

External Polio Communication Review

Afghanistan

24-30 September, 2011



LIST OF ACRONYMS

C4D	Communication for Development
CBO	Community Based Organization
CDCs	Community Development Councils
CCFP	Cluster Communication Focal Point
CHS	Community Health Supervisor
CHW	Community Health Worker
CM	Community Mobiliser
DCFP	District Communication Focal Point
DDAs	District Development Assemblies
EPI	Expanded Program on Immunization
HR	Human resource(s)
HRA	High Risk Area
HRC	High Risk Clusters
HRD	High Risk District
HQ	Headquarter
IEC	Information Education Communication
IPC	Interpersonal Communication
KAP	Knowledge Attitude Practice
MOPH	Ministry of Public Health
NGO	Non-governmental Organization
NIDs	National immunization Days
OPV	Oral Polio Vaccine
PCN	Polio Communication Network
PEMT	Provincial EPI management Team
PSCO	Provincial Polio Communication Officer
PSA	Public Service Announcement
REMT	Regional EPI Management Team
RI	Routine Immunization
RPCO	Regional Polio Communication Officer
ROSA	Region of South Asia
SIAs	Supplemental Immunization Activities
SIADs	Short Interval Additional Doses
SMS	Short Messaging Service
TAG	Technical Advisory Group
TORs	Terms of reference
TV	Television
UN	United Nations
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organization
YICC	Youth Information and Communication Centres

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Summary

Since 2005 Independent Polio Communication Reviews have been an integral part of Polio Eradication Initiative efforts in all endemic countries. Two such independent communication reviews were conducted in Afghanistan in 2007 and in 2008.

In view of the usefulness of these reviews to objectively evaluate the existing communication strategies and interventions and to guide future communication strategies and interventions, a third polio communication review was conducted in Afghanistan, from 24-30 September 2011. Focused on the Western, Southern and Northern Regions of the country, the review addressed priority themes and issues that had been identified by prior TAG meetings and by internal assessments undertaken throughout the year by the national and sub-national teams.

The review team comprised of six international communication professionals representing diverse institutions and backgrounds in public health, communication and immunization.

The review methodology consisted of appraisal of various programme documents and reported and evaluation data, meetings with stakeholders at national level (government officials, polio partners including UNICEF, WHO, BMGF) and at provincial levels (provincial health department officials, WHO, UNICEF, BPHS implementing NGOs representatives), discussions with field staff (including Health facility in-charges, medical officer, health workers like vaccinators, midwives, and community health workers and their supervisors, and members of the Polio communication network) and independent monitoring teams), and meetings and focus group discussions with a multitude of players in Polio partners PEI efforts (including implementing NGOs, religious leaders, media representatives, representative of Department of education). The teams worked with the polio partners at all levels to understand the field realities, to review strategic documents and data, and to review preliminary recommendations before they were finalized for this report. Debriefing meetings were held at both provincial and national levels.

Each team attempted to arrive at a shared analysis of the problems with the provincial teams, and subsequently agree on a limited number of priority recommendations, which should be implemented within a 6-12 month period of time and monitored with indicators and milestones.

Team A that visited Southern **Region (Kandahar)** conducted an **overall assessment of the efficacy of the Polio Communication Network** and linkages with Communication and Capacity Building, team B that visited **Western Region (Herat)** focussed on reviewing how **partnerships including cross-sectoral ones and media can be better used for Polio communication**, and team C that visited **Northern Region (Mazar-e-Sharif)** attempted to understand better **how polio and EPI communication can be strengthened and integrated** into existing communication approaches

The three teams focussed on the three distinct components mentioned above and made recommendations on these components; however, some common recommendations emerged from all regions:

1. The existing National Polio Communication Strategy (2010-11) falls short in guiding national and local level communication activities . An updated and standardized national communication strategy (2012 - 13) for PEI and EPI advocating for a mix of communication approached and complete with communication outcomes, indicators, and key messages for different audiences and stakeholders is required. Regional, provincial and district-level strategies should be developed and aligned to ensure all field activities are focused towards achieving common objectives and measurable outcomes for polio eradication and improved EPI.
2. Communication materials and messages (for Polio and EPI) need to be pre-tested, branded and standardized; and flexible enough to facilitate local adaptation. Likewise, mass media products must be part of a well-planned national mass media communication strategy again with use of pre-tested and standardized messages.
3. Intensification of radio as a vehicle for mass media and community engagement that has been initiated in 2011 needs to be further strengthened, and should particularly target priority geographical areas like the Southern region, youth and women
4. The Existing IPC training modules for vaccinators, communication partners and the Polio Communication Network need to be updated and standardized. The IPC training methodology, duration or methodology are

not standardized and are often not conducted or conducted inadequately. This needs to be addressed through increased partner commitment to IPC, clear and standardized modules and guidelines for trainings and strengthened monitoring of adherence to these guidelines.

5. Additional partners who can engage with communities on polio and EPI need to be mapped, prioritizing those who can reach high risk groups such as women, inaccessible and nomadic populations in the South

Major recommendation for Southern region (and others with similar epidemiologic situation) included:

- Establishment of clear criteria for identification of high risk areas for the programme, first operationally and then for communication issues
- Evaluation PCN deployment plan based on high risk communication criteria, and possible expansion of the PCN network to other HR clusters.
- Establishment of a formal HR system, based on merit for PCN staff deployment and their continuation in their positions including linking submission of reports/ documents to performance evaluation and retention of staff.
- Conduct Learning needs assessment/KAP to assess capacity and knowledge of the PCN and develop training strategy and guidance to address learning needs and minimum standards of communication training for various levels of the PCN and vaccinators
- Work with WHO to improve quality of data collection on reasons for missed children and campaign awareness in PCA and ICM and conduct a study on reasons for missed children (including reasons for refusal) to verify monitoring data
- Initiate or strengthen engagement of schools, involvement of women in all aspects of the programme, strategies to reach children out of households and increased involvement of religious leaders as influencers and increased involvement of partners who are involved in communication

Major recommendations for the Western region and others as applicable included:

- Better coordination of stakeholders / partners in areas without the PCN through creation of a formal feedback process between National EPI and provincial planning process, expansion of quarterly communication reviews, currently only done at national level, to include priority provinces and recruitment of Provincial Polio Communication Officers in priority provinces.
- Mapping of potential partners and identification of a smaller number to engage with for strategic communication based partnerships.
- Map UNICEF programme and geographic areas of focus and identify strategic areas of convergence / integration with a focus on priority areas for Polio.

The team that visited the Northern Region made the following key recommendations:

- Develop comprehensive integrated national communication strategy for both polio eradication and EPI services and develop district level communication plans which feed into regional communication plans
- Review messages for polio free areas and ensure all materials reaffirm the link between polio NIDs and the routine immunization schedule
- Explore and assign clearer communication roles and responsibilities for BPHS NGOs especially for routine immunization in polio free areas
- Build capacity and commitment of journalists and media stakeholders at all levels through targeted workshops.

In the coming weeks, Afghanistan Polio Eradication team will revise the current National Polio Communication strategy in view of the recommendations of the independent communication review, 2011 and various other national and sub-national assessments and review conducted in the last year. The strategy will be finalized in consultation with national and international Polio partners before the end of 2011.

Background

Afghanistan is administratively divided into 34 provinces, which are sub-divided into 329 districts. Although the South and the West are the largest regions in terms of area, the most densely populated areas of the country are found in the Central and Eastern regions, as well as some parts of the West and North.

The 2011 polio communication review in Afghanistan focused on the Western, Southern and Northern Regions of the country, from 24-30 September 2011. The review addressed priority themes and issues that had been identified by prior TAG meetings and by internal assessments undertaken throughout the year by the national and sub-national teams.

The review team was comprised of six international communication professionals representing diverse institutions and backgrounds in public health communication and immunization.¹

The review methodology consisted of entry briefing document and a review of data, meetings with government officials, polio partners and staff from diverse agencies, field visits to provincial health centres, meetings with independent monitoring teams, and debriefing meetings at the province and national levels. The teams worked with the polio partners at all levels to understand the field realities, to review strategic documents and data, and to review preliminary recommendations before they were finalized for this report.

Each team was encouraged to arrive at a shared analysis of the problems with the provincial teams, and to subsequently agree on a limited number of priority recommendations, which should be implemented within a 6-12 month period of time and monitored with indicators and milestones.

Although the review had three distinct components and terms of reference (one for each region), there were some common recommendations that emerged from all regions, which should be applied according to the specific context of each area. Common recommendations that have been identified for all three regions are summarized in part I. ***It will be important to understand the common recommendations in the context of the specific challenges facing each region. A detailed analysis of regional challenges, together with recommendations to address each challenge, is included in section 2 of this report.***

A detailed implementation plan for all recommendations, by region, is also included as an annex to this report.

Scope of the Communication Review

The selection of themes and geographic areas of focus were based on a combination of epidemiological, operational and communication challenges. The teams addressed the following themes and areas:

Southern Region (Kandahar)

The Southern Team² was asked to conduct an overall assessment of the efficacy of the Polio Communication Network and linkages with Communication and Capacity Building

1. Identification process for high risk clusters with communication challenges
2. Roles and capacities of Community Mobilisers and Women's Courtyard
3. Use of communication, epidemiologic and social data for planning interventions and impact assessment
4. Key messages development and use of media channels
5. Management of the PCN
6. Cross-border communication and related IEC
7. Capacity building and training needs

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² Tapan Sen, Sherine Guirguis

Western Region (Herat)³

The Western Team was asked to review polio communication in a region with limited polio communication staffing and to understand better how partnerships and media can be used in place of a Polio Communication Network (PCN).

1. Understand how polio communication interventions are coordinated in Zonal offices without Polio Communication Network (with only a Regional Polio Communication Officer);
2. Evaluate the effectiveness of polio communication strategies especially partnerships, in the region;
3. Strategic partnerships to strengthen community level interventions – current partnerships with Education, WASH and Child Protection sections and opportunities for integration / convergence;
4. Training of vaccinators on IPC skills; and,
5. Relevance of mass media and outdoor display materials (billboards, banners and posters) in the polio context since PCN is not present and whether these are adequate.

Northern Region (Mazar-e-Sharif)⁴

The Northern Team was asked to review EPI communication in a region with limited EPI or polio communication staffing, and to understand better how polio and EPI communication can be strengthened and integrated into existing communication approaches

1. Understand how communication interventions are coordinated in zonal offices without dedicated polio or communication staff;
2. Evaluate linkages between polio and EPI communication strategies and activities;
3. Explore opportunities to engage other UNICEF sections or develop strategic partnerships with other local CBOs or groups;
4. Assess current IPC skills and training tools

Part 1: Common Recommendations

1. A National Communication Strategy for Polio and EPI is required

Polio and EPI communication strategies and approaches in polio-affected as well as polio-free areas of Afghanistan are basic, and largely limited to the airing of radio and television public service announcements (PSAs) around polio campaigns. In the northern region, almost all communication activities are nationally driven because of the acute lack of communication capacity in the region. (UNICEF has no regional polio or dedicated communications officer to support local initiatives). In the Southern Region, the absence of a national strategic approach to guide all polio communication activities means that local messages are varied in content, quality and efficacy. It is also not clear to all stakeholders what communication outcomes the PCN is expected to achieve. A standardised strategy - complete with communication outcomes, indicators, and key messages for different audiences and stakeholders- needs to be developed by Kabul and rolled out to the provinces and beyond.

The national strategy should include a mix of communication approaches that include the use of mass media and IEC materials as well as locally organized participatory approaches that encourage community ownership, engagement and dialogue about immunization services.

Based on a national strategy, regional, provincial and district-level strategies should be developed and aligned to ensure all field activities are focused towards achieving common objectives and measurable outcomes for polio eradication and improved EPI. The next communication review should assess progress against the outcomes and indicators set forth in the national communication strategy.

³ Susan Roe, Chris Morrey ⁴ Yin Yin Aung, Thomas Moran

⁴ Yin Yin Aung, Thomas Moran

2. Communication materials and messages (for Polio and EPI) need to be pre-tested, branded and standardized; and flexible enough to facilitate local adaptation

There are a handful of basic IEC materials produced for EPI and Polio at the national and provincial level, but in general, they do not have synergy or impact on visibility due to the fact that materials do not share a common brand (for EPI) or a common look and feel (for Polio and EPI). While the IEC materials seen in Kandahar all shared the polio brand, those in Herat did not. In Mazar, routine immunization (RI) materials did not have a common brand.

Most material was also very text heavy and inappropriate in contexts where the majority of people are not literate. It is important to create standardised IEC materials linked to the polio programme through branding and designed for use in a context in which both audiences and service providers often have low literacy levels.

Mass media products are being used in NIDs but they would be more effective if they were part of a well-planned national mass media communication strategy which would ensure the use of tested and standardised messages prior to NIDs and ideally between rounds as well for routine and polio vaccination.

Given the very diverse contexts in the various regions of Afghanistan, communities and mothers in particular are likely to have different motivational triggers to vaccinate their children. Therefore, local strategies and messages will need to be developed based on an analysis of existing data and commissioned social research. A pre-testing study that would inform the best way to position polio and EPI communication messages in the various contexts is another area that Kabul should look into.

3. Radio as a vehicle for mass media and community engagement needs to be strengthened, and should particularly target Southern region, youth and women

Radio is the mass media platform that reaches the largest number of Afghans and should be the main vehicle for the dissemination of messages. Radio stations that particularly target the Southern region, women (such as Merman in Kandahar and Muska in Helmand) and youth should be considered, given the importance of these groups for bringing children to the door for vaccination.

Focus group discussions with women in Kandahar and others in Helmand consistently requested formats that offer more in-depth information beyond simple radio spots (such as radio dramas or soap operas). Other formats that seek to engage and interact with target groups through Q&As, games, etc. should also be explored.

4. Strengthened and standardized IPC Training is required for vaccinators, communication partners and the Polio Communication Network

All vaccinators, partners and PCN members seem to be given IPC training. However, all teams regularly heard that the quality and standardization of IPC trainings was inconsistent. IPC training for vaccinators in all regions was often dealt with in a perfunctory manner and if time was given for training, it was short or cut altogether. There is presently limited training for other stakeholders apart from training modules related to social mobilization. Training was the one part of the job that every member of the PCN cited immediately when asked what their role was; but what was meant by training seemed to differ for each person. There is a 2-day PCN Training of Trainers module at the central level in Kabul, but we did not get a sense that this is being used in a consistent manner. Some staff told us their trainings took one day, while others said it took 2 hours. There did not seem to be consistent guidelines or materials applied, and there was no evidence of a training impact evaluation that measured the quality of training and recall of key training issues or messages.

IPC training should also be conducted with a range of stakeholders and partners (i.e. doctors, nurses, CHS, CHW, REMT, PEMT, influencers – mullahs, teachers, community leaders - vaccinators). This would help build IPC capacity amongst partners and other stakeholders and at the same time create greater understanding of its importance and application. IPC training is particularly critical for vaccinators; given that this group are the only service providers who engage with almost every single family. We need to maximize the interaction we have with families through vaccinators, and build their capacity to encourage and motivate family members to bring eligible

children to the doorstep. This needs to be supported by communication messages for vaccinators, which also promotes and encourages the critical role that they are playing in the polio eradication campaign.

IPC training both for all stakeholders could be improved by strengthening the materials used in training sessions. With low level of literacy among staff in the field, it is critical to develop very simple training modules with visual aids in order to impart skills and messages: audio visual aids such as DVDs can be explored to help standardize the quality of training.

For the PCN in particular, training should be developed or enhanced in the following areas: management and analysis of data, strategic understanding of the role and use of IEC material, IPC skills for community mobilisation, use of planning, reporting and monitoring formats and management and performance evaluation of staff.

Strengthened monitoring and follow up of training courses for vaccinators and PCN staff at a minimum should be conducted to ensure the training occurred and was of reasonable quality. Simple post-training testing would help determine recall and small incentives such as certificates could be included to indicate the training had been successfully completed. (Other incentives could also be included such as an award for the best role play or other aspect of the IPC component of the training which would also help ensure the IPC training component is carried out.)

5. Additional partners who can engage with communities on polio and EPI need to be mapped, prioritizing those who can reach high risk groups such as women, inaccessible and nomadic populations in the South

Given the limited skilled human resources available for EPI and Polio Communications, partnering with other organization and groups, both to expand our reach for Polio and EPI communication, as well as to maximize the access we already have to offer additional public health messages, will be critical to achieving our goals.

There is considerable space and support amongst stakeholders to integrate polio with other development programmes and public health messages. For instance, the UNICEF Education programme has women's literacy projects and community based schools which could incorporate polio messages through curricula materials but could also go further to explore ways to actively engage women and school children in awareness raising and IPC activities. The PCN activities that target school children could be expanded to all schools in a district (not simply those with a paid PCN member) and a package of interactive materials could be developed that would engage and interact with children on a wide variety of issues. WASH has partnerships and planned activities with District Development Assemblies (DDAs) and Community Development Councils (CDCs) which could be utilized together with IEC materials and/or training to incorporate polio messaging into their work on sanitation and health.

WFP's literacy and food distribution programmes should be explored and partnered with, as they offer unique opportunities to reach women or otherwise accessible populations. Youth Information and Communication Centers (YICC) are another partnership that should be explored in particular.

Internal (within UNICEF) and external partnerships should be mapped out to determine the most strategic ones that can help expand our coverage and reach high risk groups such as women, inaccessible and nomadic populations in the South in particular.

Common Barriers

Teams identified some challenges that may pose barriers to implementing the recommendations fully in some areas:

1. Fluid security situation, which hampers access as well as the ability to monitor quality
2. Geographically isolated populations with very limited access to communication platforms
3. Limited capable human resources to drive local strategies and activities
4. Difficult to reach women and actively engage them in the programme
5. Limited commitment at some levels, and the monetization of communication activities amongst some partners
6. A wide range of partners working across the Provinces makes the partnership terrain complex

Part II: Regional and Theme-based Recommendations

A. Southern Region

Areas visited

The team visited Kabul and Kandahar

Review Methodology

1. Analysis of Campaign Data, Planning, Reporting and Monitoring Formats
2. Meetings with key stakeholders and partners at the Central and District Levels including: WHO, Government staff and Independent Monitors
3. Interactions with cluster level representatives of the polio campaign teams from Kandahar and Helmand provinces
4. Meetings with UNICEF Polio Team at Kabul and Kandahar

Key Findings and Observations

Overview of Kandahar/Southern Region

Polio has until very recently been confined to the Southern Region, particularly in the 13 High Risk Districts. (One case has just been detected in the North after 10 years of being polio-free.)

The Polio Communication Network (PCN) exists in the South and East regions of Afghanistan. The PCN has recently been substantially expanded and now includes approximately 2,200 workers at community, cluster, district and provincial level. The recommendations for the Southern Region are quite specific to this area as it is the only region with wide polio circulation but may be applied to the PCN in the East region as well.

The Southern Region, which is most affected by the ongoing war and insecurity, poses particular operational and communication challenges for the polio programme. Movement is heavily restricted, monitoring is limited, capacity is weak and almost every developmental programme is competing for the same human resources. The involvement of women in the programme is negligible and will be a persistent socio-cultural challenge to overcome. Nonetheless, the team has felt that the recommendations identified in this report should be feasible even amidst an extremely challenging context.

Identification of high risk clusters

Polio eradication in Afghanistan has currently been prioritized to 13 High Risk Districts in the Southern Region. An additional 15 High Risk Districts have just recently been proposed to the IMB during its third quarterly meeting this year, which took place on 27-30 September 2011.

Field staff in Kandahar informed us that the high risk identification process is currently being led by WHO Kabul, which will ultimately be shared down to the provinces and districts for their verification or revision. During our time in Kandahar and Kabul, we were unable to see any documentation of how high risk clusters in the 13 HRDs have been identified, nor did we receive an explanation for how each indicator included in the prioritization exercise (for example, high population density, vaccination coverage, active transmission of cases, etc.) has been weighted to distinguish the most critical elements for prioritization. It is not clear if these documents and this analysis exists. Thus, as the programme considers another phase of reclassification and expansion of high risk areas, we recommend that a clear system of prioritization be documented by WHO, with weighted indicators and performance thresholds, and that this logic is shared widely for feedback and joint planning with the partners and standardized procedures across all areas.

Once the operational prioritization is agreed upon, we also recommend that criteria is established to determine where the Polio Communication Network is deployed, and possibly how many staff are required. Communication indicators should include refusals as well as newborn, sick or sleeping categories.

Recommendations:

- 1. Establish and document clear criteria (with thresholds) for identification of high risk areas for the programme, first operationally and then for communication/social mobilization issues**
 - a. Indicators need to be established and weighted due to priority issues for the programme, as well as priority issues for communications.*
 - b. Communication indicators should include refusals as well as newborn, sick or sleeping categories. CO may consider a threshold of >6% refusal and/or >15% newborn sick or sleeping to warrant prioritization for PCN deployment*

Management of the PCN Network

The Polio Communication Network is a workforce of approximately 2200 staff, largely focused in the Southern Region of Afghanistan. Despite these large staffing numbers, current coverage of the PCN is only 24% of high risk clusters. In many areas, 10-12 mobilizers are to report to duty, but field observations suggest that it is unlikely all 10-12 are actually in place and working. Given the fact that we do not want to increase more staff, it is not clear if we are distributing the 2200 staff most strategically to the highest risk areas, and whether there may be another way to spread the coverage of these staff to areas beyond the current 24%. Conversely, even if we do maintain a model of 10-12 mobilizers per cluster, are the mobilizers currently in the highest risk 24% of polio-affected areas? Deployment criteria are not clear.

Community Mobilisers (CMs) are influencers at the most local level selected from within the community: Mullahs, Teachers, Community Health Workers, and Community Elders (and Women' Courtyard-- dealt with later on in this section). They are well accepted by the community and many of them have played critical roles in converting refusals. In the PCN areas, they are an important part of the polio campaign and all efforts should be made to consolidate and reinforce the network further. However, several gaps need to be addressed in order to strengthen the efficacy of the network.

While the PCN staff have specific ToRs and scope defined for them (which the review team was not able to see, but heard of), there are no set guidelines for their selection. This weakness is often taken advantage of by politically interested influential people who recommend the selection of favoured candidates irrespective of their capabilities. Many staff interviewed stated they had been brought into the network because their father was a community elder, or an imam, or some other person had influenced a hiring manager to give them a job. Based on interaction with CMs and their supervisors from Kandahar and Helmand provinces, as well as from studying the quality of the communication planning and reporting formats submitted by them, it seems that capacities and capabilities vary widely, with few appearing to sufficiently carry out their expected tasks.

We looked at planning and reporting formats meant to be completed by PCN staff at various levels. Most did not follow the prescribed planning formats. Some claimed that they are unaware of them, while many, who do use them, do so without attention to detail. Understanding of campaign data in terms of campaign awareness percentages was also found to be low, with the CMs claiming 95% awareness in their clusters without reference to any data, simply their "feeling."

The quality of managers varies widely. For example: in the Cluster Communication Plan for Bust District(Helmand), under the section 'Training of CMs', the Cluster Communication Focal Point entered the objective: "*To train communication mobilisers according to new methods of communication to convince the community for vaccination and create demand for immunisation.*" In the same planning document for Kajaki district (Helmand province), the CCFP merely entered "*to increase their knowledge about vaccine*". With such variation of quality, training quality and the ability to achieve consistent results in the field becomes suspect.

Another area of weakness within the CCFPs and CMs is their low appreciation of the role played by IEC material and how to use and manage them. While the CCFPs distribute posters, banners and leaflets to the CMs during

training sessions, the CMs rarely follow a structured and strategic plan for their deployment in areas where they would work best. This may be why we notice a lone poster suddenly on a wall along a dusty highway and none on a busy market place. Monitoring of IEC is also not carried out systematically by the CCFPs or anyone in the Network.

Turnover of staff in the PCN is frequent and erratic. Whenever a high level of coverage is attained in a particular cluster (say, over 90%), that cluster is (apparently) not considered by the Partners to be high risk anymore and the PCN is disbanded. This works as a disincentive for good performance. Once staff have been suddenly let go, they contribute to a rising resistance for the programme, which at least partially explains the sporadic spikes in refusal from one round to the next.

The programme is competing with many other development programmes and sectors to hire qualified, literate staff. Coverage from one month to another may spike up or down due to staff taking higher paying jobs, some of which are seasonal such as poppy cultivation or Cash for Work programmes. In addition, the top management of the PCN does not seem to have the skills required to plan and manage activities at the required level, suggesting the current level of pay is not able to attract the requisite skills, which do exist in the country, but are rare and are in high demand.

Recommendations:

- 2. Evaluate PCN deployment plan based on high risk communication criteria, and consider expanding coverage of the PCN network by reducing number of mobilizers per cluster and shifting balance of mobilizers to neighbouring HR clusters.**
 - a. Develop exit and entry guidelines for PCN staff, as well as team composition in each area. This should be based on the scale and scope of the communication problem, as well as the population and physical distance of area to be covered.*
- 3. Establish a more formal HR system, based on merit. PCN staff deployment should be stabilized annually (unless performance issues warrant changes), and deployment plans should be reviewed on an annual basis based on updated high risk analysis.**
 - a. Consider holding a national workshop with key stakeholders and select management levels of the PCN to identify ways to strengthen the operational management and structure of the PCN.*
 - b. Develop clear TORs for each level of the PCN, and objective recruitment panels for selection and retention.*
 - c. Establish a staff performance evaluation system based on TORs.*
 - d. Assess remuneration levels at least for the DCFPs and above to ensure the management structure of the PCN has adequate skills to plan and monitor communications activities*
 - e. Consider hiring provincial or district-wide staff on a 3rd party contract so they can more freely move around and monitor*
- 4. Strengthen performance accountabilities at all levels of the PCN (see data and monitoring recommendations)**

Capacity building and training needs

Training was the one part of the job that every member of the PCN cited immediately when asked what their role was; but what was meant by training seemed to differ for each person. A series of cascade trainings apparently take place within the PCN before each polio round: the Provincial Communication Focal Points (PCFPs) train the District Communication Focal Points (DCFP), who train Cluster Focal Points (CCFPs), who then train the Community Mobilizers. There is a 2-day PCN Training of Trainers module at the central level in Kabul, but we did not get a sense that this is being used in a consistent manner. Some staff told us their trainings took one day, while others said it took 2 hours. There did not seem to be consistent guidelines or materials applied, and there was no evidence of a training impact evaluation that measured the quality of training and recall of key training issues or messages.

It was not clear what training materials exist for the sessions and it seemed that trainings relied on IEC materials like posters and leaflets for the training sessions. A large format flip chart prepared several years back was not in circulation and the DCFPs and CCFPs whom we met were unaware of its existence. With low level of literacy

among some DCFPs and even lower level among several CCFPs it is critical to develop very simple training modules with visual aids in order to impart skills and messages.

With such limited capacity at various levels, and based on the ToRs expected of the PCN, training should be developed or enhanced in the following areas: management and analysis of data, strategic understanding of the role and use of IEC material, IPC skills for community mobilisation, use of planning, reporting and monitoring formats and management and performance evaluation of staff.

Training should also be extended to, and enhanced for, vaccinators, who are the only service providers who engage with almost every single family. We need to maximize the interaction we have with families through vaccinators, and build their capacity to encourage and motivate family members to bring eligible children to the doorstep. Ensuring vaccinators adopt the right tone and manner of communication is an aspect of training that needs attention. This needs to be supported by communication messages for vaccinators, which also promotes and encourages the critical role that they are playing in the polio eradication campaign.

Recommendations:

- 5. Conduct Learning needs assessment/KAP to assess capacity and knowledge of the PCN**
- 6. Develop training strategy to address learning needs and minimum standards of communication training for various levels of the PCN and vaccinators, and offer guidance for how training will be rolled out**
 - a. Need to develop different training packages for various levels of PCN and polio network, based on TORs. Basic elements should include IEC (understanding how to distribute and manage IEC, IPC skills, use of data management and analysis, reporting and monitoring formats, staff performance and management*
 - b. Ensure vaccinators are given sufficient training on IPC messages*
 - c. Develop tools for vaccinators to ask 5 critical IPC questions when visiting households (e.g. develop clipboards with visual cues, for example)*

Using data for communication planning

Communication data is currently not being used to focus on local areas or social challenges. Although planning and reporting frameworks have been established centrally, not everyone seems to be aware of them or are using them. For example, one CCFP we met with prepares the Communication Plan on a blank sheet of paper. The CM said that if he were trained on it, he would be able to use the 'new' format.

The planning tool could also be strengthened by including space to identify challenges based on previous round's data, as well as space to set performance targets for success, which could then be measured and monitored by supervisors and the national team in the monthly communication review meetings.

Due to a lack of data being used, we don't fully understand why we are missing children. The staff didn't have a clear understanding on the trends for refusals from one round to another, where children are when they're not at home or what is behind such large proportions of children sick or sleeping.

As mentioned above, training is also a challenge in this area, where independent monitors are not adequately trained to collect PCA data, which leads to poor quality data. Campaign awareness data is filled out incorrectly and is often times surveying children in the absence of the caregiver. "No" is the default response if there are questions about how to fill this out, so we are likely under-reporting awareness, but we don't really know. Intra-campaign monitoring forms include categories to identify where children are when they are listed as "child not available", but in all forms we reviewed (over 20), these categories were not being reported. Instead, monitors were recording the name of the child who was not available for follow-up, but there is currently no way to analyze this data after the round in order to pro-actively adjust our strategies to reach children who are not in the household when teams visit.

Recommendations:

- 7. Revise planning frameworks to include baseline data for the identification of challenges, as well as quantifiable performance targets that can be monitored by PCA or Intra-campaign monitoring**

- a. *Establish standardized thresholds for priority areas and activities to focus on (e.g. resistance >6%, sleeping, newborn, sick >10%, campaign awareness >85%, etc.)*
 - b. *Identify a few simple key performance indicators for PCN (e.g. % of refusals converted, % of campaign awareness, etc.)*
- 8. *Link the submission of programme documents (e.g. planning documents and activity reports based on plans) to performance and retention of staff***
 - 9. *Work with WHO to improve quality of data collection on reasons for missed children and campaign awareness in PCA and ICM***
 - 10. *Conduct a study on reasons for missed children (including reasons for refusal) to verify monitoring data***

Social mobilization and community engagement

A critical objective of the PCN is to engage communities using targeted messages. However, the absence of a strategic approach to guide all communication activities means that messages are varied in content, quality and efficacy, and it is not clear to all stakeholders what outcomes the PCN as a whole is expected to achieve. A standardised set of key messages and sub messages by different audiences and stakeholders for high risk districts needs to be developed. This is an issue that requires attention from Kabul.

The IEC tools that are in circulation in Kandahar district (some of which have been designed in Kabul), are very text heavy and are not understood by many community members, including influencers and women. Inclusion of self-explanatory visuals, with some light accompanying text, should be considered in revised IEC materials. At present the only dominant visual on any IEC material is the child receiving polio drops. While that is a recognizable image to represent the polio campaign, it is also the campaign logo which features in every communication material. Hence in order to sustain interest in communication material and to combat the fatigue of looking at the same image each month, it will be useful to explore other relevant visuals as response-triggers. A study into what motivates mothers to care for their children's health could generate ideas on how to generate creative campaign ideas to position polio vaccination. This is another area that Kabul can look into.

Getting messages to women remains a substantial challenge. There are currently limited activities designed to reach women with communication messages and OPV and limited opportunities to do so. Perhaps the bravest effort that the review team noticed was the motivation and the conviction with which the members of the Women's Courtyard work despite the obvious threat to their security.

The Women's Courtyard initiative plays an important role in reaching women largely through literacy classes that take place in women's homes. Courtyard mobilizers engage women on polio facts, and the need to bring children to the doorstep for vaccination when the teams visit. The members we met were proud of their work, and felt a social commitment towards eliminating polio from Afghanistan. In fact, they were some of the few members of the PCN who provided very practical, useful strategies to improve outreach. For example, they provided suggestions of women's radio stations that could be targeted for messages, and said they would welcome more in-depth engagement beyond radio spots. They would like to see radio serials, for example. They suggested innovative ideas to place vaccination teams at a local shrine site (Harkah Sharif) and at picnic sites (Baba Sab) during family days each week where thousands of women and children gather, even from insecure and inaccessible areas. They stated they would be willing to work in these locations to mobilize mothers. This initiative has received some criticism and indeed, it is not easy to ensure consistent performance given the difficult working conditions for women in Kandahar. However, the review team felt strongly that this initiative should be nurtured, strengthened and expanded as much as possible; the engagement of women has been the backbone of eradication efforts in many other countries, and nowhere is it more critical than in Afghanistan.

Another opportunity to reach women is through school children. Community Mobilisers who are teachers have the task of orienting children on polio messages and equipping them with relevant information that they can take home with them. A specialised School Package formatted to attract children (e.g., quiz, songs etc.) will be an impactful intervention to engage this target group more effectively.

Converting refusals often need special communication effort and higher source credibility for such communication is important. This can be done by enlisting the support of respected religious leaders who can reach out to the community by advocating for polio drops through radio, TV, printed IEC material and outdoor media. Currently,

mass media efforts by religious leaders are limited to mosque announcements; this may be enhanced by showing religious leaders on local television inaugurating campaigns or vaccinating children, or by featuring religious leaders in media inserts and on posters.

Recommendations:

11. Develop a communication strategy that identifies objectives of the communications programme, outcomes we want to achieve (increased knowledge, threat perception, demand, etc.), and key approaches that will be implemented

- a. *Identify target groups and standardize messages for community engagement*
- b. *Develop a standardized communication package that has been pretested, with provisions for adaptation at the local level. Communication materials should be positioned based on pre-test research that identifies the most effective motivators for mothers to vaccinate their children (perhaps based on a concept of a preventable threat among many other threats that cannot be controlled, for example)*
- c. *Develop an advocacy package to increase political and social commitment.*

12. Initiate or strengthen the following approaches to deliver the communication strategy:

- a. *School engagement: in particular should be strengthened given the importance of this target group in reaching women and bringing children for vaccination.*
- b. *Strategies to reach women should be explored, including Harkah Sharif on Thursday, and Wednesday Baba Sab (family picnic day), women's radio (Merman in Kandahar and Muska in Helmand), health clinics, marriage ceremonies, WFP literacy, food distribution, or other programmes targeting women*
- c. *Strategies to reach children outside of the household should be explored based on PCA and Intra campaign monitoring data on child not available (e.g. madrasa's, markets, etc.)*
- d. *Consider a campaign featuring religious leaders as visible influencers and proponents of the programme*
- e. *Partnerships with other organizations who do communications work*

Cross-border communication and related IEC

The reference area for the team was Spin Boldak where the Afghan border crossed into Kila Abdulla district with Chaman as the border town. Campaign awareness and vaccination- both seemed to be progressing well with good co-ordination. Co-ordination takes place both at the District and Regional levels. The Regional team is in touch with their counterpart in Quetta, Pakistan. Monthly interactions take place at the district level.

Families with children cross over to the other side to visit relatives, for work or for medical treatment. Spin Boldak has 3 vaccination teams active in the border area. Throughout the year there are 2 teams for children who cross over on foot and 1 team for children travelling in vehicles. The DCFP along with CCFPs visit the border area during the polio campaign and undertake campaign awareness by putting up banners, posters and distributing leaflets. There is a plan to put up a new billboard. Loudspeaker announcements are also made during the round. In order to ensure that the children coming in from Pakistan are not missed a shed has been put up at the Afghan border entry point.

B. Western Region

Snapshot of Herat / Western Region

The Western Region is composed of 4 provinces, Herat, Badghis, Ghor and Farah which borders the Southern Region and the region has a population of more than 5 million. The Western Region presents as area with on-going transmission and one which has polio cases within the last three years. In 2010, Afghanistan reported 25 confirmed polio cases including two from Farah Province of the Western Region. At this point in time in 2011,

Afghanistan has 30 cases, three of which come from Farah Province with the last case being confirmed in early August of this year and 1 additional case in Badghis in early September as well.

Challenges related to polio eradication in the Western Region include limited human resources (at regional, provincial, and districts levels) and the need for intensified IPC and capacity building. Delivery of health services and both polio services and communication dimensions require engagement and support based on NGOs and other local level partnerships and these groups ability to negotiate in order to gain access to insecure areas. In addition, special attention and focus must be given to mobile / migrant and nomadic populations moving into the region from the South related to traditional lifestyles and changing security situations.

Terms of Reference:

To review polio communication in a region with limited polio communication staffing and to understand better how partnerships and media can be used in place of a Polio Communication Network (PCN).

- Understand how polio communication interventions are coordinated in Zonal offices without Polio Communication Network (only Regional Polio Communication Officer);
- Evaluate the effectiveness of polio communication strategies especially partnerships, in the region;
- Strategic partnerships to strengthen community level interventions – current partnerships with Education, WASH and Child Protection sections and opportunities for integration / convergence;
- Training of vaccinators on IPC skills; and,
- Relevance of mass media and outdoor display materials (billboards, banners and posters) in the polio context since PCN is not present and whether these are adequate.

Review Methodology

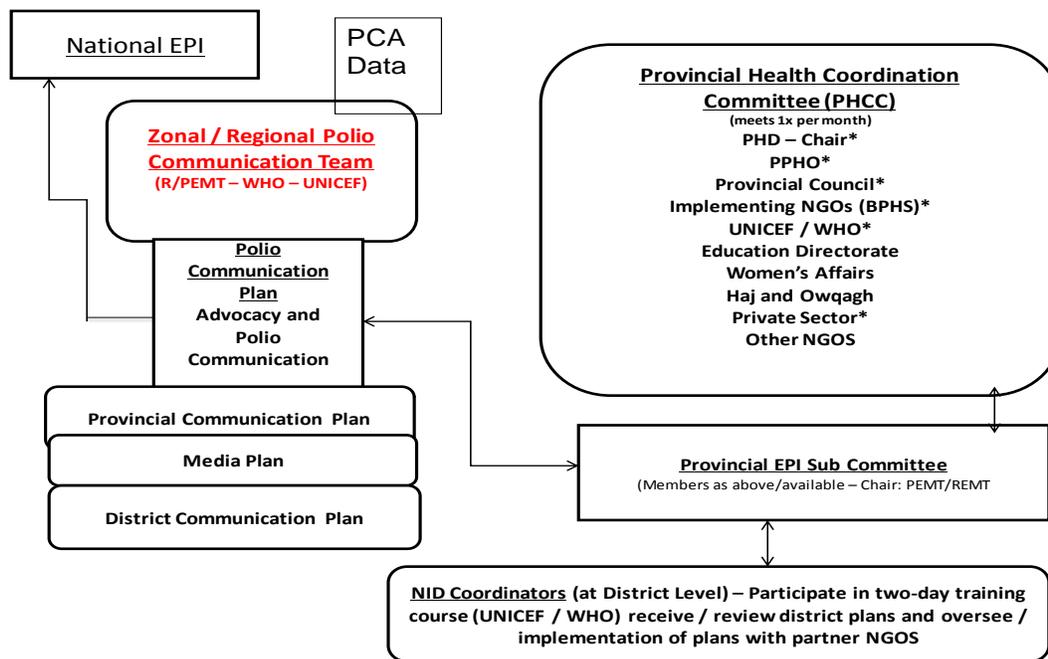
The review was conducted using a combination of information gathering techniques including discussions and briefings with key programme staff, review of relevant materials, reports and data, undertaking field visits to the MoPH and clinics to meet with health service providers, individual and group interviews with UNICEF staff from the polio programme (at both national and provincial levels) and those working in other programme sections, and through discussions and interviews with other programme partners (including implementing NGOs, religious leaders, media representatives and the Education Directorate).

The Polio Communication Officer for Herat was also present at meetings and available to provide context and additional perspective. A doctor from a local hospital acted as an independent translator.

Findings and Key Observations

- 1. Understand how polio communication interventions are coordinated in zonal offices with only a Regional Polio Communication Officer and no Polio Communication Network (PCN) as found in the South and East.**

The overall coordination structure is in place and functions well for the development of provincial activity plans and fits well with the provincial health systems. However, the coordination and planning tends to weaken as plans move to the District level. This can be seen in the diagram below which demonstrates how the communication activity plans are prepared, reviewed and rolled out.



The diagram above reflects our discussions with the Dr. Ahmadi the Regional Polio Communication Officer (RPCO) for the Western Region based in Herat. The planning process begins with an analysis of the PCA data from the previous campaign which is reviewed by the Zonal/Regional Polio Communication Team made up of the REMT/PEMT, WHO and UNICEF. The team uses this analysis to prepare draft Provincial and District level communication activity plans as well as a media plan for the next round. These are then sent to the Provincial EPI Sub-Committees for Herat, Farah, Ghor and Badghis where they are reviewed and revised. They are then sent back to the Zonal Team and to the National EPI programme. Once this is done District level NID Coordinators are called to a two day training course to discuss the District plans and prepare for implementation. Each Province also has a Health Coordination Committee (PHCC) which discusses a range of issues including NIDs and other polio activities.

The structure works well in theory providing spaces for consultation, engagement of partners and information flow to the National level. In practise this process is often rushed and there is sometimes limited time for preparation and/or feedback meaning the reality is often that the plan is developed by Zonal Team without a great deal of further input from EPI Sub-Committees or the National EPI programme. Furthermore, the Polio Communication Officer, being one person in Herat working in a context of travel and time restrictions, is unable to provide the level of monitoring required to determine if the training is conducted adequately or if the partners are fully implementing the plan at the District level. Because of these limitations the process leaves three major gaps - National oversight, Provincial/District partnership engagement in development and implementation of the communication activity plans and more detailed monitoring particularly at the District level.

Overall this process is appropriate and fits well with the Provincial Health structure but given the epidemiological, security and access context in the region, well planned, coordinated and effective communication activities are essential to the polio programme in each of the four Provinces. As there is no PCN, all of this depends on the active and effective engagement of multiple partners (e.g. government, BPHS implementing NGOs, religious and community leaders, UN Agencies, International NGO and bilateral programmes) which work in various locations across the Provinces. Each Province and District has its own constellation of partners that need to be engaged, supported and monitored in the implementation of the communication activity plan. In order to make sense of this complex situation the programme needs to be strategic in deciding which partners to work with, needs to work within or align with a clearly defined national strategy, utilise standardised messages and IEC materials and have the capacity to monitor the implementation of communication activities across all four Provinces and down to the District level. This task is made very difficult given the gaps in the present structure noted above.

In order to strengthen the integration of national strategies and plans into Provincial and District plans a formal feedback process needs to be established between National EPI and the provincial planning process. This will

allow for more oversight from the National level to ensure that national strategies are reflected in the planning but will also allow for input from the Provincial and District levels back to the National level providing a better understanding of the issues, gaps and initiatives happening in a region that remains at significant risk for polio transmission. The quarterly polio communication reviews provide another opportunity to strengthen the link between National and Provincial levels and an opportunity for increased dialogue, capacity building and planning which would be further enhanced if similar reviews were held in the provinces prior to the National one so they could be integrated into those discussions. However, the biggest issue may be that capacity at the Provincial level is not nearly adequate to the task. One person based in Herat cannot be expected to coordinate (let alone expand) such a complex system across four provinces. Consideration needs to be given to expand this capacity so that each Province has a Polio Communication Officer or equivalent based with the government.

2. Evaluate the effectiveness of polio communication strategies, especially partnerships, in the region.

As noted above there is a process for developing communication activity plans which incorporates partners at both provincial and district levels. There are two core types of partnership - implementing BPHS NGOs and other partners responsible for dissemination of messages (Education Directorate, mullahs and others). The partner makeup of each Province varies and while there will be some groups that remain constant such as mullahs, the Directorate of Education and some BPHS implementing NGOs, the make-up of these partnerships changes from Province to Province and partnerships are largely based at Provincial rather than the zonal level. This means that partnership building needs to be done within each Province and the constellation of partners will vary.

While the BPHS implementing NGOs are expected to carry out the entire spectrum of polio communication activities according to the plans other partners tend to play more of a message dissemination and influencer role. For instance the Directorate of Education utilises UNICEF polio guidelines to prepare a set of polio messages which are then sent to a focal point teacher in each District. This focal point is expected to distribute these messages to teachers within the District and ask them to read them out to students. Organisations like the Hajo Howqaf Directorate send polio messages out to mullahs to be read in mosques. While this system works reasonably well at the level of distributing messages it seems to be less effective at ensuring these messages are delivered in a systematic way and also misses opportunities that would enable these partnerships to do more. Partnerships could be strengthened if there was more capacity in each Province such as a PCO or equivalent. This would provide a dedicated Provincial level post focused on coordinating and building partnership networks relevant for each Province. Partner's roles and engagement could be further enhanced through the use of standardized IEC materials, increased monitoring and follow up and provision of capacity building and additional training.

3. Strategic partnerships to strengthen community level interventions – current partnerships with education, WASH and Child Protection sections, opportunities, integration, convergence etc. (Please see preliminary mapping of internal programmes/partners in annex 2.)

There is considerable space and support for integration and convergence with polio communication activities amongst UNICEF and other UN agencies' internal programmes, and planning has already begun to identify areas of immediate opportunity for awareness raising and community engagement. This is a positive step and one that, due to its internal nature, has the potential to be rolled out quickly. The key programmes in UNICEF are Health and Nutrition (which is already integrated in the West Region and likely elsewhere), WASH, Education and Child Protection. The team did not have an opportunity to meet with anyone from Child Protection but in our meetings with WASH and Education it was clear that areas where integration and convergence are possible are already being discussed.

For instance, the Education programme has women's literacy projects and community based schools which could incorporate polio messages through curricula materials but could also go further to explore ways to actively engage women and school children in awareness raising and IPC activities. WASH has partnerships and planned activities with District Development Assemblies (DDAs) and Community Development Councils (CDCs) which could be utilized together with IEC materials and/or training to incorporate polio messaging into their work on sanitation and health.

However, as suggested in relation to external partnerships these internal partnerships should also be mapped out to determine the most strategic ones in relation to geographic coverage with a special focus on areas which are high risk due to challenges such as low coverage, accessibility, recent polio cases and/or mobile populations.

4. Training of Vaccinators on IPC skills

There is, of course, IPC training for the vaccinator teams which is given as part of the overall training prior to rounds. However, while we were not able to review this directly we heard consistent mention that during training IPC was often dealt with in a perfunctory manner and if time was short was often cut altogether. There is presently limited training for other stakeholders apart from training modules related to social mobilization.

IPC training could be improved by strengthening monitoring and follow up of training courses for vaccinators to ensure the training occurred and was of reasonable quality. Simple post-training testing would help determine recall and small incentives such as certificates could be included to indicate the training had been successfully completed. (Other incentives could also be included such as an award for the best role play or other aspect of the IPC component of the training which would also help ensure the IPC training component is carried out.)

IPC training should also be conducted with a range of stakeholders and partners (i.e. doctors, nurses, CHS, CHW, REMT, PEMT, influencers – mullahs, teachers, community leaders - vaccinators). This would help build IPC capacity amongst partners and other stakeholders and at the same time create greater understanding of its importance and application.

5. Relevance of mass media and outdoor display materials (billboards, banners and posters) – polio context, since PCN is not present are these adequate etc.

There are a few basic IEC materials produced at national and provincial level but they do not have synergy or impact on visibility and recognition that comes from standardized and branded materials. Some of the IEC materials we observed in Herat did not feature the polio logo and were text heavy and not useful in contexts where the majority of people are not literate. It is important to create standardised IEC materials linked to the polio programme through branding and designed for use in a context in which both audiences and service providers often have low literacy levels.

Mass media products are being used in NIDs but they would be more effective if they were part of a well-planned national mass media communication strategy which would ensure the use of tested and standardised messages prior to NIDs and possibly between rounds as well. Radio is the mass media platform that reaches the largest number of Afghans and should be the main focus for the development of products such as PSAs. Previous communication activity plans the team reviewed showed that these were being utilised in Herat but not at a high enough insertion rate to be fully effective (though it should be noted that efforts had been made to ensure that the spots were aired during periods of high listenership). Beyond radio PSAs and specific messaging for use prior to NIDs could be supplemented with other formats such as radio dramas or SMS.

Strategic Recommendations

Coordination of Stakeholders / Partners Without the PCN

1. Integrate national strategies and plans into Provincial and District plans by creating a formal feedback process between National EPI and provincial planning process.
2. Expand national quarterly communication reviews to include priority provinces.
3. Place Provincial Polio Communication Officers in priority provinces.

External Partner Strategies

4. Need to map potential partners and identify a smaller number to engage with.
5. Develop and disseminate standardized IEC materials to key partners.
7. Provision of capacity building and training in use of IEC materials.
8. Strengthen monitoring and follow up related to partner performance.

Internal Integration and Convergence

9. Conduct mapping exercise to identify strategic areas of convergence / integration with a focus on priority areas.
10. Integrate polio messages in IEC training and curriculum materials developed for strategic programmes.

IPC Training

11. Ensure IPC training modules are included in training at all levels with monitoring and follow up.
12. Develop and roll out IPC training for a range of strategic stakeholders and partners.

Mass Media and IEC

13. Develop nationally branded and standardized IEC materials for use at national, provincial and district levels.
14. IEC materials should be designed for low literacy participants groups including audiences and service providers
15. Develop mass media products with radio as the first priority and increase insertion rates prior to NIDs.
16. Explore the use of other formats such as radio drama and SMS.

Possible Barriers (Challenges)

- District capacities for effective communication are presently weak and varied.
- There is limited polio communication support in the region with only one PCO for four provinces and 40 Districts.
- Some of the implementing partners are not performing well.
- There are serious security and access issues in Farah and in other areas throughout all four Provinces.
- Demands on District Coordinators are already significant and asking them to do more without support may be problematic.
- There is a wide range of partners working across the Provinces which makes the Partnership terrain complex.

C. Northern Region

Snapshot of Mazar-e-Sharif/ Northern Region

This chapter outlines recommendations for the communications programme, with a specific focus on polio and EPI communications in polio free areas of Afghanistan.

The recommendations were generated by a small team of communication and immunization experts representing WHO and UNICEF⁵, with prior experience of reviewing the Afghan polio programme, who travelled to Kabul to meet national stakeholders and then on to Mazar e Sharif in the Northern Region of Afghanistan.

The team commends the work done by national, regional and state teams who have successfully kept the region free from polio for more than a decade with limited human resources dedicated to communications and with only basic media sensitization strategies in place. However, would like to re-affirm the real risks to this progress by largely uncontrolled circulation of virus in neighbouring Pakistan and an expanding outbreak in the south and east of the country.

Maintaining the tremendous progress made in polio free areas of Afghanistan remains an absolute necessity in 2012 as the country works towards national polio free status.

As no polio communications review has been conducted in Afghanistan since 2008 this report does not evaluate the status of implementation of any previous recommendation. New recommendations with national and local responsibilities are given in 5 priority areas - Planning, Messaging, Partnerships, Media, Capacity.

Team Objectives - Northern Region

As part of a larger review team tasked with other geographical responsibilities the Mazar e Sharif team was tasked to:

⁵ Dr Yin Yin Aung, UNICEF ROSA; Thomas Moran WHO HQ

1. Understand how communication interventions are coordinated in zonal offices without dedicated polio or communication staff;
2. Evaluate linkages between polio and EPI communication strategies and activities;
3. Explore opportunities to engage other UNICEF sections or develop strategic partnerships with other local CBOs or groups;
4. Assess current IPC skills training tools;

Review Methodology

The recommendations are based on the panellists' review of available country documents including the most recent national and local strategies and evaluations, intra and post-campaign monitoring data, summary presentations as well as direct feedback from a broad range of key stakeholders which met the team.

In Kabul the team met with:

- MoPH – Dr Gula Khan
- UNICEF health and polio staff
- UNICEF Chief of Health
- UNICEF Chief of C4D
- WHO Polio Team Leader

In Mazar e Sharif the team met with:

- Regional EPI Management Team – Dr Basir – REMT Manager
- Partners – UNICEF regional team, WHO regional and state teams
- BPHS implementing NGO partner for Mazar e Sharif – CHA -
- Local Journalists/Reporters – Print, TV, Radio
- Vaccinators and Health Staff at the Noor – e – Khuda, Comprehensive Health Centre

Communication Summary - Northern Region

Polio and EPI communication strategies and approaches in polio free areas of Afghanistan are basic and limited to the airing of radio and television public service announcements (PSAs) around polio campaigns. In the northern region, almost all communication activities are nationally driven because of the acute lack of communication capacity in the region. (UNICEF has no regional polio or dedicated communications officer to support local initiatives).

With little likelihood of additional human resources dedicated to polio and EPI communication being deployed to polio free areas of Afghanistan, tried, tested and cost effective strategies such as the strategic placement of radio PSAs, the delivery of key messages through trusted community based organizations (CBOs) and more regular sensitization of local media groups will be most effective in ensuring local communities continue to receive timely and accurate information on the importance of immunization services and the real threat that poliovirus and other vaccine preventable diseases pose to their children.

An integrated national communication plan which clearly delineates specific communication objectives for both the polio programme and EPI, linked to activities that are scheduled even when polio rounds are not being conducted is essential to ensure this.

This plan should include a balance of strategies that include the use of media and IEC materials as well as locally organized participatory approaches that encourage community ownership and neighbourhood linkages to immunization services.

With 85% of districts in Afghanistan able to interrupt transmission of poliovirus by implementing quality SIA campaigns using OPV it is important that parents know of the effectiveness of this tool and how close the country is to polio immunization.

Strengths

- Good use of radio PSAs during NIDs which reach a high percentage of the local population
- The limited polio materials produced locally include messaging for routine immunization
- Good coordination and partnership between government, UNICEF and WHO at regional level

Challenges

- Limited human resources – No UNICEF polio or communications staff (H&N Officer and two national staff)
- Reliance on materials and strategies from national level – limited local strategies
- No clear evidence of planning or regular or effective use of communications data e.g. PCA data and Routine Immunization Checklist communication indicators

Recommendations

After a review of programme communications at the national and regional level the review team identified 5 priority areas in which recommendations could be made to strengthen the programme. Within these areas the communication challenge or issue has been identified before any recommendation is given.

The 5 priority areas for recommendations are:

1. Planning
2. Messaging
3. Partnership
4. Media
5. Capacity Building

1. Planning

Key issues

- Need for integrated communication plan that supports both polio eradication and the Comprehensive Multi-Year Plan (cMYP)
- District level routine micro-plans do not always include communication and social mobilization components

Recommendations

- Develop comprehensive integrated national communication plan for both polio eradication and EPI services
- Develop district level communication plans which feed into regional communication plans

2. Messaging

Key issues

- New messages and tools needed that highlight programme achievements and reaffirm the importance of routine immunization in sustaining gains made in polio free areas
- Some locally produced communication tools are not branded which is particularly important in areas where literacy levels are low
- No recognized branding for EPI

Recommendations

- Review messages for polio free areas and ensure all materials reaffirm the link between polio NIDs and the routine immunization schedule
- Ensure all materials produced to support polio campaigns are branded
- Consider introduction of national branding and logo for EPI programme

3. Partnership

Key issues

- Need to identify strategic partners which are able to deliver polio and EPI messaging through their programmes
- The role and responsibilities of BPHS NGOs in delivering communications support is not clear

Recommendations

- Identify at least two partners and develop a simple package of materials or lesson plan for distribution

Possible partners include Women's Literacy Programme or Youth Information and Communication Centres (YICC)

- Assign clearer communication roles and responsibilities for BPHS NGOs especially for routine immunization in polio free areas

Media

Key issues

- Need for additional radio insertions for campaigns especially using local FM radio stations
- Opportunity to increase radio programming with focus on polio eradication and routine immunization

Recommendations

- Considerably scale radio insertions before and during SIAs
- Develop radio programmes in different formats that support both polio eradication and EPI services

5. Capacity Building

Key issues

- Vaccinator IPC skills training module needs updating with key expectations clarified
- Monitoring the role and impact of Community Health Worker's in delivering health messaging is difficult
- Local journalists need to be actively engaged to build capacity to effectively report on immunization issues

Recommendations

- Update IPC skills module and explore audio visual aids such as DVD to help standardize the quality of training
- Devise a simple visual tool with polio and routine immunization messaging that should be carried by CHWs at all times
- Build capacity and commitment of journalists and media stakeholders at all levels through targeted workshops

Barriers

The review panellists have identified three over-arching and three communication barriers that may hinder rapid implementation of the recommendations above.

Over – arching

- Fluid security situation in some areas
- Geographically isolated populations with very limited access to communication platforms
- EPI delivered by dozens of different service providers

Communications

- Limited HR to drive local strategies and activities
- Difficult to build interest from partners, media and communities in areas of the country where transmission of polio has been successfully interrupted
- Limited incentives and capacity of CHWs

Monitoring implementation and evaluating impact and outcomes

Stakeholders should monitor the impact of the 2012-2013 national polio strategy coupled with the implementation of the above recommendations by:

- Including SMART communication objectives for both polio eradication and EPI in the integrated national communications plan 2012-2013 (Lacking in the last national plan)
- Consistently monitoring PCA and routine checklist communication indicators with quarterly feedback from national team to region and provinces
- Ensuring all priority communication activities and strategies are included in national plan with appropriate evaluation of impact

Conclusion

The Independent Afghanistan Polio Communication Review, 2011 has helped synthesize the lessons learnt in the area of Polio communication in Afghanistan in the last two years, it has also helped identify the changes needed in strategic direction of the communication efforts and highlighted areas of weakness that must be addressed if communication is to fully play its role in Polio Eradication Efforts in Afghanistan.

In the coming weeks, Afghanistan Polio Eradication team will revise the current National Polio Communication strategy in view of the recommendations of this review and various other national and sub-national assessments and reviews conducted in the last year. The strategy will be finalized in consultation with national and international Polio partners before the end of 2011.