

# Lessons Learned from 5 Country Studies of Communication Support for Polio Eradication and Routine Immunization

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## Background

**Who:** UNICEF, WHO/AFRO, USAID (BASICS II, CHANGE, JHU/PCS)

**Where:** Mozambique, Zambia, DRC, Mali, Nigeria

**When:** October/November 1999 (when polio NIDS had ended in some but not all of these countries)

**Why:**

- **Document communication activities** – 6 reports (on Communications Initiative web site or request from [changeinfo@aed.org](mailto:changeinfo@aed.org))
- **Disseminate effective ideas** – reports widely disseminated on paper electronically, and ideas incorporated into other documents such as Communication Checklists
- **Make recommendations** – debriefings and report in each country

**How:** 4 to 5 person teams (about half external and half from country) that spent about 2 weeks in each country reading documents and interviewing diverse people (from minister to mothers), aiming to answer over 150 questions

## Major Findings

**Massive** mobilization and **communication efforts for polio NIDS**, with multiple partners (e.g. over 25 major partners in Mozambique)

**Minimal** mobilization and **communication efforts for routine immunization** or surveillance, primarily health **talks and posters**. DRC and Zambia also have basic immunization messages in their immunization or child health card. In general, the team found Zambians to have good knowledge and motivation to have children immunized due to education given in health clinics, schools, churches and communities. One community passed a resolution fining immunization defaulters.

In most countries, there was **limited promotion routine immunization in polio communications**, and some of the opportunities taken actually caused confusion

**Results:** NIDs “successful,” some reaching well over 100% coverage; **routine coverage stagnating** or falling in most countries

There was a lot of **centralized, top-down planning and execution** of polio communications, resulting in **some materials** being **inappropriate** for major regions and audiences, and some being distributed late or not at all. However, some countries did leave some scope for local initiative: Zambia in particular provided training and guidelines (on resource mobilization, message dissemination, dealing with rumors and the media) to support districts and communities.

#### **What worked well** (for NIDs):

- **IPC** and involving **local leaders and networks** (health committees; religious, traditional, social and service groups)
- **Inter-agency and inter-sectoral collaboration**, including with NGOs and for-profit companies
- **Engaging public officials and media**
- Using a **mix of media** (mass, group, individual)

#### **Areas** generally **needing improvement**:

- Carrying out and **using research** for program and materials design
- **Making communications more strategic** – not just giving people information but systematically defining desired behaviors and analyzing and addressing barriers and motivations
- **Local involvement in communications planning** (except in Zambia)
- **Lead time** for planning and arrival of funds
- **Supervision, monitoring and evaluation** of communications
- Reliability of population and coverage **data** (121% in Mozambique)
- **Funding, management, and quality of routine immunization services**
- **Treatment of families by health staff**

### **Selected Recommendations**

**Research-based, national umbrella strategies** that provide basic technical content and message consistency but that also encourage local adaptation and planning

Routine immunization programs should strive to **use ideas that worked** in polio eradication:

- **Inter-agency coordination**
- **Involvement of multiple sectors**, including the private sector and schools
- **Focus on IPC, local leaders and networks**
- **Effective advocacy**, including personal accountability of public officials
- Strong **partnership** with the **media**

But this is not enough, and all of these ideas cannot be easily moved into routine immunization.

Therefore **new initiatives** are also needed to:

- **Engage people** -- get people at all levels excited **about routine immunization**. One way to do this is to identify and collect information on a few key indicators and to feed back information to communities, local health staff, district officials, etc. If handled carefully, this might create pride and friendly competition. (“Our commune did even better than many of the other communes in the region. Their NIDs only had a coverage rate of 112% or 115%, but ours reached 130%!” [EPI staff member in Mali])
- **Promote a client focus** within health services, improving both attitudes and IP skills of health workers
- **Promote the concept that immunizing children is a shared responsibility** of health services, communities, and parents; encourage community participation in referring and facilitating children’s immunizations
- Increase **program resources and improve management**
- Prepare, implement, monitor, and evaluate research-based **communication plans that are fully coordinated with service delivery and community participation**.
- **Build and institutionalize communications capacity**.

**\*Major Findings: Mozambique Study of Barriers to Routine Immunization**

- **Mothers' knowledge** of vaccination and diseases is very **poor**; however, their **motivation** to get their children vaccinated is extremely **high**.
- **Difficult physical access** to services appears to be the main barrier in this setting (although not in many others).
- **Service quality and reliability** are major issues here as in many settings.
- Focusing on communication alone in this situation will yield limited results; a **comprehensive approach** to reducing barriers and promoting immunization is **needed**.