primary responsibility of coordinating regional activities, conceive and produce education and training materials for local community capacity building, reinforcement of IPC skills of vaccination teams on the management of AEFI.

District level: Assist with training of community relays; organize synchronized discussions with the participation of religious leaders, traditional heads, political, administrative and health authorities,

Community level: Involve community local front-line workers (social mobilizers) in the sensitization of the population on vaccination on a home-by-home basis after proceeding to an account of the target population, town hall meetings, provision of films on immunization, identification and mobilization of community networks. The community workers are "facilitators" to promote collective dialogue, learning and action to increase the knowledge as well as the commitment for vaccination, identify bottlenecks (cultural barriers, norms, rumours) and solutions to overcome them, decide on local interventions, ensure their implementation and monitoring.

5.2 Monitoring communication activities

Monitoring is a continuous process that takes place throughout implementation and is done to measure programme progress and put corrective measures into place where and when necessary. Fixing monitoring indicators is part of the planning process. Monitoring also involves giving and receiving feedback about the progress of the project to and from the donors, implementers and participants. Monitoring relies on the definition of appropriate indicators and the setting up of effective reporting systems.

Although collecting monitoring data helps to identify programme strengths and weaknesses, monitoring alone cannot fix a problem. For example, outcome data may show that mothers' knowledge about immunization is high while impact data show that desired behaviour is low (no change in drop-out rates). Thus, if monitoring has correctly identified a programme weakness, this should signal further inquiry about why the programme objective (lowering drop-out rate) has not been achieved. It may be a communication issue, service delivery, supply or management issue – but it is not faulty monitoring that has caused the gap.

Monitoring of communication processes and outcomes should be done in conjunction with other EPI monitoring, adding communication indicators to existing immunization monitoring forms/mechanisms at all levels. Communication specialists follow many indicators specific to the communication process, so EPI and communication partners/officers will need to identify which indicators are meaningful to integrate into EPI monitoring activities. Effective monitoring helps determine if all hard-to-reach groups are being reached; if appropriate channels are being utilized; the impact of communication interventions on the participant groups' KAP; and the need for and nature of actions to undertake/ implement for continuous improvement of activities.

5.2.1 Principles for selecting indicators

1. Select an indicator (see Table 5.2).
2. Define your denominator: the universe (e.g. total population in a country or population of a district) from which the numerator will be defined to calculate proportions.
3. Define a specific timeframe for applying the indicator in question.
4. Define the level of data collection.
5. Define the means of data collection to ensure that the indicator selected will be able to measure progress.
6. Analyse the data using selected performance indicators.

Table 5.2 provides useful information to programme managers about communications indicators – the level of the health system they can be used, means of their collection and timeframe/frequency.

5.2.2 Types of indicators

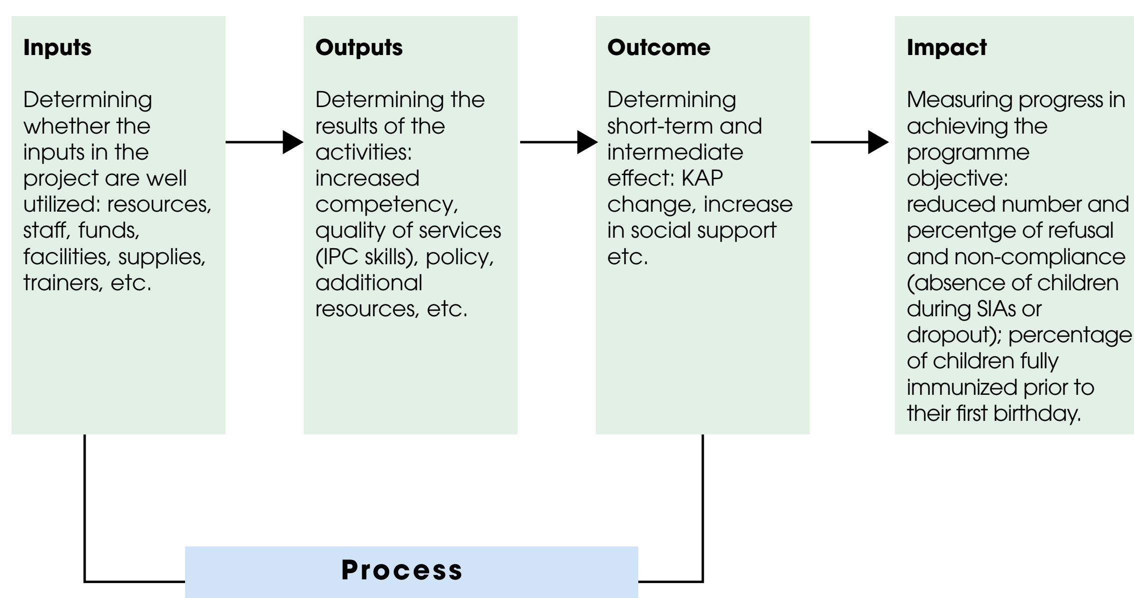
There are five types of indicators that need to be tracked and analysed in order to assess the strengths and weaknesses of a communication activity and foster evidence-based decision-making. These indicators are linked to inputs, outputs and outcomes contributing to the communication programme goal (Figure 5.2).

Table 5.2 Communication indicators

No.	Indicator	Calculation	Level	Means of collection	Timeframe or frequency
1	Designated national EPI communication manager with appropriate experience	Yes/No	National	Interview candidates for the post of EPI manager	Annual or two-year contract
2	Percentage of districts/regions/provinces with designated experienced communication staff	Numerator: number of districts/regions provinces with designated staff for communication Denominator: total number of districts/regional/provincial EPI units	Provincial Regional District	Interview provincial, regional and district managers to select the best candidates	Annual or two-year contract
3	Written national communication plan with clearly stated behavioural goals and derived from a situation analysis, of current behaviours and actions needed to promote desired behaviours	Yes/No	National	Verify with EPI manager and/or ICC	Annual or strategic plan (five years)
4	Percentage of districts/regions/ provinces with written communication plan with clearly stated behavioural goals	Numerator: number of districts/provinces with communication plan Denominator: total number of districts/provincial/ regional EPI units	Provincial District	Review with provincial, regional and district EPI managers Analysis of communication plans	Annual
5	National level provides guidelines, training, supervision and funding to encourage subnational planning and implementation of communication	Yes/No	National	Interview EPI manager Review with provincial, regional and district EPI managers Collect ICC meeting notes	Quarterly
6	100 per cent of all relevant levels have active interagency committees or teams contributing to the planning and management of communication	Numerator: number of districts/ regions/provinces with active interagency committees contributing to the planning and management of communication Denominator: total number of districts/regional/provincial EPI units	Provincial Regional District	Interview EPI manager	Annual

7	National programme has detailed operational plan for communication	Yes/No	National	Analysis of national programme	Annual
8	National programme regularly reviews, monitors and updates the national communication plan	Yes/No	National	Review of EPI records	Quarterly
9	Percentage of district/regional/provincial units that regularly review, monitor and update communication plans	Numerator: number of districts/regions/provinces conducting regular reviews of communication plan Denominator: total number of districts/provincial EPI units	Provincial Regional District	Interview with sample of provincial, regional and ristrict EPI managers	Quarterly
10	National programme has sufficient funding to conduct planned activities	Yes/No	National	Analyse EPI work plan budget	Quarterly

Figure 5.2 Indicators to be tracked and analysed in evaluating communication activitites



- **Input indicators** track the means allocated for implementation of the activities either financial, personnel (technical assistance volunteers), equipment and supplies. They show/indicate capacity/planning.
- **Process indicators** track the activities in which the inputs are utilized, for instance in training, in material development, message delivery. Examples of process indicators include: number of seminars on EPI communication conducted in a certain period of time, number of trainings on EPI communication conducted in a certain period of time, number of community meetings on EPI conducted in a certain period of time.
- **Output indicators** track the direct and immediate results of input and processes at project level.
- **Outcome indicators** refer to the intermediate results at the target population level that are closely linked to the project, e.g. health impact.
- **Impact indicators** measure achievement of programme objectives. Communication's contribution can only be inferred because many other factors influence programme impact. An example of impact indicator is the decrease in non-compliance (number of unvaccinated child or percentage of dropout).

Communication output and outcome indicators are activity based, thus one set of indicators may not be relevant across countries. Even within a country, identifying these indicators will depend on what communication activities are being implemented and at what level. For example, district-level activities are monitored on district forms. Facility or village-based activities need to be monitored and data used at that level.

Table 5.3 illustrates indicators that track typical communication activities at the district and facility level. Input, process, output and outcome indicators measure communication directly. Impact indicators are those currently being tracked by the programme and reflect their contribution to change but not direct impact. Also, from these monitoring data, it is not feasible to conclude that one activity is more influential than another.

Table 5.3 Indicators for tracking communication activities at district and facility level

STRATEGY	Activities	Process	Output	Outcome	Impact
Advocacy	Community level Mobilize religious leaders to promote polio vaccination in weekly sermons during month before NID	Number of religious leaders attending meeting	Number religious leaders promoting NID in sermons	Percentage caregivers knowing about NID prior to vaccination with the mosque/ church as a source of information	Increase in child vaccination
Social mobilization	Community level Mobilize community volunteers to track defaulting children for routine EPI	Number household visits in the community	Number un/ under-immunized children tracked	Knowledge and attitudes of caregivers regarding NIDs and RI	Percentage children fully vaccinated before their first birthday
Communication for social and behaviour change	District level Engage civil society organizations to participate in the mobilization of mothers for EPI	Number civil society organizations devoting resources for immunization	Civil groups active in influencing mothers in ways that will benefit children	Increased effectiveness in civil society work	Percentage of children fully immunized before their first birthday

The usefulness of monitoring data is to show trends over time. Monitoring is a process of routinely gathering information on all aspects of the project to enable comparison.

The EPI manager needs to ensure that data are regularly collected, compiled, analysed and used to address issues that were identified by the monitoring. This implies that the EPI plan of action needs to be revised on a regular basis to reflect the gaps identified by the monitoring and other reasons. It is therefore important to conduct regular evaluation of the programme to response to these needs.

5.2.3 Tools and types of monitoring activities

Tools for collecting data for selected indicators include supervision checklist, supervision report, observation checklist, plan of action as well as national minimum norms and standards, health management information system (HMIS) reports, national sentinel surveillance system reports, and activity progress report, FGD guide, community mapping, case reports, facility records, performance monitoring reports, etc.

Some suggested monitoring activities for communication include conducting regular spot checks of material distribution at representative points in the field, hiring a media monitoring company or recruiting volunteers to determine if planned programme activities are being implemented according to set schedules, reviewing and documenting feedback from the field (from supervisors, health teams and caregivers) regarding what materials are present and sources of people's information on immunization, monitoring key media channels, conducting exit interviews with caregivers at vaccination sites or door-to-door to determine which messages they received and their KAP regarding NIDs and routine immunization services, holding focus group discussions between rounds or after a campaign, including questions on social mobilization and communication messages (reach, comprehension, impact).

5.3 Evaluating communication programmes

At the end of a specified implementation period, communication interventions will need to be evaluated as part of the overall EPI evaluation. The evaluation of the communication component can be carried out within the overall EPI evaluation exercise or separately to have a more comprehensive view of the role of communication for improving coverage and quality of

services. The evaluation can be conducted internally by the EPI staff or externally with the participation of experts, which ensures the objectivity of the exercise. The EPI manager should make sure the evaluation team has a communication specialist to make an in-depth analysis of the communication component.

Evaluation can be formative (taking place during the life of a programme, to improve the strategy or the programme's functioning) or be summative (drawing lessons from a completed programme). In both instances, evaluation will compare the actual outputs, outcome and impact of the communication interventions to the planned ones and determine the extent to which and how communication efforts have influenced the quality and quantity of the immunization services. Evaluation helps communication managers to account for the investment made, refine strategies and identify and correct gaps in programme implementation.

The evaluation should look at the outputs, outcome and impact of the communications activities, as well as on other external factors that might influence programme implementation. From this, it should be clear that both monitoring and evaluation are best done when there has been proper planning (with specific, measurable, appropriate, realistic, time-bound – SMART – objectives and targets) against which to assess progress and achievements.

Evaluate process, outcome and impact of your plans. Use the evaluation for re-planning and then apply corrective measures.

5.4 Communication and the Global Vaccine Action Plan and the Regional Strategic Plan for Immunization

5.4.1 GVAP – strategic objective on communication

Strategic objective 2 of the GVAP states "individuals and communities understand the value of vaccines and demand immunization as both their right and responsibility". Significant improvements in coverage and programme sustainability are possible if individuals and communities understand the benefits and risks of immunization; are encouraged to seek services; are empowered to make demands on the health system; and have the ownership of the planning and implementation of programmes within their local communities. Although there has generally been a high demand for vaccination services, accessing hard-to-reach populations, attaining higher coverage levels and achieving equity objectives may require additional approaches to succeed.

Generating individual, household and community demand will require using traditional platforms more effectively as well as adopting new strategies to convey the benefits of immunization, emphasize immunization as a core component of the right to health and encourage greater use of services. New efforts to promote immunization could take advantage of social media and approaches used by commercial and social marketing. For example, new mobile and internet technologies should be utilized, drawing on the experiences and successes of other innovative public health campaigns.

Communication and social research to identify the barriers to and drivers of vaccination should inform the development of appropriate messages. Lessons on vaccines and immunization should be included in the primary school education curriculum. Multisectoral approaches, such as female education and empowerment, will help improve utilization of immunization and health services in general.

Where appropriate, programme strategies could also include measures to provide an incentive both to households to seek immunization services and to health-care providers to improve their performance in vaccinating children, particularly those not reached previously.

Some reasons for hesitancy are undoubtedly amenable to improved communication and advocacy initiatives designed to counteract growing anti-vaccination lobby groups and to increase understanding of the value of vaccines as against the danger of diseases. Health-care workers should receive training in effective communication to enable them to deal with the media and with local communities when there are reports of serious AEFI, in order to allay fears and tackle vaccine hesitancy.

Bringing about change will require new and strong community-based advocates with local knowledge, credibility and the front-line experience necessary to drive change. The participation of in-country CSOs will be crucial to developing strong advocacy efforts. Current advocates must include educators, religious leaders, traditional and social personalities, community health workers and immunization champions. Researchers will also have an important role in providing credible responses to misinformation regarding immunization.

Generating individual and community demand will reinforce a country's commitment to vaccines and immunization. Activities to generate demand for immunization should build on the broader goal of helping people to hold their governments accountable regarding access to health services.

Exercise 6 – The six objectives of the GVAP

All groups should review the background document on GVAP (http://www.who.int/immunization/global_vaccine_action_plan/en/index.html).

Group 1: Refer to the list of six strategic objectives and discuss the possible contribution of strategic objective 2 in realizing the other GVAP objectives. Present your deliberations to the plenary using the table below.

Other five strategic objectives of GVAP	How strategic objective 2 on communication can support this strategy?
1. All countries commit to immunization as a priority.	
2. The benefits of immunization are equitably extended to all people.	
3. Strong immunization systems are an integral part of a well functioning health system.	
4. Immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies.	
5. Country, regional and global research and development innovations maximize the benefits of immunization.	

Groups 2, 3 and 4: Discuss strategic objective 2 on communication with the proposed lists of activities. Answer the question: What is actually being or can be done in your group's countries to address the activities specified for your group.

Group 2: Engage individuals and communities on the benefits of immunization and hear their concerns.

Activities	What is being done?	What else can be done?
1. Engage in a dialogue which both transmits information and responds to people's concerns and fears		
2. Utilize social media tools and lessons learned from commercial and social marketing efforts		
3. Leverage new mobile and internet-based technologies		
4. Include immunization in the basic education curriculum		
5. Conduct communications research		

Group 3: Create incentives to stimulate demand.

Activities	What is being done?	What else can be done?
1. Create incentives for households and health workers		
2. Conduct social research to improve delivery of immunization services and ability to meet needs of diverse communities		

Group 4: Build advocacy capacity

Activities	What is being done?	What else can be done?
1. Recruit new voices, including those of educators, religious leaders, traditional and social media, CHWs (among others)		
2. Train health workers in effective communication techniques, especially to address vaccine hesitancy and to respond to AEFIs		
3. Engage, enable and support in-country CSOs to advocate the value of vaccines to local communities and policy-makers and media		
4. Create national or regional advocacy plans that involve in-country CSOs		
5. Link global, national and community advocacy efforts with professional and academic networks		

5.4.2 RSPI – strategic objective on communication

A central tenet of RSPI is that it is essential to move to demand-driven immunization, where demand creation and communication ensure everyone recognizes the right and responsibility to be immunized and understands the risks and benefits of vaccines and immunization. This puts a great emphasis on the need to broaden communication efforts across all available channels. Social communication and marketing approaches based on in-depth understanding of research on the barriers to and drivers of immunization need to be used. For child immunization, effective communication and service also are important during vaccination so that mothers or caregivers understand the schedule to follow and remain motivated to complete the set of vaccinations.

Civil society organizations have an important role not only as the voice of the public in holding the government to its obligations, but also as mobilizers of the communities for immunization services. Their participation in national committees would benefit immunization programmes.

Accountability for immunization rests with individuals, communities, health workers, institutions, the government and partners. National strategic plans will define the commitment and responsibility of each stakeholder for immunization. Country ownership puts the responsibility for holding all stakeholders accountable for their declared commitment to immunization squarely on the shoulders of the government. The government may require additional capacity to fulfil this role.

Monitoring and evaluation of the communication plan

Monitoring will give ongoing information on the progress and challenges of plan implementation, and the quality of the activities. Quality monitoring should be used to help adjust the plan along the way. Like all EPI activities, tmonitoring should provide quantitative evidence – not anecdotes – about the impact of the programme. Monitoring indicators can be divided into three main categories:

- **Input indicators:** track the resources that go into the programme (e.g. staff, volunteers, funds, equipment). For example: number of staff hired on time; percentage of funds released by a certain date; and number of key documents produced on time.
- **Output indicators:** including process indicators, track the activities and products completed (e.g. training workshops, community meetings, radio announcements aired). For example: number of IPC training workshops held at district level on time; number of radio announcements aired on time; and number of IEC packages delivered to health centres on time.
- **Outcome indicators:** track the results or changes in the target population as a result of the activity. For example: percentage of health workers providing correct IPC during sessions; percentage of caretakers who cite health worker information as the source for their return visit to the clinic; percentage of change in vaccine uptake in a formerly resistant area, with new community engagement plan; and number of newborns identified by community health worker, who attended an RI session.

Monitoring indicators require:

- A baseline, to know the starting point against which to measure progress.
- A target against which to measure progress. The target will probably be part of the SMART objective.
- A realistic number. Don't monitor for absolutely everything. Pick the areas that are most important, and will demonstrate real progress.
- A source for validating the indicators (e.g. from supervisory reports, rapid surveys).
- A frequency for validation e.g. quarterly. Validation methods should be incorporated into existing EPI reporting tools as much as possible to streamline reporting (e.g. add to administrative reporting tools, to campaign monitoring, to post-introduction evaluations).

Monitoring results should be used in reporting back on the communication plan to the national immunization team and any technical oversight bodies.

Evaluation should determine the degree of impact of the EPI communication programme. The impact of communication isn't always easy to measure, as other factors will also contribute, and it can be very difficult to attribute progress (or lack thereof) in EPI only to communication. However, an evaluation should be able to indicate whether behaviours the communication plan was addressing, are indeed changing in the timeframe hoped.

Evaluation can be conducted in several ways:

- A full evaluation of communication only, conducted by an experienced external third party. This may be especially relevant for a unique, large programme that included evidence-based, new programming.
- Through a dedicated review, involving partners and sufficient time to thoroughly review the quality, outcomes and impact of the programme.
- For new vaccines, communication programming can be partially evaluated through a post-introduction evaluation, by including some key questions relevant to the main activities of the communication plan.
- As part of an overall EPI review.

Communication plans that are evidence-based and include much targeted objectives and activities are better candidates for a full evaluation. An evaluation should aim to not only review the communication plan at hand, but also provide lessons that can be implemented in other countries. UNICEF has full guidance on conducting communication evaluations in Module 2 of the MNCHN C4D guide (https://www.unicef.org/cbsc/index_43099.html).

Sustainability and the future

While the basics of EPI remain largely the same – ensuring target populations are vaccinated on time – EPI has evolved rapidly over the last decade with the addition of new vaccines. Polio may soon be eradicated. Inactivated polio vaccine is being introduced. More new vaccines may soon be available. New presentations and delivery systems are in the pipeline. Gavi "graduating" countries may grapple with sustainability of their EPI programmes. Access to communication technology, the internet and social media will increase rapidly. Unexpected outbreaks, such as Ebola in West Africa in 2014, will test health systems, and new vaccines may be created in record time. Each of these issues has communication implications. Over time, EPI will be increasingly integrated into primary health care services. The goal, of course, should be for every mother and child to receive the full complement of services, including immunization, at one well-managed, fully stocked health centre, and for every person to receive the care they require over their life course. EPI communication must anticipate and keep pace with the changes. Every EPI manager and communication specialist should be thinking of the following issues.

- **Basic integration of EPI communication into annual and multi-year plans:** A multi-year cycle will allow the time necessary to conduct formative research, implement, monitor and evaluate an ambitious communication plan.
- **Use the Gavi communication funding opportunities:** In eligible countries, HSS funding can be used strategically to build a strong, sustainable base for community engagement. New vaccine introduction funding for communication can also be better used to produce more sustainable materials for example, rather than pay for a national launch event.
- **Plan for use of ICTs and social media, and manage expectations:** As indicated in this guide, access to ICT is growing rapidly and opportunities to use messaging and special applications are adapting to local needs. While the temptation may be to integrate ICT and social media quickly into a communication plan, it is probably better to carefully plan and gradually implement an ICT or social media component with thoughtful monitoring, rather than rush projects that may have poor results. As with all communication for development, ICT and social media are one channel of information, and successful communication outcomes depend on using multiple activities and channels.
- **Collect and report results to gain more support from government and partners:** Success breeds success – and demonstrating that communication activities have a real impact will generate more interest in the activities, and ideally more support.

This includes planning for more high-quality communication evaluations; conducting and publishing research; and networking with peers. It also includes reporting outcomes to bodies such as the ICC, the National Immunization Technical Advisory Group, the WHO Strategic Advisory Group of Experts on Immunization (SAGE) and UNICEF, and other partners and media.

- **Communication should be "owned" by the national EPI programme:** Ultimately, the government and its partners need to lead all aspects of EPI, including communication. Keep government counterparts fully involved and leading at all times. This is critical as more and more countries "graduate" from Gavi support.
- **Use integration opportunities as much as possible:** Rotavirus and pneumococcal vaccines are a key opportunity to integrate communication with pneumonia and diarrhoea programming. There is clear guidance on how to do this. Periodic child health days and African Vaccination Week can deliver a basic package of essential primary health commodities, including deworming, vitamin A and basic antenatal care together with immunization.
- **Move towards integration of EPI with communication for MCH:** Today, the same populations who miss out on vaccination will likely have poor access to all primary health-care services. Children may come to the health centre for one need, but not be offered an opportunity for vaccination. SAGE has underscored the failure to integrate immunization services, and points out that one-third of children who come to health-care facilities are due a vaccination but are not offered it – with these possible unreached children "passing right in front of our eyes and not being vaccinated." [6]

If your country is moving towards integration of services, then ensure communication moves with it. Collaborate with maternal, newborn and child health (MNCH) counterparts, and begin to explore how lessons from EPI communication can inform MNCH programming, and vice versa.

In the future, all families should have access to information about all aspects of basic health care. The immunization session contact – which has the biggest reach in many countries – is also an opportunity to provide neonatal care, maternal health services, breastfeeding monitoring, nutrition, family planning, infant diagnostics for HIV, malaria, pneumonia and diarrhoea prevention and treatment, and treatment of common minor ailments. For programmes, each of these areas requires a distinct set of interventions that are carefully monitored. For parents, integration would simply represent convenient and welcome care.

In the next decade as countries graduate from Gavi support, economies grow and countries move from low- to middle-income status, some groups risk remaining poor and at high risk. It is our job to maintain a focus on the needs of these high-risk groups and to ensure that immunization truly reaches every community.

Linking communities with service providers

Perhaps the best investment an EPI manager can do is to reinforce the creation of active links with community health committees. Creation of a feedback loop between the two will contribute to building bridges and understanding, including building a crucial element of trust. EPI will no longer blame low coverage on the ignorance of caregivers, who will learn to work with the delivery system despite the system's limitations. This interaction will also result in a strong commitment and understanding of vaccines, its benefits and changing target groups to include adolescents and young men and women.

6 WHO Strategic Advisory Group of Experts on Immunization, 2014 Assessment Report of the Global Vaccine Action Plan, 23–24 (http://www.who.int/immunization/global_vaccine_action_plan/SAGE_DoV_GVAP_Assessment_report_2014_English.pdf).

Recommended reading

UNICEF (2011). Communication framework for new vaccines and child survival. New York: United Nations Children's Fund.

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World Bank (2015). World Development Report 2015: Mind, Society, and Behavior. Washington DC. Available at: http://www.worldbank.org/en/publication/wdr2015 (accessed 14 December 2016).

Websites

Ministry of Health, Kenya – Immunization manual for medical and nursing students:
http://www.polioeradication.org/content/publications/2002_commschecklists.pdf

UNICEF – Communication for Development (MNCHN C4D) Guide:
https://www.unicef.org/cbsc/index_43099.html

UNICEF – Communication handbook for polio eradication and routine EPI:
http://www.unicef.org/immunization/files/polio.pdf

UNICEF – Building trust in immunization: Partnering with religious leaders and groups:
http://www.unicef.org/ceecis/building_trust_immunization.pdf

WHO – Training for mid-level managers (MLM). 2. Partnering with communities:
http://www.who.int/immunization/documents/MLM_module2.pdf?ua=1

WHO – Implementing the Reaching Every District approach: A guide for district health management teams:
http://www.who.int/immunization_delivery/systems_policy/AFRO-RED_Aug2008.pdf

WHO – Immunization, Vaccines and Biologicals (Create HPV vaccination communication strategies):
http://www.who.int/immunization/hpv/communicate/en/

Annex 1: Identifying immunization problems and causes during discussions with health staff and communities

Problems	Possible causes of problems
Many children get some immunizations but do not complete the basic series (utilization problem – which may reflect a service availability or quality problem)	1. Health workers have not clearly explained to parents what vaccinations are due, when they are due and why they are needed. 2. Health workers do not understand what vaccinations are due, when they are due and why they are needed. 3. Barriers discourage parental return, e.g. hours of clinic operation, cost and long waits. 4. Health workers do not clearly explain to parents when vaccinations are administered at the clinic. 5. Health workers have not shown parents respect or conveyed an interest in the child's health. 6. Vaccination services are unreliable (vaccine shortages, etc.) and/or (when given via outreach or mobile units) not offered frequently.
Children and mothers are not immunized when coming to the clinic for sick visits (service problem)	1. Health workers forget to check records or ask about what vaccines and doses a child/mother has received. 2. Health workers do not understand or accept programme policies such as immunizations may be given to mildly ill children. 3. Health workers fail to explain to parents that it is often acceptable to immunize a mildly ill child. 4. Immunizations are not available on that day. 5. Immunization supplies are not available. 6. Mothers (and possibly health workers) fear a child getting "too many" vaccinations in the same visit.
Health workers cannot determine what immunizations a child has received (service and/or utilization problem)	1. Health workers forget to remind parents to bring the immunization card. 2. Clinic records are not organized to allow easy retrieval of a child's records. 3. Some mothers lose or forget to bring the immunization card. 4. There is a shortage of immunization cards.
Pregnant women do not seek immunization for tetanus (utilization problem)	1. Health workers failed to use every contact with women of childbearing age to explain the need for, and importance of, tetanus toxoid immunization (particularly when they bring their children to get immunized). 2. Barriers discourage women from seeking immunization, e.g. cost, gender and cultural issues.
Children are not receiving all vaccines that they are eligible to receive during a visit (utilization and/or service problem)	1. Health workers misinterpret the vaccination schedule (e.g. don't give measles to an eligible child because they believe the child first must complete the "earlier" vaccinations). 2. All immunizations are not available or offered at the clinic on the same day. 3. Supplies of some immunizations are not sufficient. 4. Mothers (and possibly health workers) fear a child getting "too many" vaccinations in the same visit.
Children and pregnant women never come to the clinic to begin immunization (access problem)	1. The clinic is located too far away. 2. Clinic hours are not convenient or are not understood by the community. 3. Outreach activities are too infrequent, are offered at the same time as important family or community activities, and/or are not well publicized in the community. 4. Cultural, financial, racial, gender or other barriers are preventing use of immunization services.

Annex 2 : Health worker communication with caregivers

Interpersonal communication skills of health workers and district EPI managers are important when providing vaccination services and communicating with communities. Caregivers often rely on vaccinators to provide them with needed information regarding their child's vaccination status as well as when and where to receive additional vaccinations. Country experiences have shown that the role of the vaccinator as a communicator is a critical element, with improved service delivery, to lowering drop-out rates and reducing missed opportunities for vaccination. The district manager needs to work with the facility teams to ensure that immunization skills, including communication, are regularly monitored and updated. The following example provides some guidance on how and what vaccinators should communicate with caregivers.

Example of health worker communication skills in practice

Here is a description of how vaccinators, in ideal circumstances, should interact with caregivers (who are usually, but not always, mothers). Every programme should adjust these recommendations based on a realistic assessment of the feasibility of implementing them in a given setting (in light of the time available for patient visits, number of people typically waiting for services and other factors). The most essential elements of every immunization encounter are that the vaccinator treats the caregiver with respect, explains when and where to return for the next vaccination, and advises on possible side-effects and what to do.

The ideal health worker/caregiver interaction:

1) The health worker welcomes, greets and thanks the caregiver in a friendly manner for coming for vaccination and for her patience if she had to wait.
2) The health worker explains to the caregiver in simple terms and the local language the disease(s) against which the vaccination protects.
3) The health worker mentions possible minor side-effects and explains how to handle them.
4) If the child has a common mild illness, the health worker explains that the vaccination is still safe and effective and important, and administers it.
5) After the vaccination is given, the health worker writes the date of the current vaccination(s) given on the immunization card.
6) If the vaccine received is one in a series (e.g. DPT1 or 2, OPV1 or 2, or HepB1 or 2), the health worker explains to the caregiver the need for the child to complete the series to be fully protected against the disease(s). The health worker uses the vaccination chart on the immunization card as an instructional guide. Where SIAs are conducted, the vaccinator may have to explain that, in addition to the routine doses on the card, all children under age five (or older, depending on the SIA) are urged to get doses during special SIA vaccination days to be even further protected from VPDs.
7) The health worker writes the date for the next vaccination on the immunization card and tells the caregiver. If appropriate, the health worker associates the date with a "trigger" such as a holiday or seasonal event that will help the caregiver remember to bring the child back for vaccination. The health worker asks the caregiver to repeat the date, to be certain that it has been understood.
8) The health worker explains to the caregiver that if she and/or the child cannot come on the return date, they can obtain the next vaccination at another location or another date close to the due date.
9) The health worker reminds the caregiver that she should bring the immunization card to the location where the child receives the next vaccination.
10) The health worker congratulates the caregiver if the child is fully vaccinated.
11) The health worker asks the caregiver if she has any questions and politely answers all questions.
12) If special supplementary vaccination campaigns are planned in the coming months, the health worker informs the caregiver about the date of campaign, what vaccination is being given, and (if known) where she should bring the child for the supplementary vaccination.
13) If consistent with national policy, the health worker asks the caregiver if she has received her five doses of tetanus toxoid vaccination and explains the importance of protecting the mother and her future children against tetanus. (If the mother is not sure, the health worker should ask to see the mother's vaccination record.)
14) If vitamin A is being given, the health worker explains to the caregiver that it is important to bring the child back in six months (and give the date) for subsequent vitamin A supplementation to help protect her child from infections.

Communications plan template: Inactivated polio vaccine (IPV) introduction

This communication plan template is intended to offer an outline of the communications activities that should be considered in preparing to introduce IPV. The table below should be completed along with a descriptive communications plan as suggested in the accompanying guidance document. When this table is completed and adapted to the local context, please include a list of activities per category, and insert new rows as needed. Not all types of activities are essential, although they are recommended to support a successful introduction. If desired a column for indicators can be added.

Category of activities	Activities (examples)	Target audience	Budget breakdown				Budget total (sum of all contributions)	Timeline (based on November introduction)	Responsible
			Country contribution	UNICEF contribution	WHO contribution	Gavi or other contribution			
1. Coordination: This may include consultation and review meetings with government and partners and formation of an IPV communication subgroup at national/provincial/district level.	1.1 Organize consultation meetings with government and partners							January	
	1.2 Establish/re-activate IPV/new vaccine (NV) communication subgroup at national/ provincial/ district level	National and subnational partners. Refer to terms of reference (TOR) in guidance document						January to December	
	1.3 Develop TOR for desk review/KAPB study exercise							February	
	1.4 Organize communication plan review meetings							Quarterly	
2. Communications planning: This should include research intended to inform development of the overall communication strategy and plan that includes SMART objectives, activities, key messages and materials.	2.1 Conduct desk review of relevant EPI and communications research							February	
	2.2 Contract agency to conduct KAPB study among population group and health workers related to IPV/NV and RI	Caregivers, community elders, religious leaders and influencers, health workers							
	2.3 Contract agency to undertake FGDs with caregivers and health workers to generate qualitative data	Caregivers, family elders, health workers						March and April	
	2.4 Develop C4D/communication plan							April	
	2.5 Develop key message documents for specific participant groups	Mothers, mothers-in-law, grandmothers within underserved community X (primary)						May	

		Fathers, religious leaders and health workers within underserved community X (secondary)						May	
		Policy-makers, media							
	2.6 Develop relevant communication materials – leaflets, posters, flyers, brochures (after pre-testing)	See above						June	
3. Issues management (crisis communications) protocol: In the early stages of planning for IPV introduction a protocol should be established to prepare for any unexpected situations that may require a public response. The protocol should include the formation of a core communications team, processes for evaluating a situation and determining any actions, and subsequent efforts to monitor the situation and agree any further communications.	3.1 Designate spokespersons for AEFI/issues management	Designated spokespeople						May	
	3.2 Develop standard operating procedures for AEFI/issues management							May	
	3.3 Organize media training for spokespeople							July	
	3.4 Develop of FAQs and key message briefs for spokespeople							July	
4. Media planning: This section may include a mass media plan, activities and the development of materials (e.g. press release, statement) to effectively deliver key messages through forms of media. This may also include training activities for local journalists to build an understanding and support for immunization.	4.1 Develop mass media plan – based on research and channel analysis							August	
	4.2 Contract agency to develop public service announcement for TV and radio	General public, but can be targeted at caregivers, elders, health workers						August	
	4.3 Develop social media strategy	Young people who are online, discussion forums						August	
	4.4 Develop press release for IPV launch introduction – refer to media kit	Media						October	
	4.5 Develop key message documents and briefing decks for those briefing the media	Subject matter experts						October	
	4.6 Organize briefings of journalists	Key journalists including anti-vaccine journalists						1 week before launch	
	4.7 Organize editors round table meetings	Influential editors and journalists						1 month before launch	

5. Advocacy and stakeholder engagement: This section may include advocacy activities, events and materials to build the commitment of in-country partners and stakeholders for IPV introduction. For any print materials, the budget should reflect production, printing and dissemination costs. For events, the budget should reflect all costs, including those associated with travel and administration.	5.1 Develop advocacy plan for target group identified through desk review/KAPB study							June	
	5.2 Develop advocacy package with print materials (including FAQs, key messages)							June	
	5.3 Organize advocacy events with parliamentarians	Parliamentary health committee members						July–November	
	5.4 Organize advocacy events with religious leaders and key influencers	Religious leaders, community elders, music artists, sportspersons, film stars						July–November	
6. Social mobilization: This should include all social mobilization activities and efforts targeted to community leaders and third-party contracts with institutions and stakeholder groups who will deliver IPC messages, distribute print materials, and engage with communities in relation to IPV introduction.	6.1 Conduct mapping of NGOs/CBOs operating in underserved communities for social mobilization							March	
	6.2 Develop provincial and district level social mobilization plan – based on research							April	
	6.3 Organize community meetings in underserved areas, with a focus on marginalized groups	Caregivers, young men and women in marginalized groups						August – November	
	6.4 Disseminate posters, flyers	Caregivers, young men and women						October	
	6.5 Organize or leverage public events – sports competitions, carnivals, music and film showing to engage communities	Caregivers, young men and women						August–November	
7. Capacity building in communications: Capacity building needs assessments and reinforcement trainings for service delivery staff, government staff, institutions and community mobilizers. As this applies to IPV introduction, opportunities should be considered to strengthen capacity across appropriate areas of RI implementation.	7.1 Training of relevant government staff and partners in IPV/NV and RI-C4D planning	Core C4D team at national and provincial level						August	
	7.2 Training of health workers in IPC skills	Health workers						August	
	7.3 Training of social mobilizers in community mapping and IPC skills	Social mobilizers and key influencers at community level						August	
	7.4 Training in crisis communications for designated team at national/provincial/district level	EPI communications team members						August	

8. Monitoring and evaluation: This section may include plans and activities for the monitoring and evaluation of selected IPV communications activities. This may include ongoing tracking and analysis of indicators identified through the initial situation analysis and formative research.	8.1 Contract agency to conduct mid-term/end line KAPB survey to track progress against indicators							February or March of following year	

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