Polio Communications

QUARTERLY UPDATE • MAY 2013

Trust

Content

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Cover photo:
A girl on the Turkham border between Afghanistan and Pakistan awaits her turn for polio vaccination.

UNICEF/2013/R. Madhok

Building Trust, Opening Doors

- As we get closer to the goal of eradication, vaccinating every child in the 'last 0.1%' of communities and households becomes an increasingly difficult task. Security threats and political and cultural challenges limit our access and make it difficult to engage with those who stand between the vaccine and the remaining children we must reach. The programme has been caught in the cross-fire of increasingly complex dynamics. Identifying innovative ways to work within this new paradigm is critical to eradication success.

- If we are to maintain hard-won gains and continue the march to reach every child, the Global Polio Eradication Initiative (GPEI) must foster greater trust in the programme, the frontline workers and the vaccine itself. While GPEI must continue to advocate, monitor and build capacity, the key to unlocking the door to these final households – and, ultimately, to eradication – now rests in the hands of local communities.

- As violence continues to rattle many of the remaining polio sanctuaries, frontline workers are reaching more children in many of the areas where polio persists. Between September 2012 and April 2013[1], nearly 50% more 'never' children – those who have never received even one dose of the oral polio vaccine (OPV) – were reached by vaccination teams in the remaining sanctuaries, according to non-polio acute flaccid paralysis (AFP) data.

[1] Data presented in this report are from September 2012 to April 19, 2013 unless otherwise stated.

UNICEF/2013/G. Crouch

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Refusal of the oral polio vaccine and resistance to the programme is often less about polio than about the rejection of something that is perceived to be foreign and therefore untrustworthy. Building trust will be essential to opening the last of the doors that have so far remained closed to vaccination efforts.

- However, improvement is not uniform across all polio sanctuaries. Where there have been direct attacks or threats against frontline workers, the impact is clear: more children are being missed. Since September 2012, the proportions of children who have never received vaccine in the Nigerian states of Borno and Yobe have increased from less than 1% to nearly 7% and 8%, respectively. In Khyber Pakhtunwa, Pakistan, the proportion has nearly doubled in the same period, rising to 3%.

- Progress in reducing or converting refusals is also mixed. The proportion of caregivers who refuse OPV remains at just over 1% in polio sanctuaries. However anecdotal information, media reports and data from selected areas indicate that trust for the programme, the frontline teams and the vaccine is fragile. Sentiments of dissent are gaining momentum in some areas. This affects household decisions as to whether or not to accept OPV.

- In Khyber Pakhtunwa, Pakistan, the number of refusals in three districts has risen significantly in the past four months, with more caregivers stating that their refusal to vaccinate is based on religious beliefs or on a preference for other services for their children. In Sokoto, Nigeria – one of the states where an anti-vaccination DVD has circulated widely in recent months – the proportion of refusals attributed to religious reasons has almost doubled since October 2012.

- In Afghanistan's southern region, the social challenges are different. Where the vaccine reaches an opened door, direct refusal is almost non-existent. But identifying how many children reside behind the door – and motivating mothers to bring them outside to be vaccinated even if they are sick or sleeping – is a difficult task in areas where women can neither interact with male vaccinators who visit their houses nor work unaccompanied as frontline workers to reach other mothers directly.

UNICEF/2013/A. Zaidi

Overview

We must expand our definition of 'access' beyond one that is characterized solely in geographical terms. Our success will be equally determined by how effectively governments and the GPEI are able to access a shared vision to eradicate polio: one that involves real community ownership and participation.

With the recorded number of polio cases at an all-time low, most experts believe we are closing in on eradication. During 2012, two more countries – Angola and the Democratic Republic of the Congo (DR Congo) – celebrated a full year without a wild polio case. So far in 2013, only 19 children have been paralyzed by wild poliovirus, compared to 47 at this time last year. In the areas where transmission of the virus is most likely to occur, non-polio AFP data show that GPEI efforts have doubled the proportion of children reached with at least one dose of OPV over the last six months (Figure 2). However too many children remain at risk.

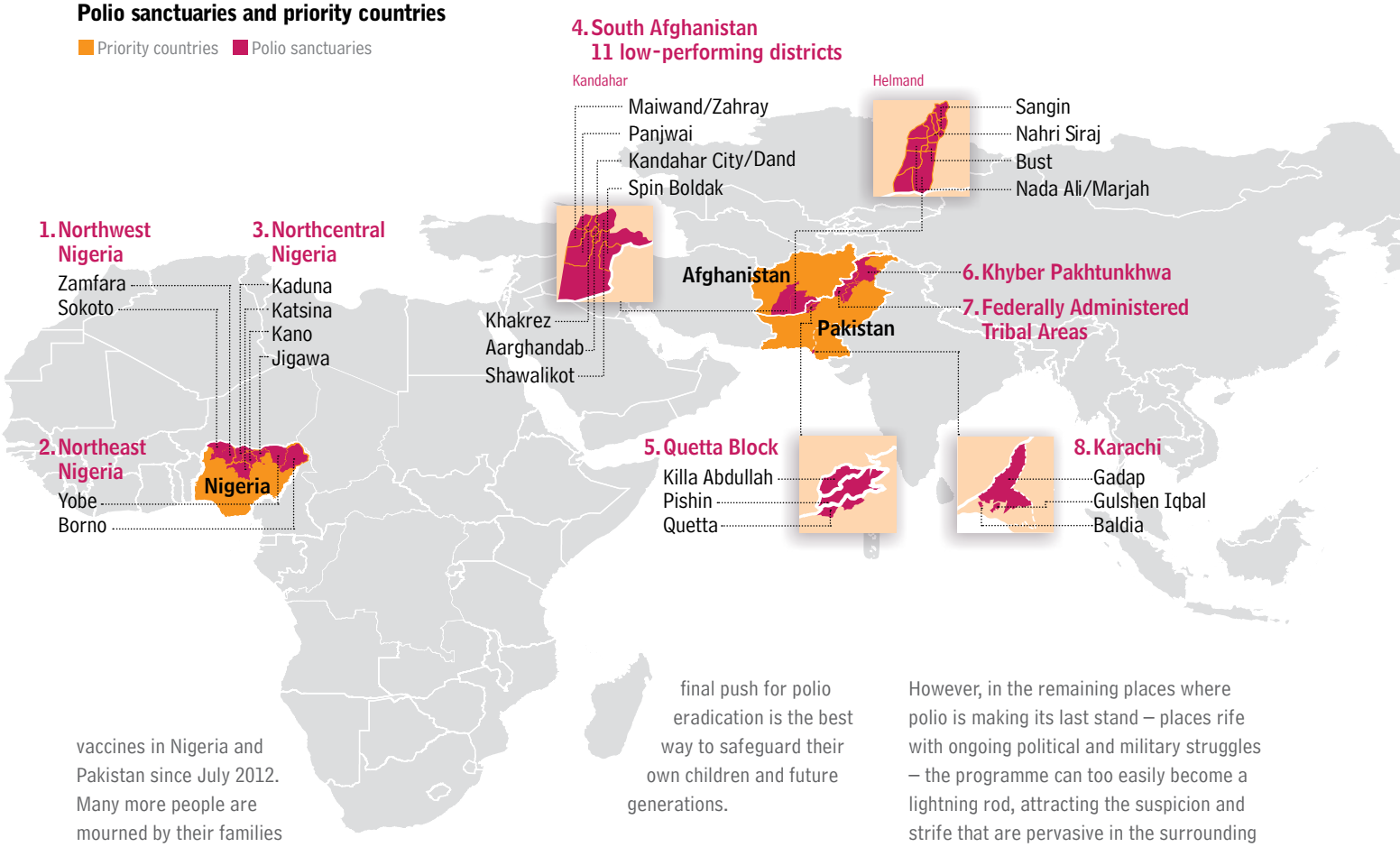
The polio programme is currently reaching 99.9% of the world's children. Polio awareness is near-universal. Across the highest-risk areas, hundreds of thousands of volunteers, advocates and leaders advance progress with each vaccination campaign.

The programme marches staunchly forward. But it does so in environments characterized by external conflict and political and cultural struggle. Some of this strife is being channelled – both deliberately and unwittingly – at polio eradication efforts, and at the vanguard of men and women who deliver the vaccine.

The programme deeply mourns the 31 frontline workers who have been killed while delivering polio

MAP 1 | SOURCE: GPEI

Polio sanctuaries and priority countries



vaccines in Nigeria and Pakistan since July 2012. Many more people are mourned by their families each day in these same areas due to ongoing conflict. Within this tragic and challenging context, the progress achieved to date seems even more remarkable.

One of the greatest obstacles to eradication is a lack of consistent access to children in the highest-risk communities where polio transmission persists (Map 1). Here we must extend the definition of 'access' beyond one that is characterized solely in geographical terms. Our success will be equally determined by how effectively governments and GPEI are able to access a shared vision to eradicate polio: one that involves real community ownership and participation. Reaching every child with OPV will mean reaching every influential leader, parent and teacher in the communities that care for these children. Communities must be engaged to share the goal of eradication and must recognize the value of vaccination as a health service they can access to protect their children from disease. They must believe that joining the world in its final push for polio eradication is the best way to safeguard their own children and future generations.

Approximately 1.2% of all children under age 5 in the critical polio sanctuaries are missed due to caregivers' refusal to vaccinate (Figure 2). This figure may seem insignificant. Yet refusal families, which can be clustered, were associated with approximately 25% of global polio cases in 2012 (Map 2). While local factors may contribute to refusals, the primary reasons that caregivers give for refusing OPV are similar across countries. They do not see the need for multiple vaccinations and prefer to receive other services; they do not see polio as a threat to their own children, and therefore it is not a concern for them; they do not believe the vaccine is safe; or they do not believe the vaccine is *halal* (permissible under Islam).

Within stable contexts, these concerns are often rooted in local political, social and cultural dynamics. In fact, it is often within these realms that solutions can be found to transform initial community resistance into support and involvement in vaccination efforts.

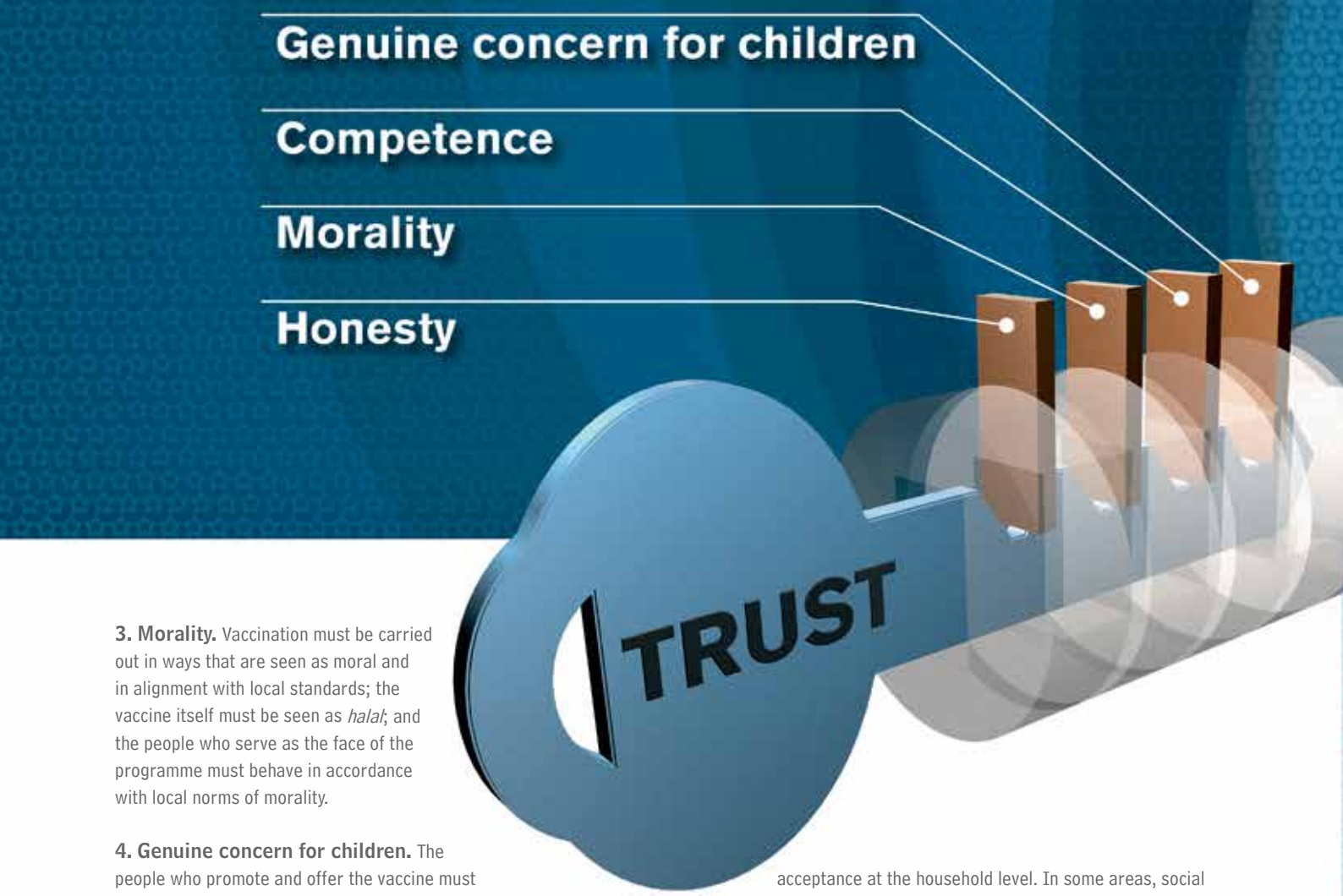
However, in the remaining places where polio is making its last stand – places rife with ongoing political and military struggles – the programme can too easily become a lightning rod, attracting the suspicion and strife that are pervasive in the surrounding environment. Increasing acceptance of OPV is a more challenging task in these areas. Refusal of the vaccine and resistance to the programme can be less about polio than about the rejection of something that is perceived to be foreign and therefore untrustworthy. Building trust is essential to opening the last of the doors that have so far remained closed to vaccination efforts.

Three dimensions of trust can be distinguished: trust in the programme as a whole, trust in the frontline workers and trust in the OPV vaccine itself. Within each of these dimensions, it is critical to address four key principles that influence trust:

1. Honesty. The programme's objectives and the methods it uses to achieve them must be transaparent and understood by everyone.

2. Competence. People must perceive the programme, its workers, and the vaccine as technically competent.

Building trust can unlock the final doors to eradication



3. Morality. Vaccination must be carried out in ways that are seen as moral and in alignment with local standards; the vaccine itself must be seen as *halal*; and the people who serve as the face of the programme must behave in accordance with local norms of morality.

4. Genuine concern for children. The people who promote and offer the vaccine must demonstrate an authentic concern for the well-being of children, both within the programme and in other contexts.

Metrics to assess community trust more rigorously are being developed in partnership with UNICEF and the Harvard School of Public Health. At least one polio-endemic country is expected to have data for these variables by the third quarter of 2013.

Across all areas, UNICEF-supported social mobilization networks are utilizing trust-building strategies by continuing to forge alliances with religious and community leaders as well as with other socially respected members of society. In Nigeria and Pakistan, social mapping is undertaken at the community level to identify those who are able to influence social norms and tip public sentiment in support of OPV.

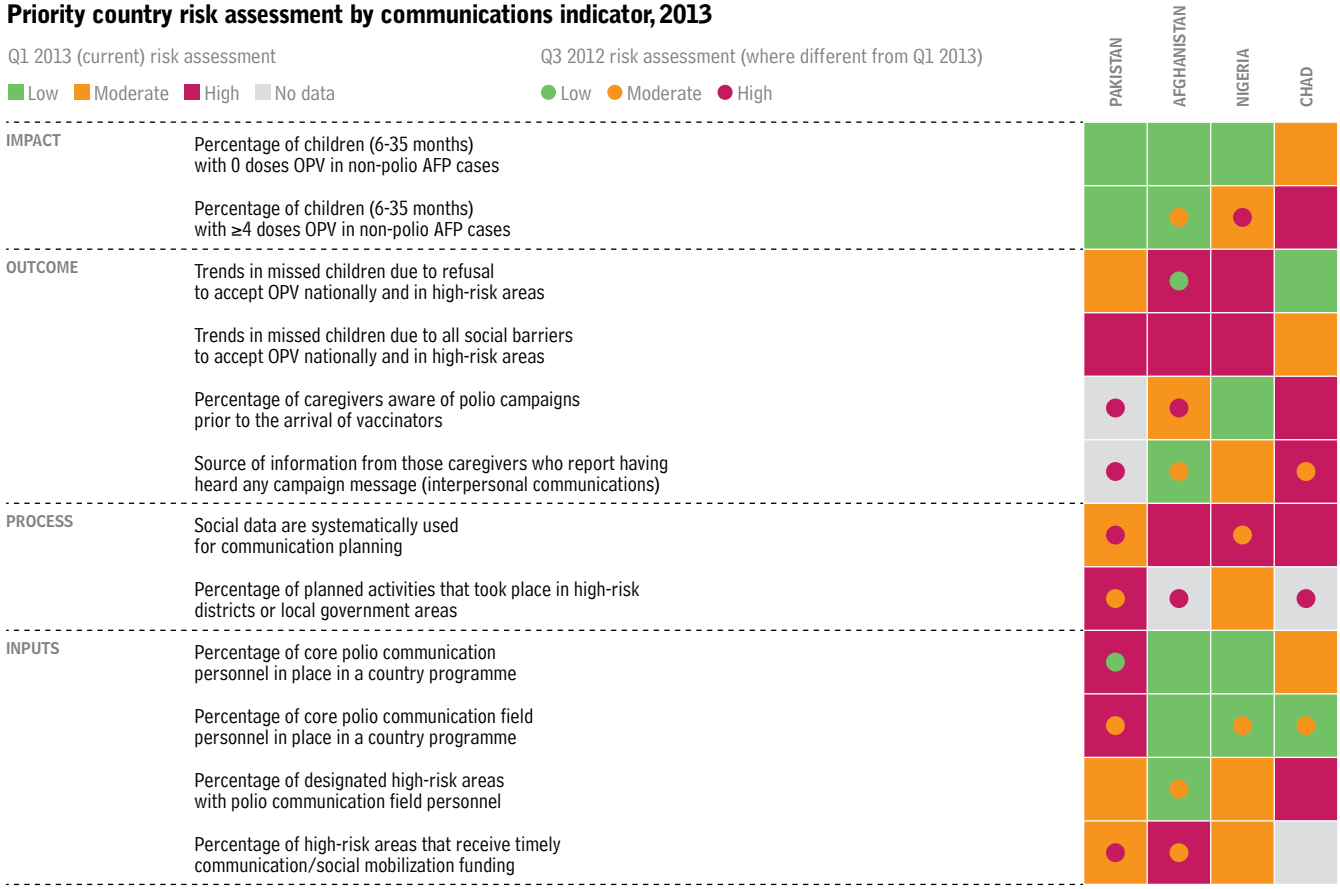
Vaccinators are increasingly being chosen by the local community – a process that is more important than ever to ensure vaccinator acceptance at the household level. In some areas, social mobilizers are helping to identify potential vaccinators; this practice should be scaled up in all high-risk areas. Service delivery methods for OPV should also be reconsidered in accordance with what might be safest and most acceptable to communities that face life-threatening risks on a daily basis.

The vaccination effort in Katanga, DR Congo – one of the most resistant Christian communities in the country – provides an example of how vaccination can be successfully brokered through a long process of dialogue and trust-building. The vaccine delivery protocol developed through consultation with an influential religious leader was unconventional, to say the least. It involved vaccinating by night, using only local volunteers, with no official monitoring. Still, the net result was that children were vaccinated for the first time in a previously impenetrable community. The creative approach to overcoming obstacles and building trust may offer lessons that are applicable in other settings with similar religious dynamics (see page 16).


Social dynamics
Politico-religious dynamics
Insecurity
Trust in the frontline workers
Trust in the GPEI programme
Trust in the OPV vaccine

FIGURE 1 | SOURCES: INDEPENDENT MONITORING DATA, UNICEF MONITORING

Priority country risk assessment by communications indicator, 2013



Indicator definitions and targets are provided in Annex 1.

33,427

... social mobilizers build community demand for OPV before each polio campaign.

TABLE 1 | SOURCE: UNICEF MONITORING

UNICEF-supported social mobilization workers in high-risk areas of polio sanctuaries, April 2013

COUNTRY		TARGET (NUMBER OF PEOPLE)	MOBILIZERS IN PLACE (NUMBER OF PEOPLE)	MOBILIZERS IN PLACE (SHARE OF TARGET, %)
Afghanistan		3,436	3,436	100%
DRC		18,688	18,688	100%
India:	**Uttar Pradesh**	5,634	5,491	97.0%
	Bihar	1,353	1,306	97.0%
	West Bengal*	1,320	1,320	100%
Nigeria		2,600	2,127	81.8%
Pakistan		1,182	1,059	90.0%

* West Bengal mobilizers are deployed through nongovernmental organisations

UNICEF Pakistan/2013

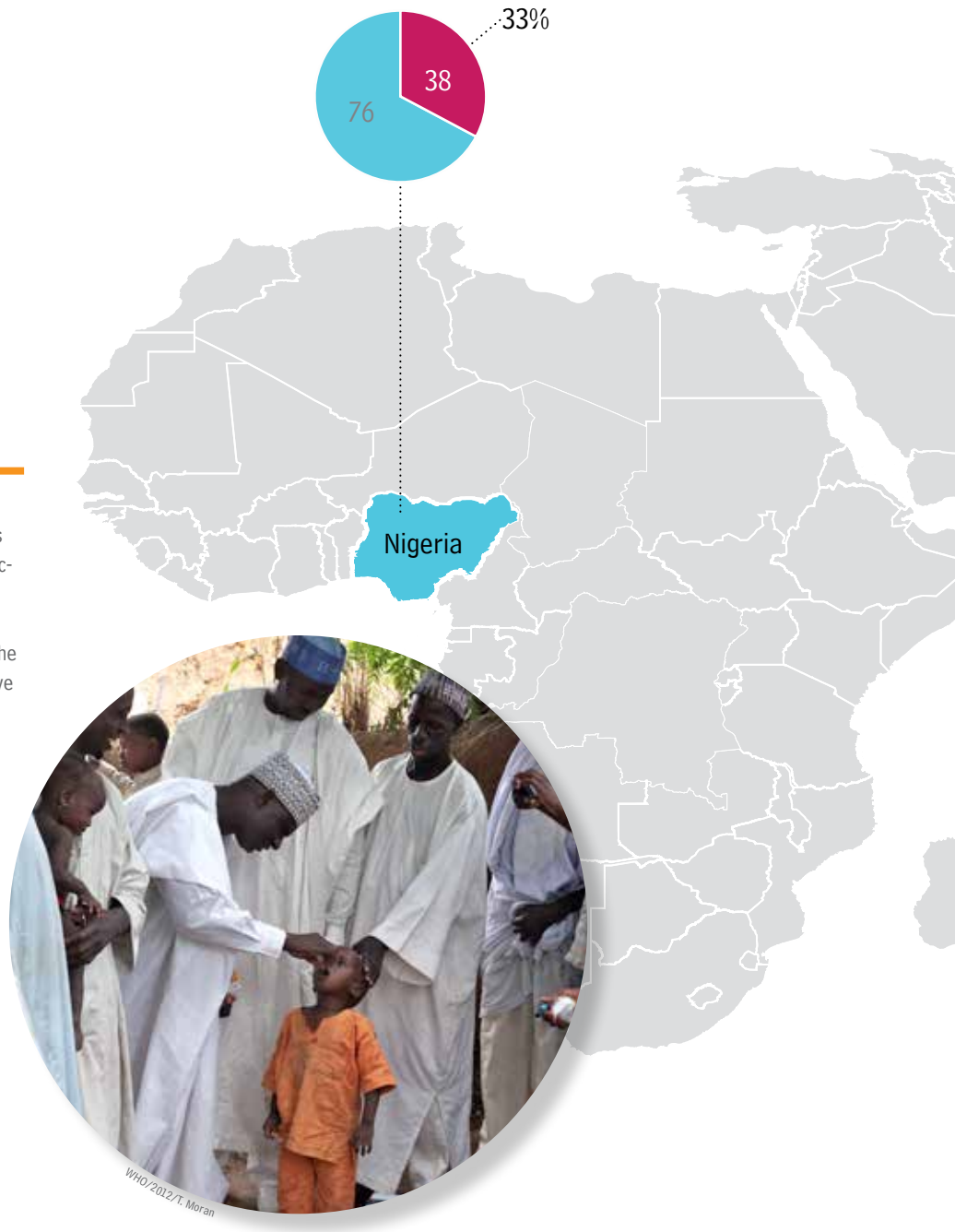
Going viral

Circulating rumours and misconceptions can impact wild polio cases

MAP 2 | SOURCE: WPV CASE INVESTYGATION FORMS 2012

Wild poliovirus cases linked to refusal families in polio-endemic countries as share of total 2012 cases (#/%), 2012

Number of cases from families who refused OPV Number of remaining wild poliovirus cases



Nigeria

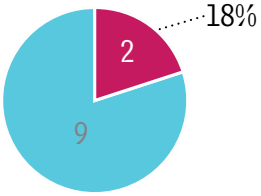
- Since October 2012, significant progress has been made to reduce the proportion of unvaccinated children in Nigeria due to refusal.
- Many parents who still refuse vaccine in the sanctuaries do so because they do not see the need for multiple doses, and prefer to receive other developmental services.
- An anti-OPV DVD recently distributed across many northern states has exacerbated the existing lack of demand for the vaccine, and has contributed to a rise in the proportion of refusals cited as religious in nature since October 2012, particularly in Sokoto.
- In Sokoto, Kaduna and Katsina, over 80% of refusals have been converted in the past few months with the support of community mobilizers and religious, traditional and community leaders.

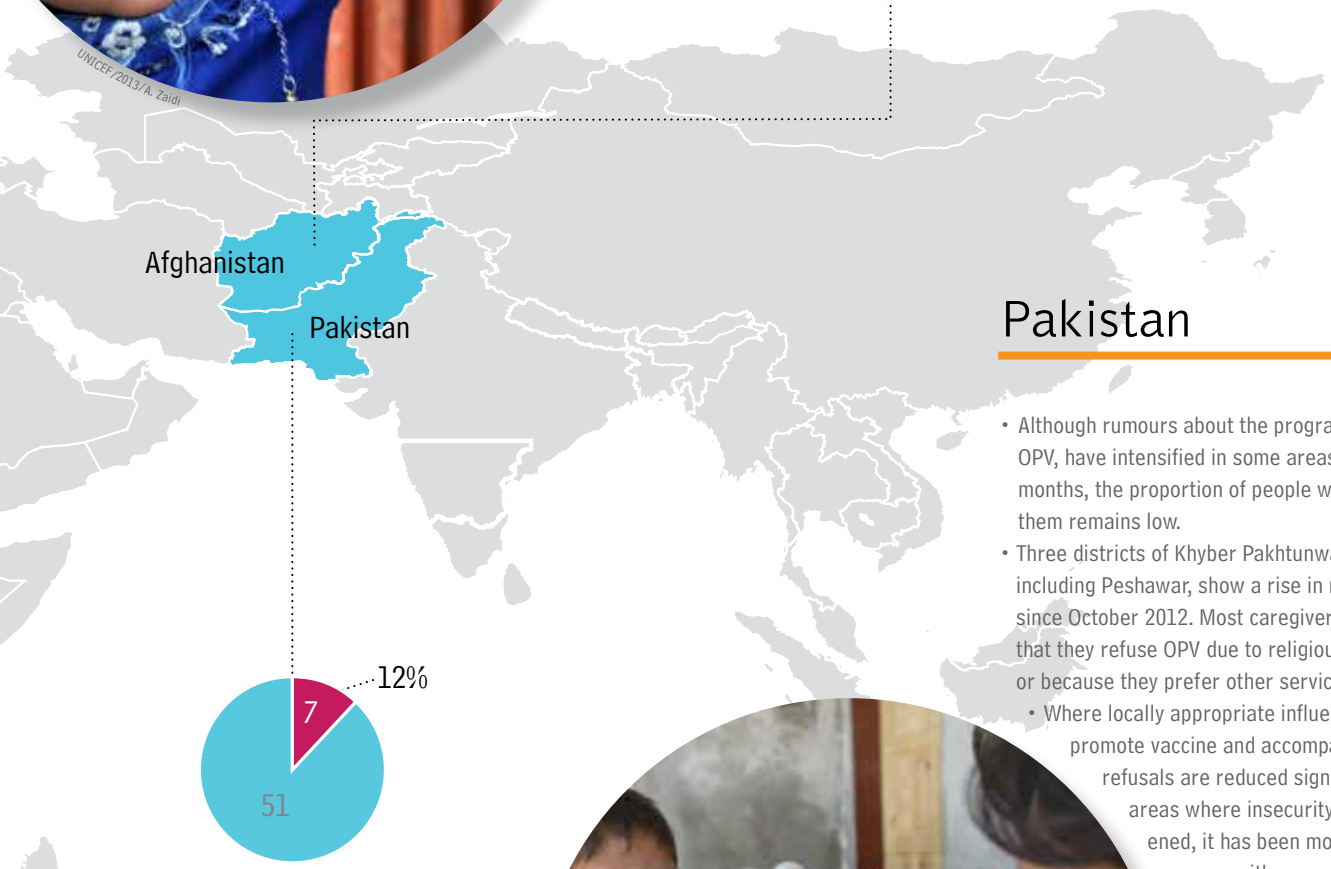
WHO/2012/T. Moran

Afghanistan

- Although the number of polio-affected children from refusal families is low, incomplete case investigation forms means the contribution of refusals to wild poliovirus cases is not fully understood. Case investigations must ensure all social data is collected and recorded.
- Applying the global definition of refusals to Afghanistan's 11 low-performing districts means this sanctuary has the highest proportion of children missed due to refusal globally.
- Three districts among the 11 low-performing districts – Spin Boldak, Shawalikot and Nada Ali – show refusal rates that are double, and sometimes triple, the overall average.
- Three key variables have been shown to reduce refusals in Afghanistan's sanctuaries: positive perceptions about OPV safety, team composition, and communication with caregivers through interpersonal channels.
- Without increased access to mothers in the deeply conservative households of southern Afghanistan, it is nearly impossible to identify all of the children eligible for vaccination. Investing in strategies to engage women – both as frontline workers and as agents of behavioural change – will be a key strategy to reduce refusals and vaccinate every child.

UNICEF/2013/A. Zaidi





Pakistan

- Although rumours about the programme, and OPV, have intensified in some areas in recent months, the proportion of people who believe them remains low.
- Three districts of Khyber Pakhtunwa (KP), including Peshawar, show a rise in refusals since October 2012. Most caregivers here state that they refuse OPV due to religious reasons, or because they prefer other services.
- Where locally appropriate influencers promote vaccine and accompany teams, refusals are reduced significantly. In areas where insecurity has heightened, it has been more difficult to engage with communities and parents about the importance of vaccination.
- Data from 2012 show that caregivers' intent to vaccinate is high. Although their likelihood of going to a vaccination centre if teams don't arrive is lower, it is still high enough to point towards fixed sites as a plausible option for service delivery in insecure areas, if required.

UNICEF/2011/J. Jalali

FIGURE 2 | SOURCE: WHO-HQ AS REPORTED IN THE GPEI STATUS REPORT, 1ST QUARTER 2013

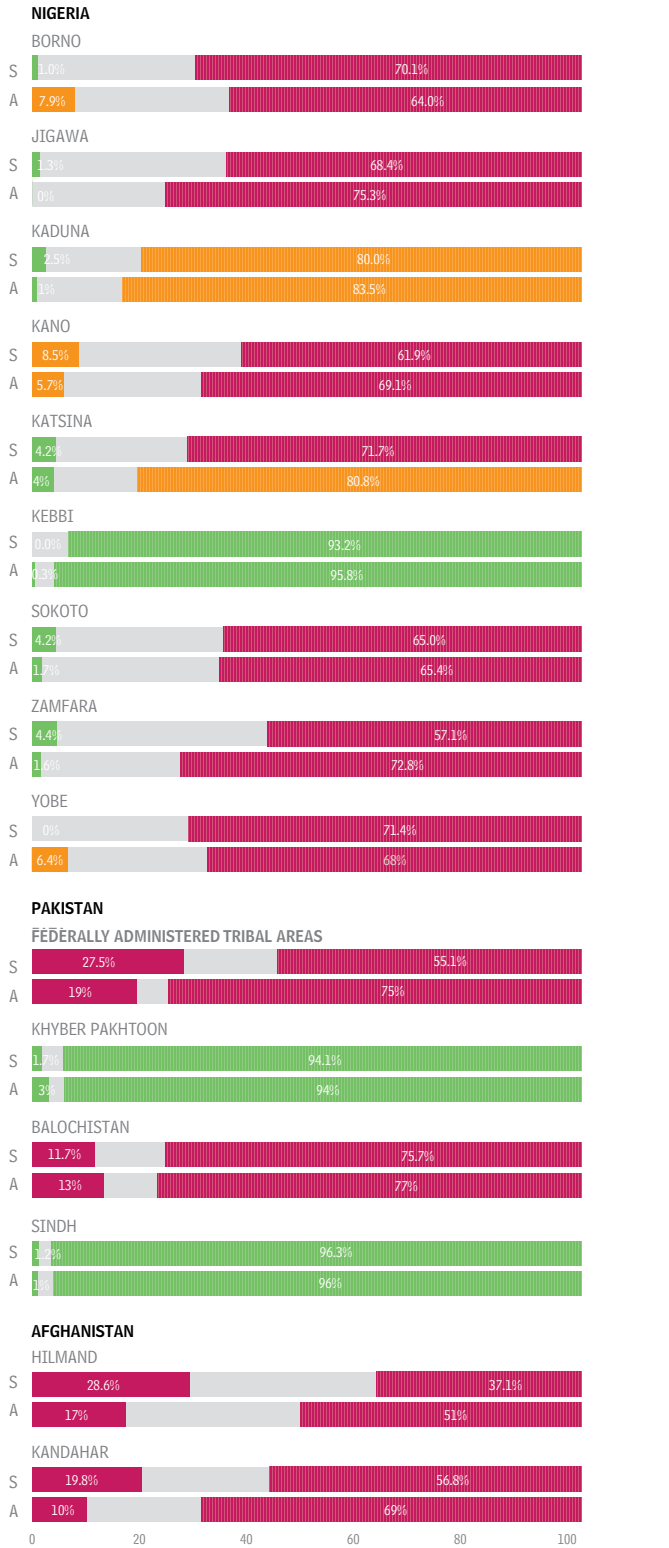
Non-polio acute accid paralysis (AFP) cases in polio sanctuaries, September 2012 – April 2013

S = September-12 A= April-13 Low Moderate High

SHARE OF CHILDREN (6–35 MONTHS) **WITH 0 DOSES OPV** IN NON-POLIO AFP CASES (%)

SHARE OF CHILDREN (6–35 MONTHS) **WITH 1-3 DOSES OPV** IN NON-POLIO AFP CASES (%)

SHARE OF CHILDREN (6–35 MONTHS) **WITH ≥ 4 DOSES OPV** IN NON-POLIO AFP CASES (%)



Note: Dates reflect one full year of data, ending in September 2012 and April 2013 for each time period

UNICEF/2013/H. Vilain

FIGURE 3 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal in global sanctuaries (%), March 2013

How to Gain the Ear of an **'Elephant King'**

Overcoming Mistrust of the Polio Vaccine among Magico-Christian Groups in DR Congo's Katanga Province.

In 1880, when the Church came, they told us to stop our practices of natural medicine and bloodletting. Les blancs – *the white people – told us:*

'Stop using medicines to protect you. Stop protecting yourselves. The only great healer is God.'

So we took our methods and we threw them out. After we'd thrown out everything, les blancs *came back to tell us: 'Come, this time I will give you medicine to protect you.'*

Pastor Paul II, an influential pastor of the Kitawala Filadelphie Sect in DR Congo, used to counsel his many thousands of followers to refuse the polio vaccine. Now, years after the GPEI first approached him in 2009, he has become an ally in the fight to end polio.

The road to acceptance has been neither short nor easy. Katanga Province, where Pastor Paul II's followers live, had the world's highest rate of refusal of the polio vaccine until recently. Over the course of 2012, refusal rates dropped by more than half in Katanga Province – from 10% of children under age 5 to 3% (Figure 4). DR Congo is now celebrating a year with no new cases of polio nationwide.

The following lessons were learned in the course of forming an alliance with a religious leader who calls himself the "Elephant King of the World."

Listen First

Pastor Paul II was first approached by the DR Congo's Ministry of Health and UNICEF communication staff in 2009. He had never before been in contact with any health authorities. It took many months to gain his trust and to understand his doctrine and its foundations. The "Elephant King" expressed his beliefs fiercely but was open to dialogue. Over time, he shared more about why the group was refusing the vaccine.

UNICEF/2013/V. Petit

The Kitawalas' doctrine held a deep mistrust for nearly everything that came from outsiders – including the polio vaccine, which is approved by the Congolese State and is produced in Europe. The Kitawalas' fear was further stoked when mass immunization teams marked numbers on houses to show how many children had been vaccinated. The Kitawalas cited the Apocalypse and the marking of homes, which they associated with 'the mark of the beast'.

Equipped with a better understanding of the Kitawalas' perspective, the local vaccination team – made up of a community mobilizer and the area's chief doctor – shared their perspective with Pastor Paul II. A long discussion began, one that revolved mainly around the role of divine will in the death of children.

Did God want human beings to step aside while children died or were paralyzed? Or might God approve of a little help from a vaccine?

A Swahili Bible was passed from hand to hand for hours at a time, over the course of months, as Pastor Paul II and the community organizers discussed the question. But even as Pastor Paul II himself became more open to the idea of vaccinating children against polio, he warned that changing the attitudes of thousands of people born into the Kitawala doctrine would not be easy.

The Kitawalas cited the Apocalypse and the marking of homes, which they associated with 'the mark of the beast'.

Be Open to Creative Ideas

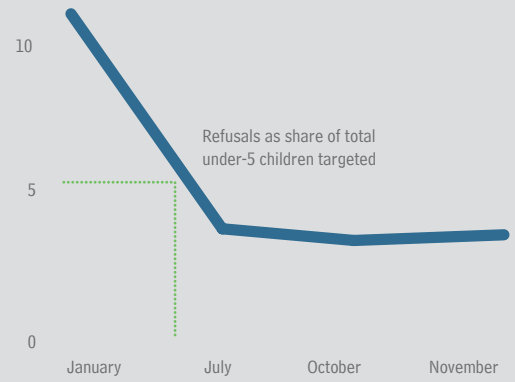
Pastor Paul II himself was now convinced that his community should be vaccinated against polio. But many of his followers – who lived in 128 missions spread across five health districts – were people who had for decades, or for their whole lives, been guided by teachings that rejected almost everything from the West.

UNICEF-supported community mobilizers and health officials spent many hours discussing the situation with Pastor Paul II. How could they bring the polio vaccine into the mission in a way that would be accepted by the pastor's flock?

Together they hit upon an idea that just might work. Pastor Paul II agreed to identify three boys from the mission to receive free training in hygiene and disease prevention. Being from the community, the boys could return and easily speak to the faithful once they were trained. Three health posts would be created for them.

FIGURE 4 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal in Katanga (%), January – November 2012



This medium-term plan seemed to meet all conditions for success and sustainability. Pastor Paul II expressed his acceptance of the plan as long as its final objectives remained secret. He sent three of his own children to be trained. Since Pastor Paul II's power was derived from his father and he is training one of his sons to succeed him, it is likely that these boys will be among the community's influential leaders.

The three boys have completed three years of the four-year course. Even now, a year before they are ready to start their work, Pastor Paul II seems to be seeing a benefit to the project. He recently proposed that two more young Kitawalas be sent for medical training. And during a vaccination campaign last October, Pastor Paul II publicly stated to a surprised crowd, "There are three important things in the life of a human being: prayer, cleanliness and vaccine."

Adapt Vaccination Strategies to Local Needs

As greater trust was built with the interlocutors, Pastor Paul II became open to bringing the polio vaccine directly into the Kadima Mission, where he and a large group of his followers live. For a leader who had so vehemently opposed the vaccine in the past, this was a major step.

Still, because of the group's historical mistrust of western medicine, all stages of the vaccination process needed to be negotiated.

Knowing the importance of reaching every child, the vaccination team adapted its usual approach. In this vaccination, there would be no finger-marking with ink to show who had received the two rose-coloured drops. There would be no marking of houses. Very few social mobilizers would be allowed, and those who were allowed would be among Pastor Paul II's closest followers. Only the nurse in charge of the local health centre, a man Pastor Paul II knew well and trusted, would be allowed to vaccinate.

A Kitawala named Kitobo leads the vaccinators into the community, silent and barefoot. He guides the group away from the homes, and away from curious eyes.

And finally, the vaccination must be carried out by night. This way, it would be less likely to attract the attention of those who might not approve. It would also avoid giving the impression to outsiders that Pastor Paul II had in any way "yielded."

The vaccination was carried out in whispers, under the spiky shadows of palm trees in the light of the moon. A Kitawala named Kitobo led the way, silent and barefoot. He guided the group away from the homes, and away from curious eyes.

Two plastic chairs were the scene of the field operation. The health centre nurse prepared vials of polio vaccine, along with vitamin A and deworming tablets. One by one, parents came out of the dark night. They carried half-asleep children and sleeping babies.

One by one, the children were brought into the light of a torch. They opened their small mouths and received the two bitter-tasting drops that had been the subject of so much negotiation. A few murmurs were exchanged, and they disappeared again into the night. By this strange, secret routine – so hushed and cautious that you'd think it must be illegal – more than 100 children were vaccinated.

Over the course of 2012, three night vaccinations were completed. More than 90% of children under age 5 have been vaccinated against polio in a community that had once been impenetrable to vaccinators.

UNICEF/2013/V. Pelit

Afghanistan

UNICEF/2012/K. Shah

The **CONTEXT**

- Afghanistan has reported only one case of wild poliovirus to date in 2013, in the eastern province of Nangarhar. This compares to five cases during the same period last year.
- Non-polio AFP data show that polio vaccination levels have increased in the southern region since September 2012. The proportion of children who have had at least one dose of OPV increased from 71% to 83% in Hilmand and from 81% to 90% in Kandahar from September 2012 to April 2013 (Figure 2).
- Since October 2012, the proportion of caregivers who know about polio vaccination campaigns before they take place has increased by 20 percentage points.
- Under the global definition of refusal – which includes any reason a caregiver provides when not accepting OPV – the proportion of mised children due to refusal in Afghanistan's polio sanctuaries is the highest in the world. Traditionally, Afghanistan's refusal calculation has not included children missed due to caregiver indifference or unwillingness to bring sick, sleeping or newborn children out for vaccination. But when these children are included alongside children whose caregivers overtly refuse the vaccine, the proportion of children missed due to refusal is 25%.
- The highest priority for Afghanistan must be to identify innovative ways to access more mothers and reach more children in the household. Without the full ownership and participation of women, the future of polio eradication – as well as progress towards broader child health goals – is at risk.

Where Are the **Remaining Children?**

Only a small percentage of caregivers – less than 0.5% – overtly refuse vaccination in southern Afghanistan's 11 low-performing districts. Yet when this group is combined with caregivers who passively refuse vaccination because their children are sleeping, sick or newly born, the area has the world's highest proportion of children who go unvaccinated due to refusal. In March 2013, 1.5% of all target children under age 5 in accessible sanctuaries were missed when caregivers refused vaccination (Figure 5).

In the districts of Shawalikot, Spin Boldak and Nada Ali, the share of children missed due to refusals is double – and sometimes triple – the sanctuary average (Figure 7).

Despite attempts to collect more detailed information through independent monitoring, specific information on why caregivers refuse OPV is still not available for the Afghanistan programme. Since the reasons for concern at the district and cluster levels are not well understood, it is difficult to ensure that local communication plans are adequately targeted to maximize vaccination coverage. There are, however, some data relating to this issue. According to a 2012 UNICEF-supported Knowledge Attitudes and Practices (KAP) study, most caregivers who refused OPV for their children in 13 high-risk districts[2] did so because they felt the vaccine was unsafe and

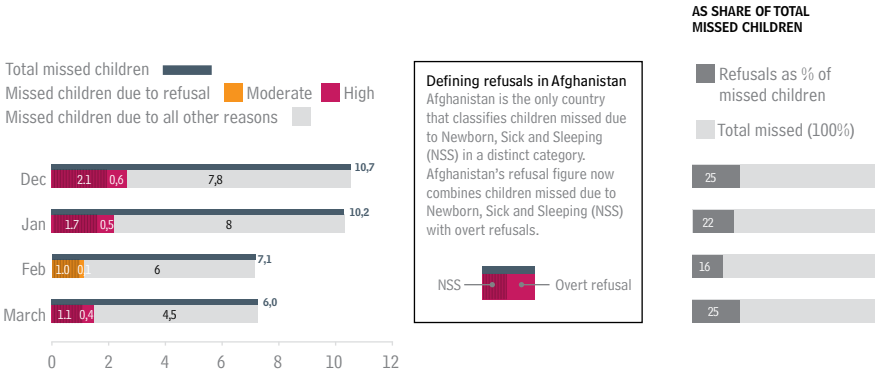
[2] At the time of this report, Afghanistan's sanctuary is defined as 11 low-performing-districts in the South Region. Previously the sanctuary referred to 13 high-risk districts; five of these were removed and three new districts were added to the sanctuary. These districts were designated as low-preforming districts because inaccessibility remained a problem, endemic circulation confirmed in the last two years, weak or declining SIA - Supplementary Immunization Activity quality in 2011 and 2012, low level of awareness of SIAs, and a disproportionally high percentage of young children with non-polio acute flaccid paralysis who have never received OPV.

UNICEF/2013/R. Madhok

> While the number of families refusing vaccination is relatively small, the data suggests that these families contributed to the burden of polio cases in 2012.

FIGURE 5 | SOURCE: POST-CAMPAIGN ASSESSMENT DATA

Trends in missed children due to refusal in low-performing districts of Afghanistan (%), Decemer 2012 – March 2013

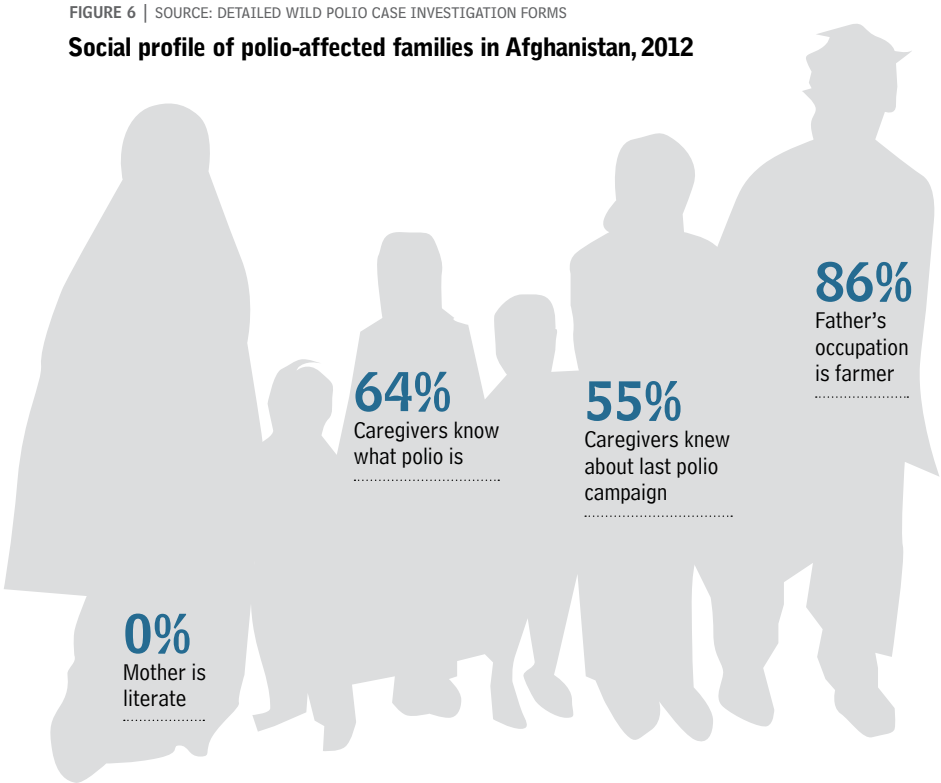


Note: All refusal figures reflect a combination of children missed due to child being sick, newborn, sleeping and overt caregiver refusal.

All data reflect accessible areas only. December data reflect accessible areas of the 13 high-risk districts

FIGURE 6 | SOURCE: DETAILED WILD POLIO CASE INVESTIGATION FORMS

Social profile of polio-affected families in Afghanistan, 2012



could cause sterility, or else because they did not believe the vaccine to be *halal*.

A Profile of Families That Refuse

While the number of families refusing vaccination is relatively small, the data suggest that these families contributed to the burden of polio cases in 2012. Not all case investigation forms were completed with accurate reasons for non-vaccination, so this information was only available for 11 of the 37 cases investigated in 2012. Two of these 11 children were from refusal families (Map 2). The figure may be inconclusive, but it points to a critical need to improve the quality of all information collected through case investigation forms - and to use this information to design more targeted communication strategies.

For 22 of the 37 cases in 2012, complete demographic information is available. One interesting observation is that 86% of these 22 polio-affected children come from farming families (Figure 6). Strategies to reach children in fields or to reach them at times that do not conflict with farming schedules must be intensified in 2013.

Furthermore, the 22 case investigations indicate that none of the mothers are able to read or write and that only 14% of fathers are able to do so. Many of the polio leaflets and posters disseminated to caregivers require literacy to comprehend. To accommodate male and female vaccinators who cannot read or write, GPEI has piloted innovative monitoring sheets that use pictures rather than words. A similar innovation is needed for communication materials aimed specifically at parents with low literacy levels.

Compared to the rest of the population in the 13 high-risk districts, families of polio-infected children had lower awareness about vaccination campaigns (55%). They also had a poorer understanding of the disease itself, with only 64% of parents able to initially identify that polio had infected their children.

Given the many life-threatening risks to those who live in the 11 lowest-performing districts, it is unsurprising that fear of polio does not rank among many parents' greatest concerns. Only 15% of caregivers in the highest-risk areas said they were

15%

Only 15% of caregivers in the 13 high risk districts are concerned that their children will contract polio.

concerned about their children contracting polio, according to 2012 KAP data. It will be important for the communication strategy to keep concern about the disease – and about other vaccine-preventable diseases – appropriately elevated.

Targeted Strategies

When parents are prepared to open the door to vaccinators, about half of children who are missed are not present for vaccination. Another 25% of children may be present, but caregivers are unwilling or unable to bring them out for vaccination[3]. Experience shows that both of these barriers can be overcome with tailored strategies.

For example, to understand where children are when they are recorded as "not at home," UNICEF communication teams initiated a more detailed method of independent monitoring in select districts. The data showed that most children could be found at the local market during the times when vaccinators were going from house to house. On the basis of this finding, the number of market vaccination teams in the southern region was increased during the October 2012 campaign. The number of children vaccinated in markets increased by approximately 8,000 that month in comparison to previous months.

Communicating Widely

Communication strategies have been gaining traction in Afghanistan over the last year. Awareness of campaign dates has risen from the lowest in the world to levels approaching 85% in recent months (Figure 8). Public service announcements carrying messages about campaign dates air each month across 50 television and 19 radio channels in the southern region. These announcements will be even more effective when aired through targeted programmes whose largest audiences are women.

Based on requests from district officials, the number of social mobilizers has been increased in all regions in recent vaccination rounds. While there were 1,900 social mobilizers in October 2012, 3,436 traveled house to house during the two most recent campaigns. The majority of additional workers have been assigned to teams in the southern region. There, the number of social mobilizers rose from 1,110 in December 2012 to 2,486 in March 2013. Immunization Communication Network (ICN) mobilizers are present in more than 90% of targeted high-risk communities in the southern region. They visit more than 206,000 households in the days before the campaign.

Within their areas, mobilizers identify all children eligible for vaccination and place corresponding "dots" on houses so that vaccinators know how many children to look for when they arrive on campaign days (see page 26). The impact of this innovation needs to be more closely measured to determine its success and its potential for scale-up.

As the ICN expands, it will be important to ensure that there are clear procedures to ensure minimum performance standards. It wll also be important to ensure that the composition of the frontline workforce is appropriate to gain access to and effectively engage communities and households. As such, key performance indicators will be critical for measuring ICN outcomes. While short-messaging-service (SMS) monitoring methods are in development, ICN is currently the only social mobilization network where data do not exist to measure how well the network is able to vaccinate children who would have otherwise been missed due to social reasons.

[3] The remaining 25% are missed due to teams not arriving at households to vaccinate.

UNICEF Afghanistan/2013

To help vaccinators identify all children eligible for vaccination, social mobilizers in southern Afghanistan have adopted a new method of 'dot-marking'. Each dot on the door represents the number of children under age 5 so that vaccinators know how many children to look for when they arrive with OPV.

FIGURE 7 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal in critical low-performing districts of Afghanistan (%), January – March 2013

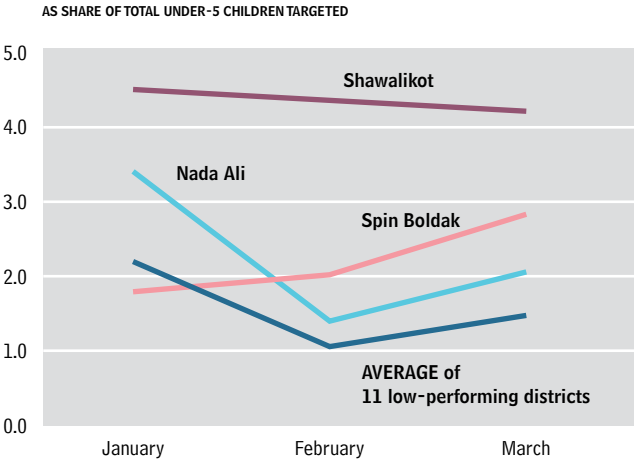
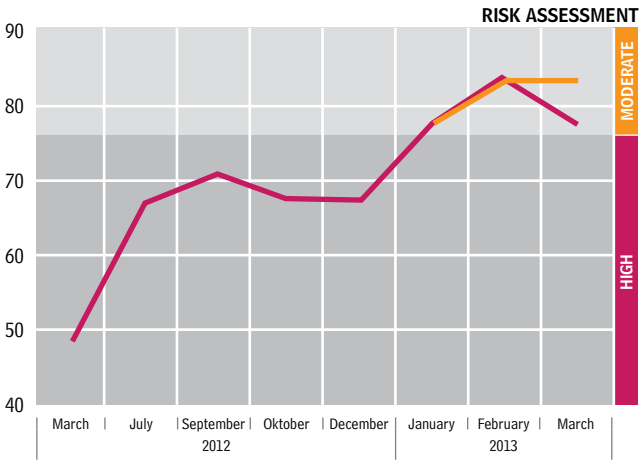


FIGURE 8 | SOURCE: INDEPENDENT MONITORING DATA

Trends in caregivers aware of polio campaigns in high-risk districts of Afghanistan (%), 2012 – 2013



Opening Doors **to Women**

Afghanistan's Most Important Champions for Vaccination Remain Nearly Invisible.

In the Hands of Children

In Afghanistan's deeply conservative southern region, male-female interaction on the doorstep is nearly impossible. Yet 90% of the frontline workers who knock on doors in this area, aiming to vaccinate every child under five, are men.

As a result, it is common to see young children carried or led outside for vaccination by other children as young as five or six years old. Such children are just barely old enough to provide this most basic level of care for their siblings. But it is impractical to expect them to understand that a sleeping toddler needs to be awakened. And they are too young to grasp that a tightly-bound newborn needs to be unwrapped for the finger-marking because – among all of the children in the house – the newborn is most vulnerable to polio infection. It is also impractical to expect a child to understand that it is safe to give a sick child a dose of OPV, and that a sibling who is sick should still be brought out for vaccination.

A mother who was able to receive correct information could be expected to understand the importance of protecting all of her children against polio. Yet in Afghanistan's 11 low-performing districts, 1.5% of all children under age 5 are not vaccinated because of either direct or indirect refusals: the mother does not understand or believe in the value of vaccinating every child when a vaccination team visits, or else she is physically unable to deliver her children to the vaccinators.

Harnessing Innovations

To help vaccinators identify all children eligible for vaccination, social mobilizers in southern Afghanistan have adopted a new method of house-marking from India: *bindi* marking. In the days before each campaign, mobilizers visit families in their catchment areas to determine how many children reside in each house. They place dots on the door to represent the number of children under age 5 so that vaccinators will know how many children to look for when they arrive with OPV. If there is a newborn, the dot is marked using a different colour. If a guest child is visiting, the child is represented with a dot placed outside of the circle. This method has started to yield higher coverage in some areas. Because mobilizers have more time before the campaign begins to speak with the siblings (or with the mother, if she is able to engage from behind the door),

UNICEF/2012/K. Shah

A social mobilizer from the Immunization Communication Network marks a door with dots to signify how many children under age 5 live in the house. Vaccination teams will know they must vaccinate these children when they arrive for the campaign.

they are able to more accurately count the number of children at each residence.

However, since only 5% of social mobilizers in the southern region are women themselves (Figure 9A), even this potentially high-impact innovation is not maximized when undertaken by a male team. Male mobilizers must still rely on discussions with children or on muffled conversations with women behind closed doors. They are unable to engage freely in the kind of personal interaction that is critical to building rapport and mutual understanding.

Reaching and Recruiting the Nearly Invisible Woman

Due to conservative social values, it may not be feasible to recruit more women to serve as social mobilizers everywhere in Afghanistan. But local targets must be set for recruiting female teams, mixed teams and even youth teams. Anyone who can access a household and reach mothers with appropriate messages should be considered as a potential frontline worker.

Findings from Afghanistan's December 2012 KAP study indicate that most caregivers would prefer that more women deliver vaccination services (Figure 9B). The study data further show that the proportion of children who have never been vaccinated could be reduced by 7 percentage points if a mother was reached with a vaccinator of the appropriate gender, age and/or appearance. This proportion could be reduced by 7 percentage points more if mothers were informed about polio through interpersonal communication channels.

This issue is beginning to enter the public discouse in Afghanistan, with debates in the regional and national media. The Minister of Public Health recently dedicated a television programme on the country's most popular network to "the role of women in polio eradication." In February, full-time focal points from the Department of Women's Affairs and Department of Education were appointed in Kandahar and Hilmand. Their primary role is to coordinate within their respective departments to increase the participation of female staff in the polio programme.

Identifying innovative ways to access households and reach women in southern Afghanistan is possibly the most important strategy for stopping the polio virus from circulating. Without the understanding, participation and ownership of Afghan women, the future of polio eradication – as well as broader child health – looks worrisome.

FIGURE 9A | SOURCE: UNICEF DATA

Composition of social mobilizers in the Southern Region, January – February 2013

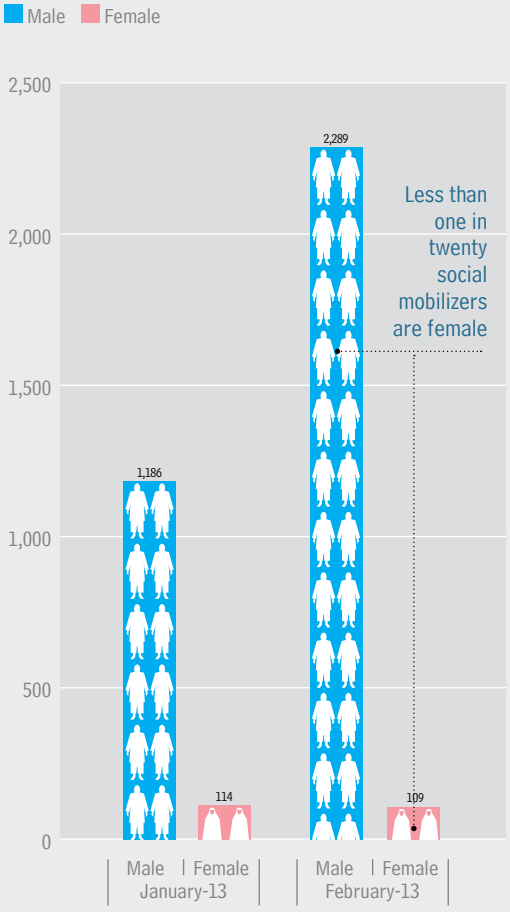
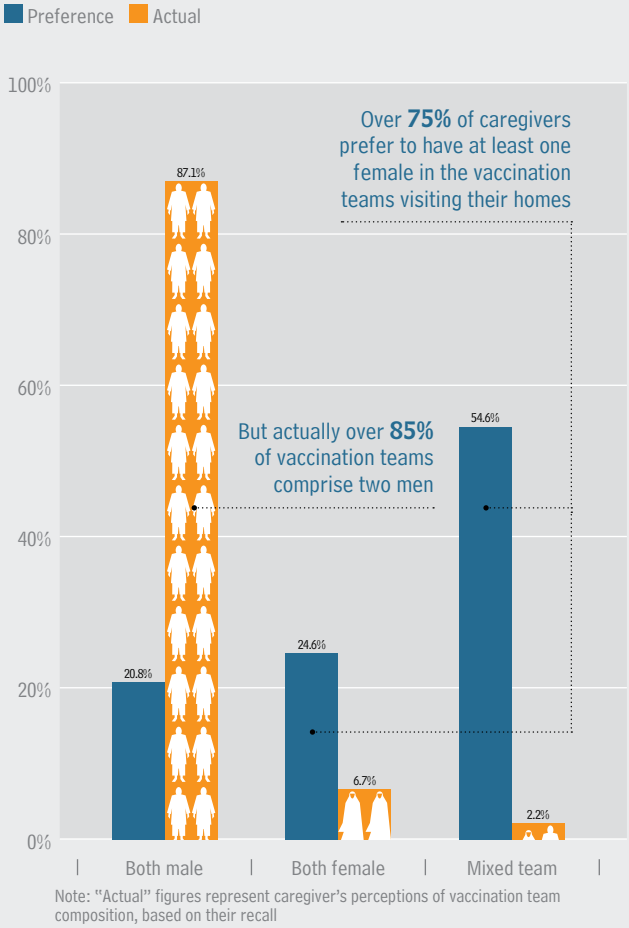


FIGURE 9B | SOURCE: UNICEF-SUPPORTED KAP STUDY, DECEMBER 2012

Caregivers' preferences about vaccination team composition in Afghanistan's high-risk district (%), December 2012



Note: "Actual" figures represent caregiver's perceptions of vaccination team composition, based on their recall

Nigeria

The **CONTEXT**

- Nigeria has reported 12 cases of wild poliovirus to date in 2013, compared to 23 for the same period last year.

- Non-polio AFP data show an increase in the number of children vaccinated in the high-risk northern states over the past six months. Since September 2012, the proportion of children never reached with the polio vaccine has declined in every state except for two. In Borno and Yobe, insecurity has negatively impacted the quality of vaccination campaigns. There, the number of children who have never received a single dose of OPV has risen by 6 percentage points since September 2012.

- There has been a dramatic increase in caregiver demand for vaccination in Kaduna and Sokoto, where the share of missed children due to refusal has been halved over the last year. Still, despite general progress in campaign quality, Nigeria has some of the highest reported rates of vaccine refusal in the world. In 2012, caregiver refusal of OPV was linked to one third of polio cases.

- Health workers continue to face threats in the areas where violence and insecurity resulted in the deplorable deaths of eight more health workers in February 2013. Polio eradication efforts are more reliant than ever on local and religious leaders to engage communities and promote immunization. Fostering greater demand for vaccination through health centres will be particularly important in areas where campaigns cannot take place due to insecurity.

WHO/2011/T. Moran

Volunteer community mobilizers serve as a conduit between influencers and the families they can most effectively reach.

UNICEF/2013/xxxx

Persistent Refusals

Several data sources suggest that vaccine coverage in Nigeria has been increasing over the past six months. According to Lot Quality Assurance Monitoring (LQAS), only 7 out of 107 very high-risk local government authorities in Kaduna and Katsina had more than 10% missed children in the March 2013 vaccination campaign. These results suggest that the remaining challenges lie within very concentrated areas and that the programme must focus its efforts there.

Although data from independent monitoring also look promising, data collection forms were revised in October 2012 and it has taken some time to train monitors on the new forms and bring the quality of data back up to previous levels. In addition, campaign disruptions in Borno and Yobe due to insecurity have resulted in data gaps. Where the more reliable LQAS has been implemented, it does not collect communication data.

The available data show progress over the last year in some areas. In Kaduna, for example, the proportion of children under age 5 missed due to refusal dropped from 2.5% to 0.3% between March 2012 and March 2013. In Sokoto, it dropped from 2.1% to 0.9% during the same period.

Generally, however, the burden of refusals remains high in Nigeria. In 2012, one third of all polio cases were from families that refused OPV when it was offered. Among children who had never had even one dose of the vaccine, 50% were among families who refused (Figure 11). At the end of each campaign, approximately one million children across the northern states remain unvaccinated due to caregiver refusal. In February this figure reached 1.3 million, possibly reflecting the impact of an anti-OPV DVD that was widely distributed ahead of the February campaign. Following this incident, 40% of refusals in Sokoto were attributed to religious reasons – nearly twice the proportion reported in October 2012 (Map 3).

Resolving Refusals

Social research shows that many caregivers in the northern states do not regard polio as a serious threat to their children, and also do not believe OPV to be an effective and safe method of prevention. These beliefs are the main contributing factors to the high rate of refusal in Nigeria. At the same time, people continue to refuse OPV because they have other felt needs that are not being addressed; households and even entire communities insist that these other needs be met before they will accept OPV. Furthermore, polio campaigns have proven to be a useful platform for politico-religious opposition. In many countries, the religious networks behind anti-vaccine movements have leveraged visibility created by polio campaigns to air their grievances.

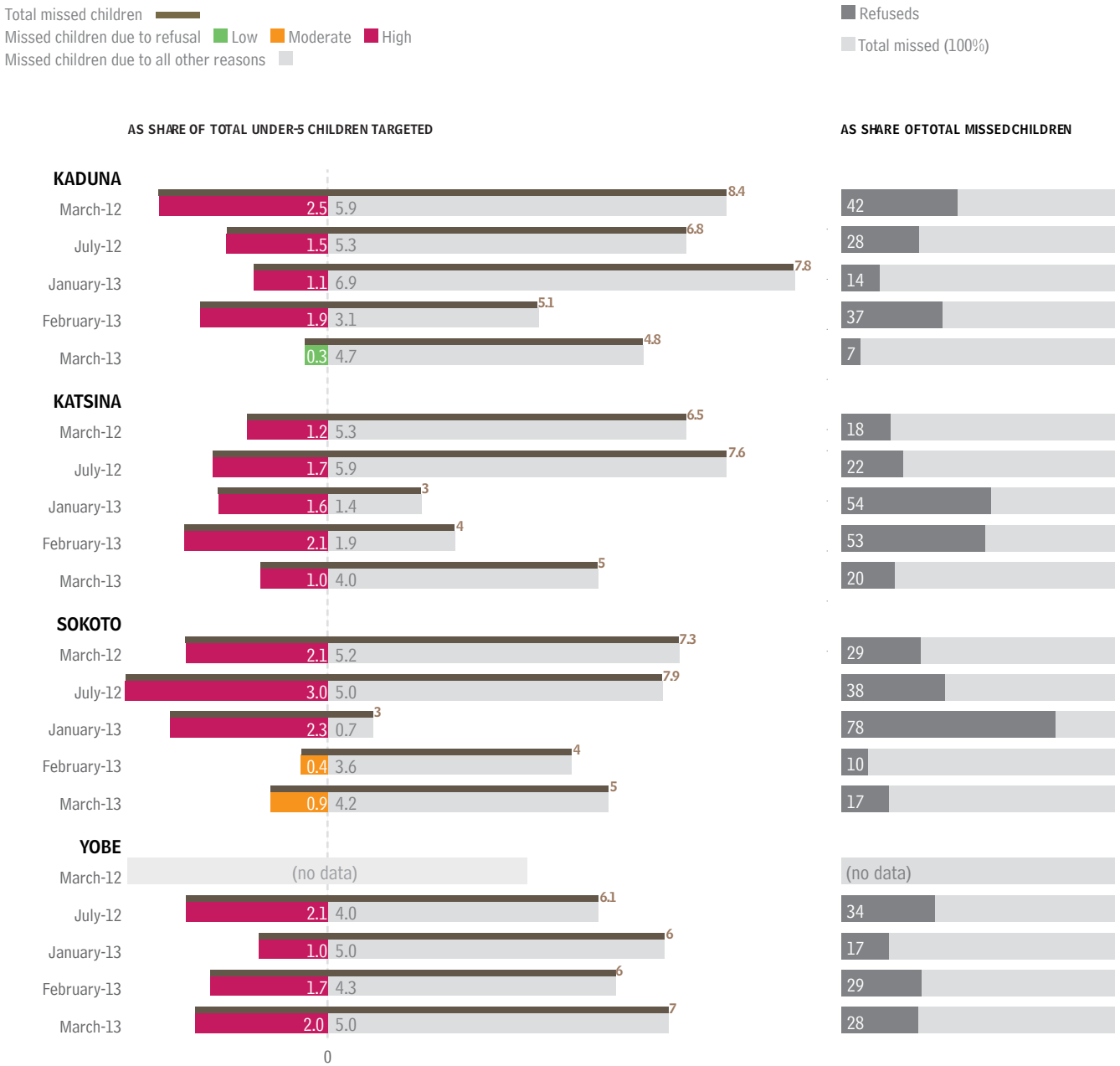
A refusal study conducted during the October 2012 campaign in Nigeria showed that religious leaders are critical drivers of decision-making and social norms. The government of Nigeria, with UNICEF's support, has been intensifying engagement with local religious leaders. The first steps in this strategy have been to undertake a mapping of religious sects in refusal stronghold areas (Map 3) and to engage with Koranic schools,

>80%

... of refusals have been resolved through religious, traditional and community leaders in all of the northern states.

FIGURE 10 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal in northern Nigeria (%), 2012 – 2013



Among children who had never had even one dose of OPV in 2012, 50% of them were among families who refused.

WHO/2012/T. Moran

as well as working through the 2,000-strong Volunteer Community Mobilizer network to create an engagement model that focuses on increasing demand through localized community ownership. Future plans include engaging religious bodies more actively during Friday sermons and intensifying efforts to reach missed children.

In the last few months, more than 80% of refusals have been converted in all of the northern states, with particularly high levels of conversion in the key states of Sokoto, Kaduna and Katsina – primarily through religious, traditional and community leaders (Figure 12). While the involvement of these leaders is crucial, the role of volunteer community mobilizers is equally so. These women serve as a conduit between influencers and families they can most effectively reach (see "Two Drops for Mecca" on page 19).

Winning Trust

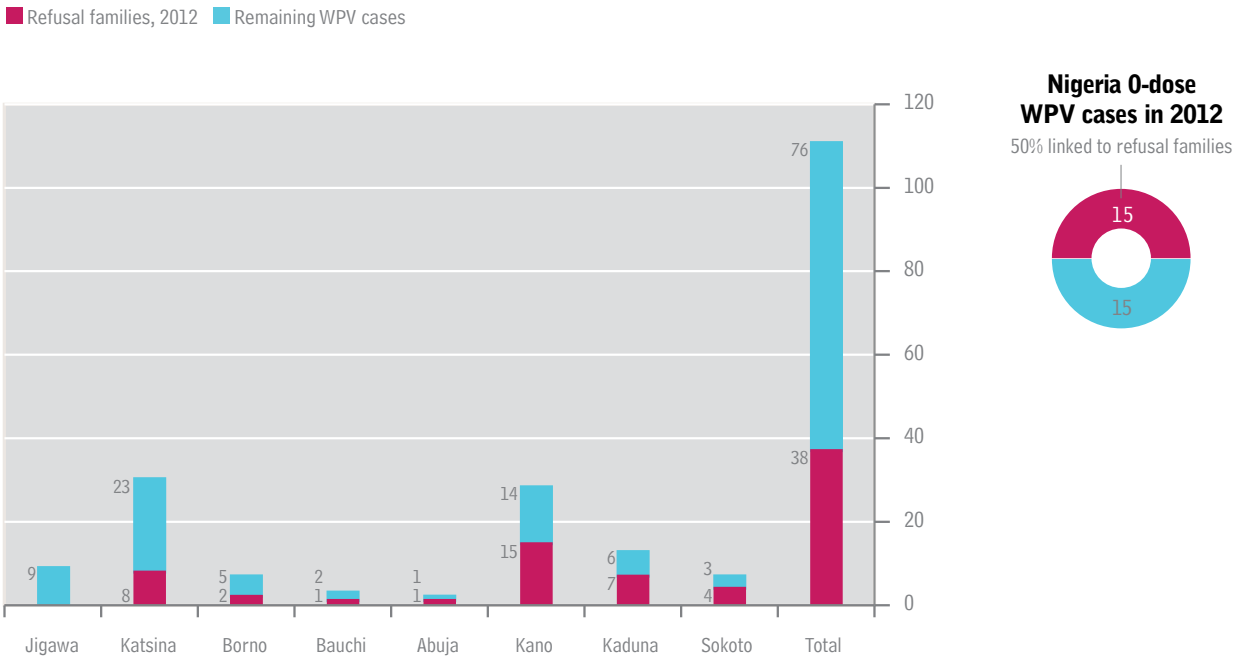
In many underserved communities, it is common to see resistance to polio immunization motivated by efforts to negotiate for more services. Families face many challenges on a daily basis and seldom receive basic services such as clean water, sanitation and education. Nigeria has adopted Immunization Plus Days as a mechanism to promote the polio vaccine within a broader array of child health services. This approach is being revitalized with an emphasis on exploring which additional services the programme could provide to specific areas or to specific populations such as nomadic tribes – with routine immunization as the first step.

The 2,000 volunteer community mobilizers recently underwent a management review to improve how the community network is supported and supervised. A strategic "rethink" on how mobilizers engage communities in relation to polio vaccination and other immunization services will emerge from this review. The mobilizer role will be strengthened to promote community ownership and engagement around broader child health goals. Based on the review and the planned assessment of volunteer community mobilizer impact, it is possible that the network could expand to include several thousand additional mobilizers deployed to the remaining "very high-risk" communities. Expansion will need to be based on clear indicators of performance to date and on specific criteria for further deployment.

With threats of insecurity looming in northern Nigeria, work with local leaders will be critical to ensure that the collision of political, social and religious dynamics does not continue to cause distrust – and polio transmission – in northern states.

FIGURE 11 | SOURCE: WPV CASE INVESTIGATION FORMS, 2012

Wild poliovirus cases linked to refusal families in northern Nigeria as share of total 2012 cases (%)



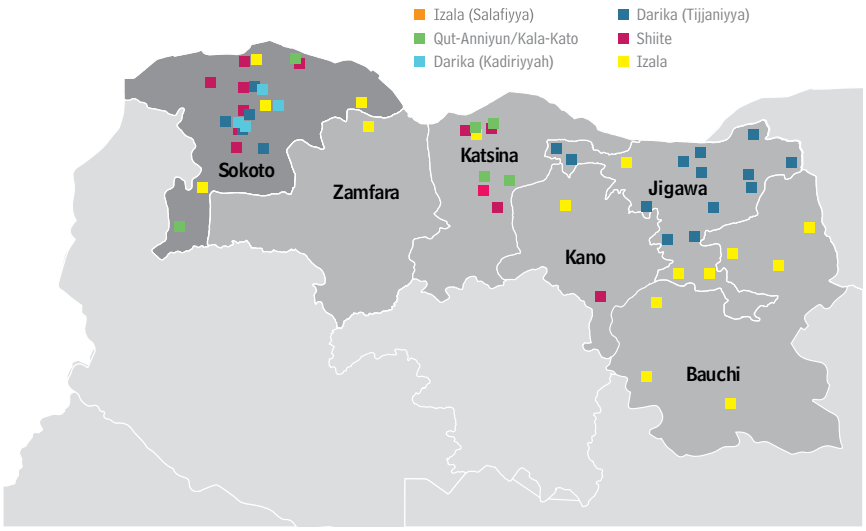
Note: Data represent analysis of 114 cases in Nigeria as of 04 March 2013.

2,127

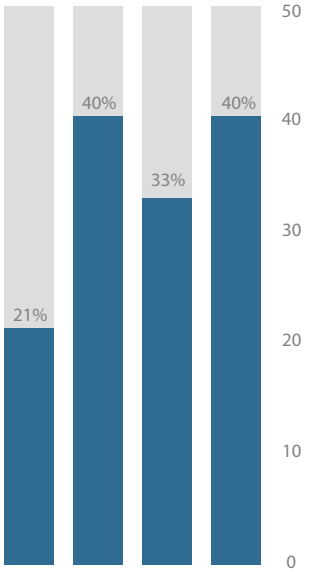
... volunteer community mobilizers now work in the highest risk settlements of nothern nigeria. Based on the results of a recently conducted management review, the network could expand to include several thougsand additional mobiliers.

MAP 3 | SOURCE: UNICEF

Mapping of religious groups in northern Nigeria, April 2013



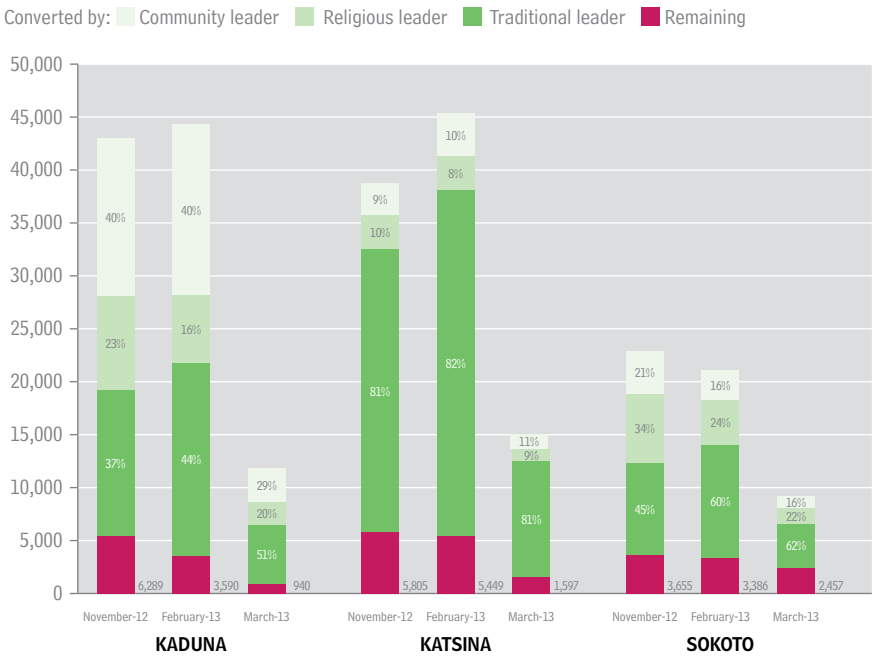
Proportion of non-compliance due to religious belief (%), Sokoto



Source: Redo data, Independant Monitoring

FIGURE 12 | SOURCE: SIA TALLY SHEET DATA, GOVERNMENT OF NIGERIA

Refusals converted by traditional, religious and community leaders in high-risk states of northern Nigeria (%), November 2012 – March 2013



Credit: WHO/2013/T.Moran

Two Drops for Mecca

The Mother of a Polio-affected Girl Opens Doors – and Helps Rid Nigeria of Polio for Good.

Aisha may not be able to read, but she never forgets a name, or a child. Her own tragedy was too great.

"Where are Hassan, Hassana and the other kids?" Aisha asks the woman of the house from the doorway.

"Hassana is in, but Hassan is outside," says their mother.

"Please call him, and also call Adnan, Walesa, Rahinatu and Hussaina."

Fifty-year-old Aisha, who wears a UNICEF-blue hijab to cover her hair, is the mother of 10 children herself. She lives 30 minutes away from the settlement of Hawan Dawaki, where she acts as a volunteer community mobilizer.

Still, Aisha knows every child below age 5 by name in each of the 220 households in Hawan Dawaki. She knows about every birth. She knows the vaccination status of every pregnant woman. Most importantly, she knows whether each one of the children in the settlement has been vaccinated against polio.

Hawan Dawaki is in the northern Nigerian state of Kano. Many children do not receive the polio vaccine here: at least 6% of children have been missed in the last six months that campaigns have taken place. Sometimes this is because parents misunderstand and therefore fear the vaccine, and refuse to allow their children to take it. Sometimes children are missed due to a lack of awareness among vaccinators about the number of eligible children in each household. In the past two months, entire communities have gone unvaccinated due to security problems that have left the state inaccessible to vaccination teams.

Whatever the reason for the lack of vaccination, irreversible paralysis occurs in one child out of every 200 children who are infected with the poliovirus. It does not matter that Aisha cannot read. She understands this statistic in the way only a mother can. Her own daughter, little Mariyam, is that "one child."

Aisha believes that Mariyam, now six years old, was missed because polio vaccinators did not know how many children in the household should have received the vaccine. She believes

UNICEF/2013/H. Vilain

> ‘Do you know that to go to the holy city of Mecca from Nigeria, you have to take polio drops?’

that her small daughter still suffers from the effects of polio today because a vaccinator did not know to ask for Mariyam by name.

And that is why Aisha now walks along the hot, dusty tracks between the houses of Hawan Dawaki, knocking on door after door and calling each child by name.

“You know why I am here?” Aisha asks at another doorstep.

“Yes, it’s about the polio eradication campaign,” says a young mother who holds a baby at her hip.

“You still don’t accept the vaccine?”

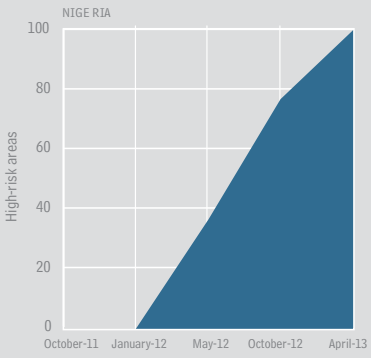
“No, he doesn’t allow us to.” The woman’s face is regretful, but her husband’s wishes are clear.

Aisha doesn’t give up. She speaks about some of the misunderstandings that the family may have about the vaccine. Then she says,

“Do you know that to go to the holy city of Mecca from Nigeria, you have to take polio drops, since Nigeria is a reservoir of the virus?”

FIGURE 13 | SOURCE: UNICEF MONITORING

Scale-up of Volunteer Community Network as share of target high-risk areas covered in northern Nigeria (%), October 2011 – April 2013



Mecca is the holiest site in Islam, the place toward which devout Muslims unroll their prayer mats to pray five times a day. It is unlikely that most of the children in this poor, remote part of Kano will be able to make the *Hajj*, the pilgrimage that is seen as a pinnacle in the life of a Muslim. Still, to argue with what is required to go to Mecca would be unthinkable.

The woman is silent. Maybe she will tell her husband what Aisha has said, but it is clear that the decision about vaccination is not hers to make.

It’s a strange balance. Aisha herself must rely on the endorsement and approval of her work by religious authorities and other local authorities – most of whom, in the hierarchy of this part of Nigeria, are men.

And yet without women like Aisha who can literally “get a foot in the door” – in a place where many women would not dare to open the door to a man – the effort to end polio in Nigeria would not have a chance.

Aisha can’t take back what happened to her daughter. But since she began her work in Hawan Dawaki, Aisha has reached 56 more households than the vaccination team used to reach. Thanks to her, 159 additional children are now protected from polio in this high-risk settlement.

Across Kano State, 557 other volunteer community mobilizers like Aisha are involved in this UNICEF-supported polio communication network. There are over 2,000 volunteer community mobilizers working in polio-endemic states in Nigeria, with plans to scale up the project this year.

In the meantime, Aisha continues through her day. She walks down the hot, dusty street. She knocks on doors. Sometimes, when the doors are opened, she will hear words like, “He won’t let me.”

But always – always – she will persist.

In the current context of violence against healthworkers in Pakistan, children have been robbed of the right to basic health services, including polio immunization. Armed escorts must now accompany vaccination teams in many of Pakistan's polio sanctuaries.

UNICEF/2013/A. Zaidi

Pakistan

The **CONTEXT**

- Pakistan has reported six polio cases to date in 2013, compared to 15 at the same time last year. All cases in 2013 have been among Pashto-speaking families.
- No other priority country faces such a high level of continued threats against the polio vaccination programme and the frontline workers who deliver the vaccine.
- The targeted killing of vaccinators and other health workers since December has significantly affected the programme's ability to carry out and monitor high-quality vaccination campaigns. Non-polio AFP data clearly show the impact of the new reality: fewer children are being vaccinated in March 2013 than in September 2012.
- Although rumours about the programme and about OPV have intensified in some areas in recent months, the proportion of people who believe the rumours – even in polio sanctuaries – remains low.
- Several districts in Khyber Pakhtunwa, including Peshawar, show a steady increase in refusals since October 2012. Most caregivers here attribute their refusal to religious reasons, a preference for other services or a belief that vaccination campaigns are too frequent.
- Social data from 2012 show that caregiver intent to vaccinate, if offered OPV, is high. Although caregiver likelihood of going to a vaccination centre if a team doesn't arrive at the doorstep is lower than intent to vaccinate, it is still high. It points towards a fixed site strategy as a possible option for service delivery in insecure areas.

Trust Under Fire

Nowhere is the polio vaccination programme facing more resistance – including violence against frontline workers – than in the remaining polio sanctuaries of Pakistan.

Due to the tragic loss of life that has occurred since December, campaigns and communication activities remain suspended in Union Council 4 Gadap in Karachi; Pishin district of Balochistan; and North and South Waziristan in FATA. Children in these areas have been consistently inaccessible to the programme for several months.

Operations in Pakistan are now staggered to allow for campaign flexibility based on readiness, accessibility and security. Intimidation and fear of violence have reduced the quality of vaccination activities, though the inability to monitor all communities means the impact of this situation cannot be fully assessed. At the same time, security is sometimes used as a convenient explanation for underperforming districts and union councils. It is difficult to determine where a lack of security is a real barrier and where low-quality vaccination efforts are simply being accepted. Making the wrong decisions based on a failure to understand what is happening could have tragic consequences.

In the highest-risk districts, the intensified vaccination strategy of short-interval additional doses is applied when windows of accessibility and security open up. Consecutive campaigns take place fewer than ten days apart, creating more opportunities to reach children who have not had access to OPV. But this approach has its limits: a considerable number of caregivers cite the frequency of campaigns as a reason for refusing vaccination.

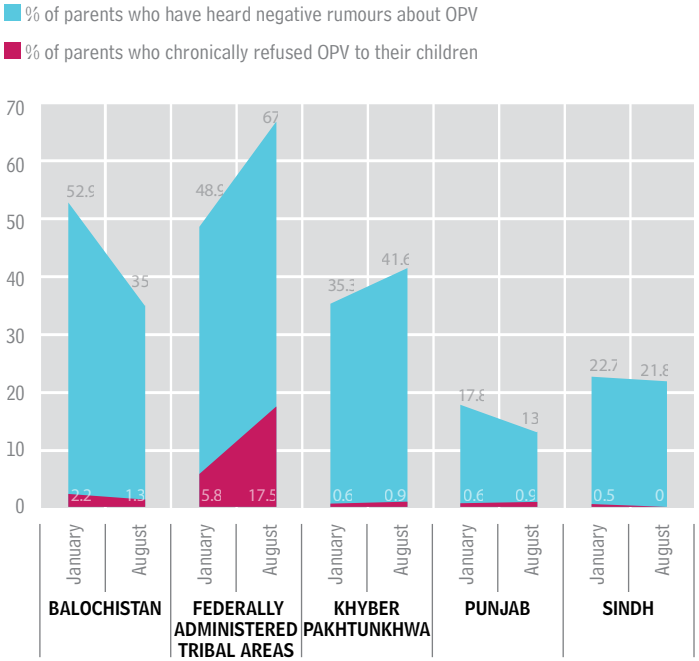
Since vaccinators are now accompanied by armed police and security personnel, there is a greater danger of vaccination being perceived as coercive. Such perceptions have the potential to inflame anti-polio sentiment if communities see police officers as enforcers rather than protectors.

The New Communication Paradigm

Communicating in this environment is extremely complex. Experience has shown that publically announcing campaign dates has increased security risks to frontline workers, since the announcement may provide advance information to people who wish to plan attacks. As a result, the programme has reduced or eliminated public announcements of campaigns in level 1 high-risk areas (those areas thought to be at highest risk for security incidents). However, without official information that a campaign is taking place, communities may also be sceptical about vaccinators who arrive at their doorstep unannounced, and may question the authenticity of the campaign.

FIGURE 14 | SOURCE: UNICEF-SUPPORTED KAP STUDIES, JANUARY AND AUGUST 2012

Prevalence of rumours circulating about OPV in Pakistan, and share of parents who believe them (%), January – August 2012



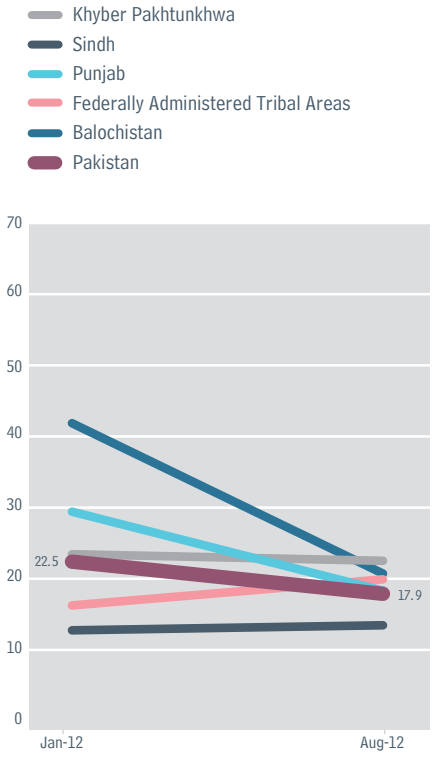
Note: Chronic refusal is defined as a caregiver who has reported refusing OPV more than once or always

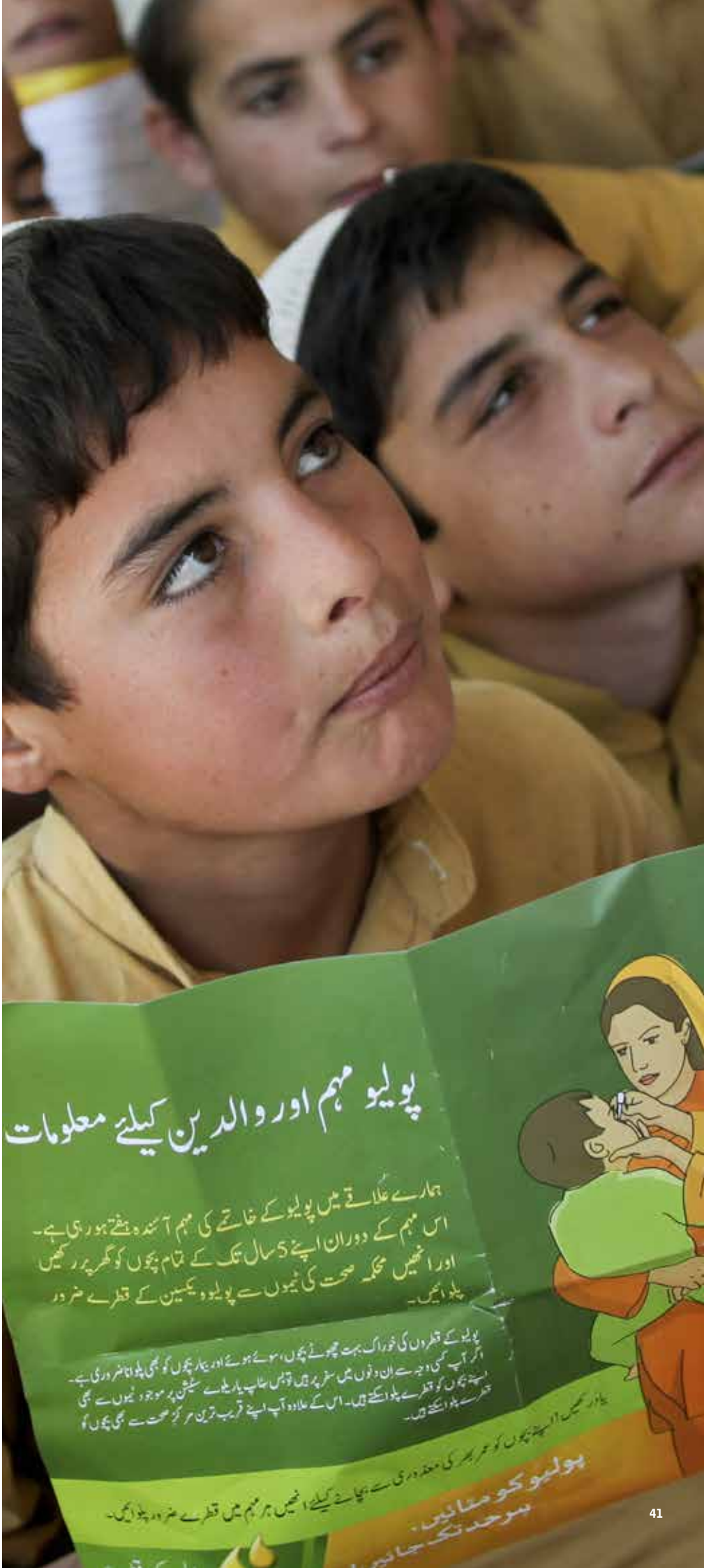
The already-low parental concern about polio is dropping. Keeping levels of concern appropriately high, even as cases decline, will require more sophisticated communication strategies.

Prior to every polio campaign up until December 2012, workers from Pakistan's social mobilization network – COMNet – would conduct individual face-to-face outreach targeting more than 100,000 households identified as most at risk of being missed. This communication is no longer possible in many high-risk areas. Household engagement is now more dangerous for

FIGURE 15 | SOURCE: UNICEF-SUPPORTED KAP STUDIES, JANUARY AND AUGUST 2012

Share of caregivers in high-risk areas of Pakistan concerned that their child(ren) will contract polio (%), 2012





UNICEF/2013/A. Zaidi

Communities that are anxious about security are often consciously motivated to understand how to better protect their children. Emphasizing the protective power of immunization for broader child health will help caregivers feel confident in their decision to vaccinate.

UNICEF/2012/A. Arif

Communities that are anxious about security are often consciously motivated to understand how to better protect their children. Emphasizing the protective power of immunization helps caregivers feel confident that their decision to vaccinate will improve their children's wellbeing overall rather than simply averting the danger of polio.

In Pakistan, as in Afghanistan, the ability to engage more women will be critical to accessing more households and children. Female-to-female interaction at the doorstep is immediately less intimidating and more effective. Yet only 28% of social mobilizers in Pakistan are female. Stakeholders must craft messages not only about vaccination but also about allowing women to participate more actively in the workforce for children's health. This is a difficult rallying call since women were among the vaccinators tragically killed in recent months.

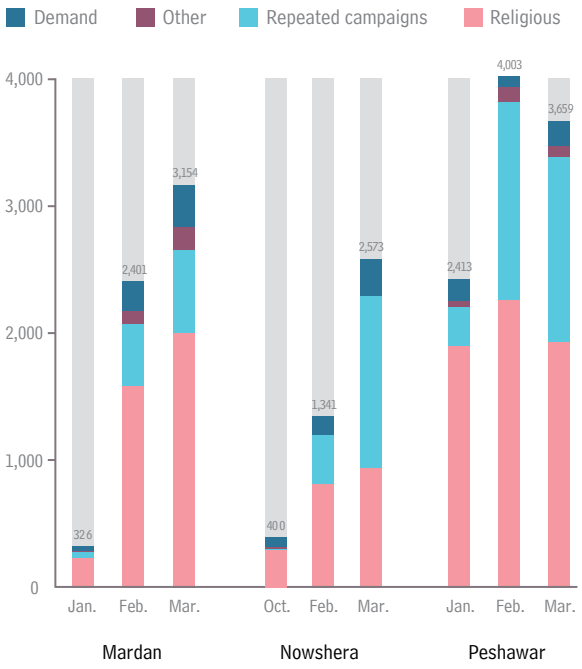
frontline workers and in some cases for caregivers themselves. There have been reports of caregivers facing intimidation for engaging with the programme in areas that are hostile to its efforts.

In the highest-risk areas, campaign announcements and communication about the importance of vaccination now take place at the doorstep and through local traditional networks in the midst of the vaccination campaign itself. This strategy relies heavily on the composition and competence of vaccinators and social mobilizers, who must now win the trust and confidence of local leaders and caregivers almost immediately. There is less time than before to linger in doorways to answer questions, so it is important for families to be ready to engage immediately when health workers arrive.

But it is not always an easy task to explain the importance of receiving OPV several times a year – or even in a week, if it is the second pass for short-interval additional doses. Data show that the already-low parental concern about polio is dropping (Figure 15). Keeping levels of concern appropriately high, even as cases decline, will require more sophisticated communication tactics.

FIGURE 16 | SOURCE: POLIO CONTROL ROOM DATA/PRIME

Trends in missed children due to refusals in high-risk districts of Khyber Pakhtunwa (%), January – March 2013



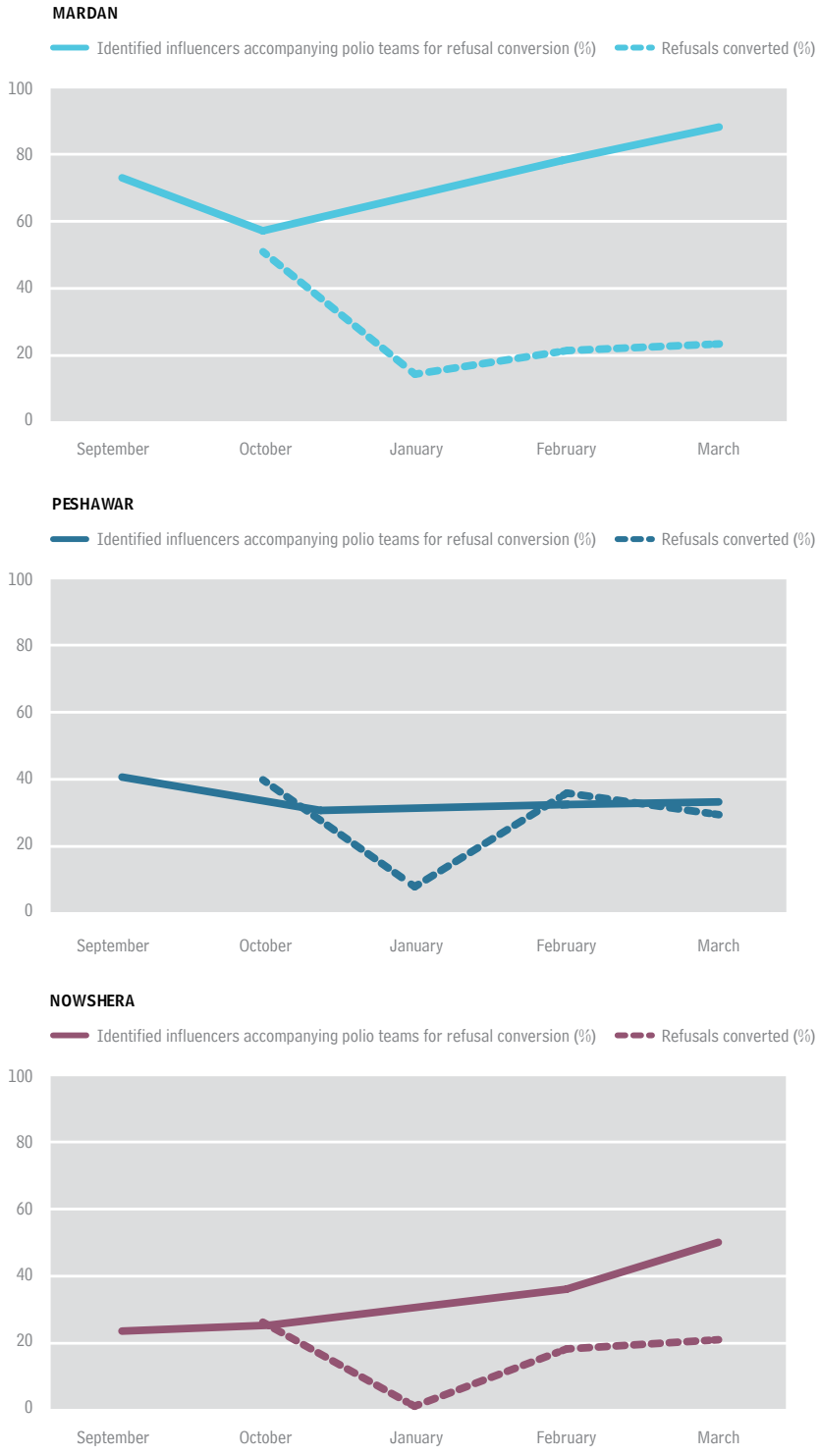
Community Ownership and Accountability

Teams are able to vaccinate more children when locally appropriate influencers promote the campaign and accompany the teams. COMNet workers have identified more than 6,000 influencers in the highest-risk areas, who are incorporated into micro-plans to help mobilize communities each month. In areas where security has declined, however, it has been more difficult to interact with communities. Either there are not enough influencers willing to participate in the identification of missed children or else the influencers who participate are not a suitable match for the types of issues and populations that must be targeted. In the highest-risk areas, it is more important than ever for mobilizers to be able to work behind the scenes to identify and engage the right influencers.

Social mobilization efforts will prioritize outreach to existing community structures and groups even more in this new security environment. Almost 5,000 schools and madrassas promote polio eradication on a monthly basis, and religious leaders have issued more than 30 fatawa (religious appeals) in support of OPV. Mobilizers and vaccinators promote these fatawa using a fatwa booklet that they carry with them. Broad social support must continue to be sought. More importantly, meaningful participation from communities must be secured in order to establish full ownership and commitment to vaccinate every child. Finding creative methods to win this support will be paramount.

FIGURE 17 | SOURCE: POLIO CONTROL ROOM DATA/PRIME

Share of refusals converted by social mobilizers and influencers in select districts of Khyber Pakhtunkhwa (%), September 2012 – March 2013



Religious leaders have issued more than 30 fatawa in support of OPV. Mobilizers and vaccinators promote them using a fatwa booklet that they carry with them when visiting households.

Diving Deeper to Understand Local Issues

Data collected in January and August 2012 showed an increase in the circulation of rumours about OPV in the Federally Administered Tribal Areas and Khyber Pakhtunwa since January. (Figure 14). At the time, these rumours were not significantly affecting household practices. Although current data suggest that refusals generally remain low, it will be important to measure public sentiment again following the recent violence against healthworkers.

Three Khyber Pakhtunwa districts that surround the key transmission zone of Peshawar – including Peshawar itself – have shown a trend of increasing refusals since October 2012, with a greater number of refusals attributed to religious reasons, repeated campaigns and preferences for other services (Figure 16). One of the three polio cases in Khyber Pakhtunwa so far this year is from a refusal family.

Refusal conversion rates in these districts – the proportion of initially refusing households that mobilizers and influencers are able to persuade to accept vaccination – are low, and have dropped even further after December's violence (Figure 17). There is a need to further unpack the rise in caregiver refusal in order to see how many refusals are based on religious issues such as concern about whether OPV ingredients are *haram* (forbidden) and how many refusals are linked to misconceptions or oppositional discourse promoted by the media, madrassas or other institutions or networks.

Enlisting the Media

The media environment in Pakistan presents a major challenge to polio campaign awareness and consequently to behaviour change. A small but influential subgroup within the media has been consistently critical of the polio programme. Between January and March of 2013, media data show overall positive coverage: on average, negative stories only made up about 5% of all stories published about the programme. However, negative stories were often high-profile and Internet-based, which meant that they reached a large readership. The stories often carried a significant amount of misinformation that threatened public confidence in the polio vaccination campaign and in the vaccine itself.

Because Pakistan's polio programme is a high-profile government programme, it is difficult to de-link the programme from a political environment that is currently dominated by concerns about the electoral process. The media often plays up this angle.

Nonetheless, Pakistan's government – with support from GPEI – is retooling its public communication approach to polio vaccination, moving away from positioning it a singular health strategy and instead emphasizing immunization more generally as the only way to protect children from many dangerous diseases. The principle of protection – a pillar central to all Muslims and all parents – is the backbone of this approach.

With UNICEF's support, the government is also conducting a campaign to equip journalists with accurate information about polio and to use editorial and op-ed pages

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to respond to misinformation. The polio vaccination programme has reached out to influential journalists nationwide and is seeking to give them first-hand knowledge of the programme and its objectives. The purpose of this engagement strategy is to show journalists both the challenges that the initiative faces and the benefits it can bring to the children of Pakistan.

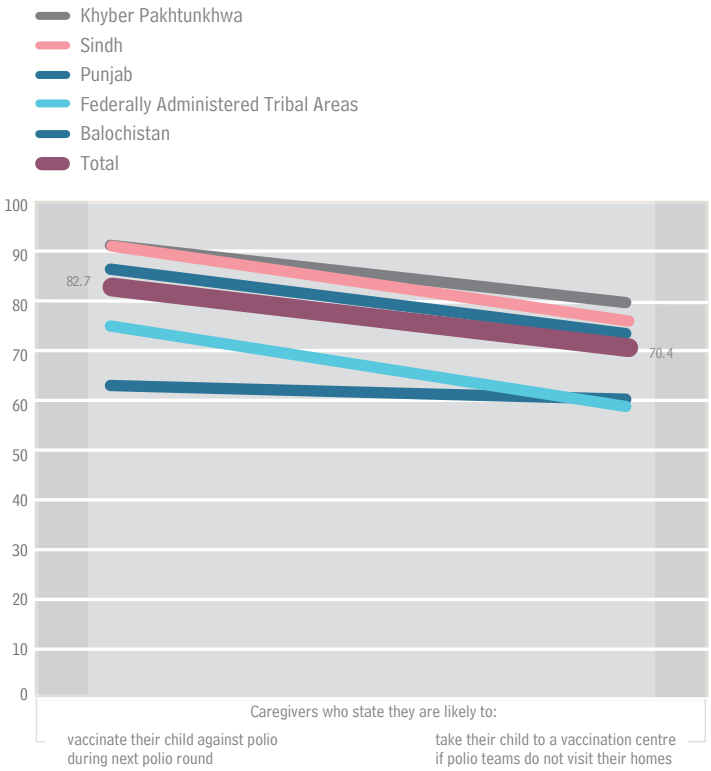
Building Trust in Uncharted Territory

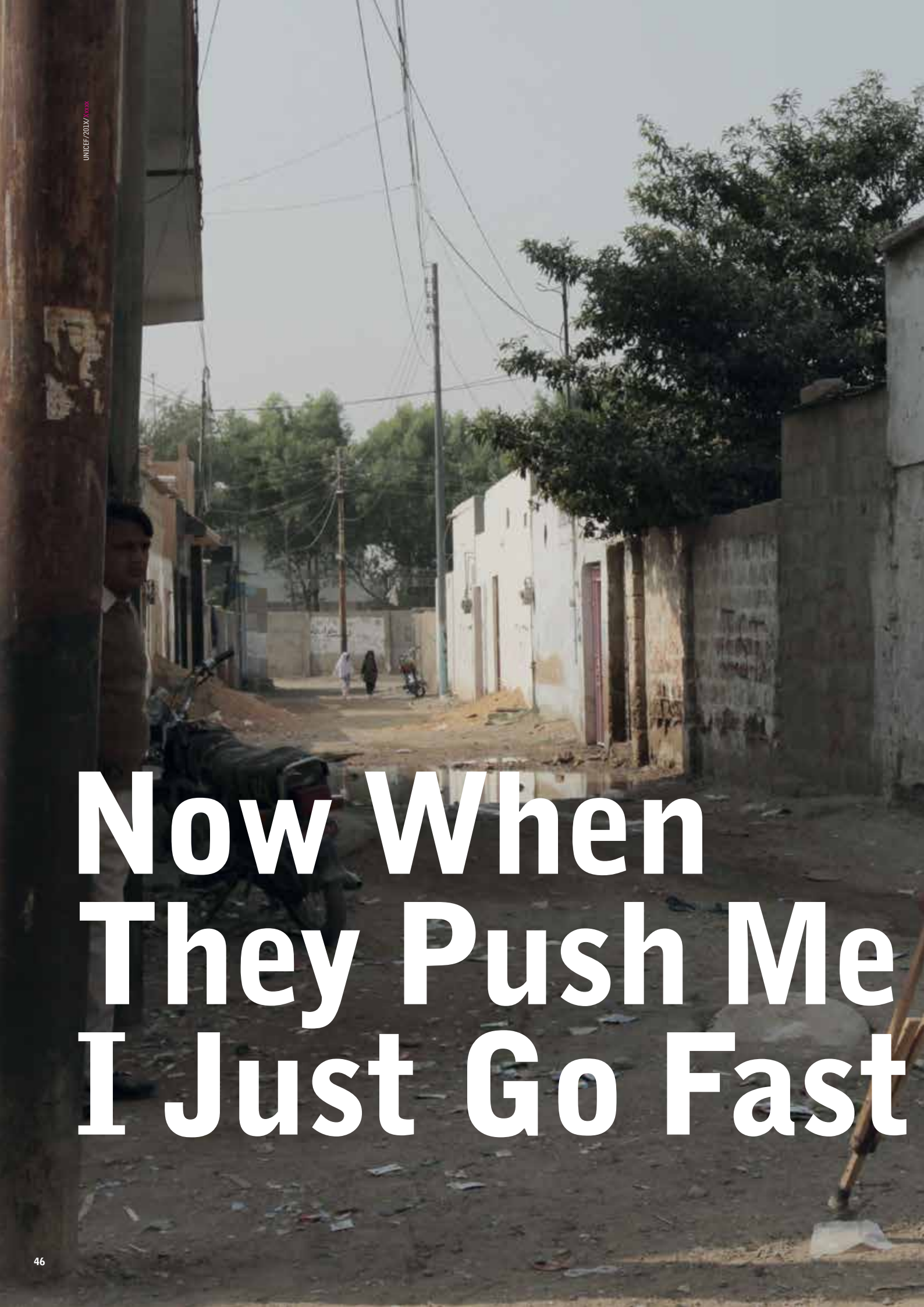
Mass media, social mobilization and media engagement will be critical to win support for polio eradication objectives moving forward. But the obstacles to progress are complex and intertwined. In many cases, the necessary response goes beyond one agency's or one country's abilities, particularly when global political decisions impact community and household behaviour.

Pakistan's new security situation represents uncharted territory for the programme, as well as for public health more broadly. The data suggest that caregivers' intent to vaccinate remains high, and that they are willing to bring their children to health facilities for vaccination (Figure 18). Succeeding in this context will require creativity, honesty and a willingness to consider how to adapt to people's needs while demonstrating a sincere commitment to building greater trust.

FIGURE 18 | SOURCE: UNICEFS-UPPORTED KAP STUDY, AUGUST 2012

Community demand for OPV in high-risk areas of Pakistan (%), August 2012





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Now When They Push Me I Just Go Fast

Qari Aqeel en route to his madrassa in Karachi.

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In Pakistan, a Madrassa Teacher Lives with Polio – and Speaks Out to Help Bring the Tragic Disease to an End.

"I kneel before Allah. But I am unable to stand on my feet before any man."

In Pakistan – a country where religious belief and polio eradication are often intertwined – courage has many faces. One of these faces belongs to Qari Aqeel.

As a teacher at a madrassa in one of Karachi's poorest areas, Aqeel educates children in the fundamentals of Islam and the Holy Quran. He also tells students, from his own painful experience, what it is like to live with polio.

Karachi is one of four main reservoirs of the polio virus in Pakistan. Due to constant population movement and insecurity, it is critical to the success of eradication efforts. As a devout Muslim, Aqeel takes his role as guardian of the children under his care very seriously. He talks to parents and children about the importance of vaccination from an Islamic perspective and tries to personally ensure that every child at the madrassa is vaccinated against polio.

Clear guidelines are given, in an Islamic Hadith, about the personal responsibility of every Muslim to care for others:

"All of you are guardians, and all of you will be asked about the wellbeing of those who you are responsible for."

Pakistan's government, with support from UNICEF, has begun to shift its polio communication approach to highlight the risk of the disease and emphasize vaccination as an Islamic responsibility.

As a part of this initiative, Aqeel has recently stepped further into his role as guardian – not just for the children who study at his madrassa, but for children all over Pakistan.

In a video aired on Pakistani television, which aims to reach 71 million Pakistani households, Aqeel takes the spotlight away from the politics and misunderstandings that can muddy the dialogue about polio vaccination. He brings the focus firmly back to what matters most: the heart-wrenching impact of polio on a young life and the imperative that people all over the world come together to end this tragic and preventable disease.

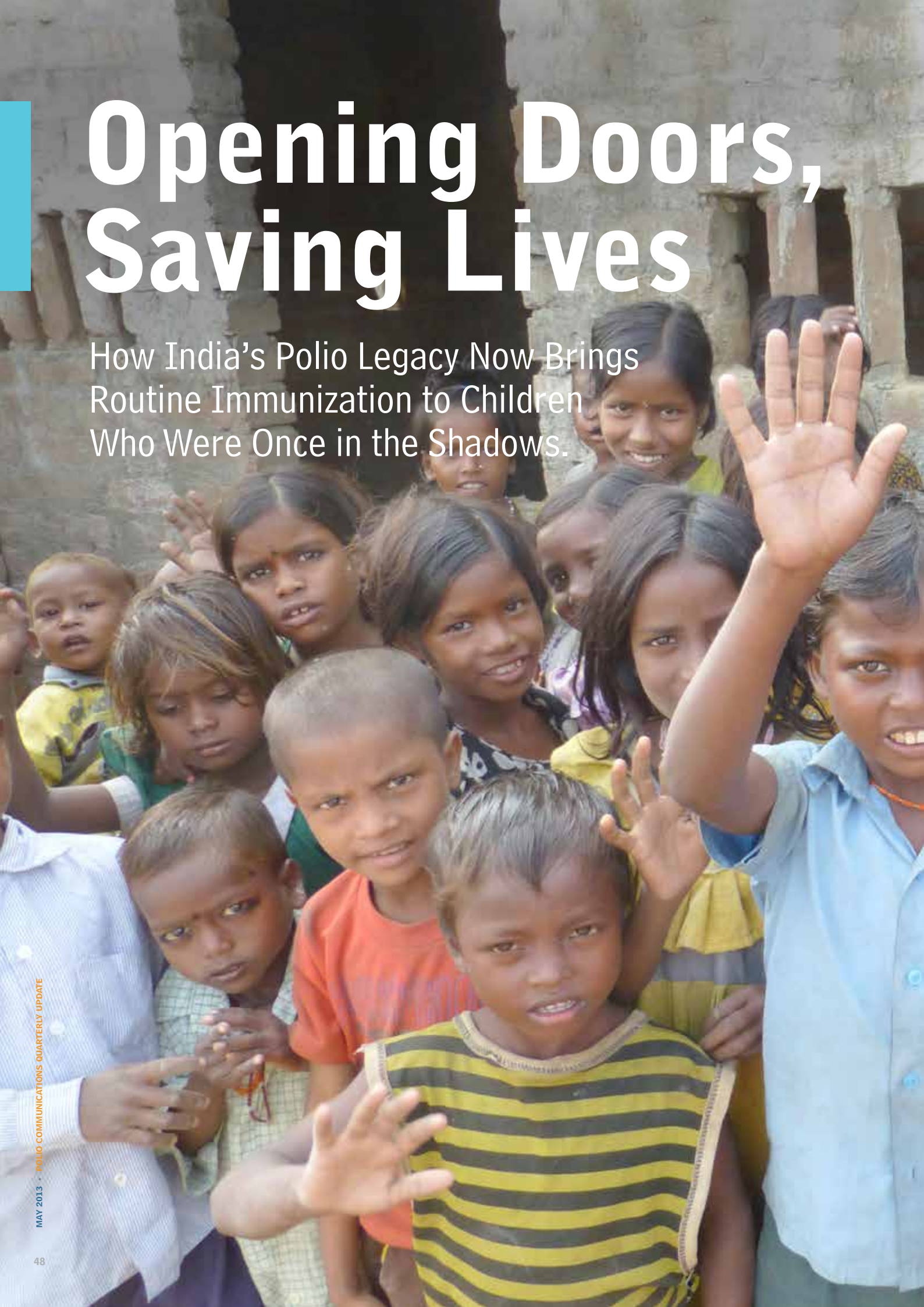
Back when he was a child, Aqeel so longed for an education and a connection to God that he braved shoving and spitting from other children to make his way through the streets of Karachi on crutches. His destination was the local madrassa.

Today, as a grown man, Aqeel might be speaking of his newly-acquired wheelchair when he says,"Now when they push me, I just go faster."

Or he might be speaking of the struggle to end polio itself.

Opening Doors, Saving Lives

How India's Polio Legacy Now Brings Routine Immunization to Children Who Were Once in the Shadows.



UNICEF/2013/P. Das

12-year-old Gulshan Kumar (centre) and his classmates at the Shiva Brick Kiln school in the Kosi River Basin of Bihar State, India.

UNICEF/2013/R. Curtis

An auxiliary nurse midwife conducts a monthly routine immunization session organized by the SMNet at the Shiva Brick Kiln in the Kosi River Basin of Bihar State, India.

In keeping with the polio underserved strategy, mosques have been requested to disseminate information about Immunization Weeks, with more than 4,500 mosques answering the call to promote routine immunization during these weeks.

Before polio eradication, you couldn't find Shiva Brick Kiln on any map. Before polio eradication, the children of the 30 migrant families who shape bricks by hand here during Bihar State's scorching dry season lived in the shadows. They were uncounted, invisible. They did not receive routine immunization to protect them from the seven vaccine-preventable childhood diseases. Nor did they have toilets or safe drinking water.

It is strange to think that polio – a disease that can rob children of the use of their legs and even their lungs – could in any way be a gift. But in India, new doorways have been opened by the massive and successful effort to eliminate polio. These doorways are now allowing other life-saving vaccines and health care services to reach children who previously lived in the shadows.

This is what the legacy of polio eradication can look like when integrated with routine immunization:

Bringing children out of the shadows. With routine immunization, as with polio vaccination, it is essential to reach the children who are most at risk of contracting and spreading deadly diseases. Polio has helped call attention to the most marginalized children living in excluded communities, including migrant groups, and in hard-to-reach places such as slums and remote villages. The maps used to plot the location of these communities for the purpose of eradicating polio can also be used to guide routine immunization activities. Updated information is shared with the Ministry of Health each month, and micro-plans are drawn up to ensure that these often-forgotten children are incorporated into routine immunization planning.

4,500 mosques

Extending Partnerships. The construction companies and brick kiln associations that were so critical to halting polio in India still serve as a network of informers on stand-by. They can be called upon to generate quick-time information about new settlements and newly arriving groups. Once a high-risk site is identified, it is assigned to a mobile team and monitored to ensure that routine immunization services reach children there.

Microplanning. In preparation for Routine Immunization Weeks, the polio social mobilization network draws up a detailed plan of social mobilization activities to support immunization sessions. The micro-plan encompasses activities such as school rallies, meetings with mothers, mobilization of key influencers to speak with targeted families and the tracking of resistant or reluctant families.

Engaging the Islamic Community. In keeping with the polio "underserved strategy," mosques have been requested to disseminate information about Routine Immunization Weeks. More than 4,500 mosques have answered the call to promote routine immunization during these weeks. Principals and teachers at madrassas in the area are also sensitized.

Conducting evening meetings. During Routine Immunization Weeks, evening monitoring and feedback sessions based on the polio model, are held each day. Attended by frontline workers and UNICEF staff at block, district and sub-regional levels, feedback is shared during the sessions for immediate corrective actions. Issues that are often identified and addressed during monitoring include vaccine and logistics management; cold chain management; and the need for supplementary nutrition and scales to weigh children.

Tracking every last child. Community mobilizers maintain records of antigen-wise immunization received by children aged 12 months and under, and counsel mothers to ensure that their children are fully immunized. Throughout 2012, the percentage of planned routine immunization sessions held in community mobilizer areas was 83% in Uttar Pradesh and more than 90% in Bihar.

Using mass media/"edutainment". In a country where families without televisions will often crowd around a single screen in their neighbourhood to follow the latest popular soap opera, "edutainment" is a natural way to reach parents with messages about immunization. Video shows called *Ammaji Kehti Hai* ("because mother says") focus on how immunization protects children from life-threatening diseases. For high-risk groups, similar activities are undertaken at work sites.

Networks built to eradicate polio are already having an impact on routine immunization in India. In Uttar Pradesh and Bihar, an estimated 8% of infants who had never attended a routine immunization session were immunized in 2012 as a direct result of targeted interventions in polio social mobilization network high-risk areas.

These days at Shiva Brick Kiln, impressive things are happening. In response to advocacy by a UNICEF community mobilizer, the kiln manager has gone beyond helping to ensure access to routine immunization for the children of the labourers. He has installed toilets and a hand pump to provide safe drinking water, and has started a school for the migrant children. These seemingly small steps are potentially life-changing for the children and their families.

Countless doors of opportunity can open up when polio eradication networks are leveraged to provide better health and well-being for children. As more countries join India among the ranks of those that have ended polio for good, the doors can keep multiplying all over the world.

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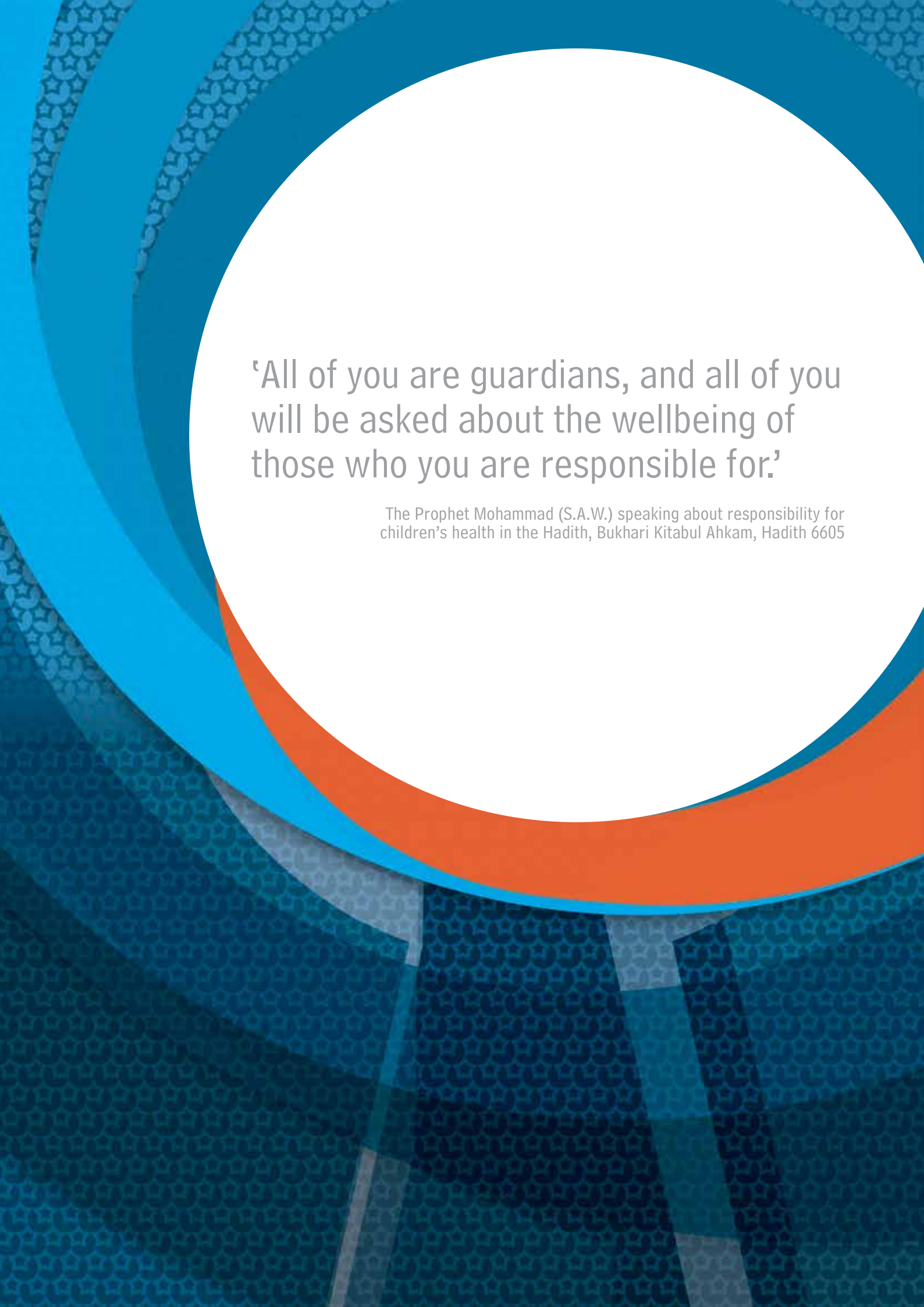
ANNEX 1

| SOURCE: UNICEF

GPEI Global Communication Indicators and Targets

Following an expert consultation, the GPEI Communication Indicators were established at the end of 2010 to help key stakeholders assess and monitor progress towards milestones outlined in the 2010-2012 Strategic Plan. They provide insights into how well the high-risk countries are performing in the areas of communications and social mobilization by measuring performance against a core set of indicators and targets. A programme's ability to collect and report on standard communications data is key to help guide or refine operational strategies, and to ensure that minimum standards are met. Although UNICEF is using well-defined indicator outcomes and targets, a subjective component is also included to determine the overall judgment of risk. In spite of meeting a milestone, additional work may still be required in a country- specific context; classification of risk has therefore been determined using both a quantitative as well as a qualitative lens.

Category	Indicator	Target and Risk Assessment		Sources of information
Impact	Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Low	≤5% (strong performance)	GPEI Risk Assessment
		Moderate	6-9% (intermediate performance)	
		High	≥10% (weak performance)	
	Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	Low	≥90%	GPEI Risk Assessment
		Moderate	80-89%	
		High	<80%	
Outcome	Trends in missed children due to refusal to accept OPV nationally and in high-risk areas	Low	Downward trends in refusal to vaccinate nationally and in high-risk areas for all SIAs (Supplementary Immunization Activity) held in the past 3-6 months; OR if percentage accounts for <0.5% of all target children under age 5 "Refusal to vaccinate" is defined as an overt refusal to accept OPV, as well as a claim that a child is sick, newborn or sleeping	Independent Monitoring Data; LQAS
		Moderate	Stable trends in refusal to vaccinate nationally or in high-risk areas for all SIAs held in the past 3-6 months; OR if percentage is 0.6-0.9% of all targeted children under age 5	
		High	Increasing trends in refusal to vaccinate nationally or in high-risk areas for all SIAs held in the past 3-6 months; OR or if percentage is ≥1% of target children under age 5	
	Trends in missed children due to all social barriers to accept OPV nationally and in high-risk areas	Low	Downward trends in all social barriers to accept OPV; OR if percentage of all social barriers accounts for <2% of target children under 5 years of age. "Social barriers" is defined as the cultural, religious, political and economic reasons that may contribute to an overt or covert resistance to vaccinate. This indicator will be aggregated from Independent Monitoring Data categories such as "refusal", "child not available", "no team" (Pakistan context), or "other", as appropriate to the specific context and analysis for each country.	Independent Monitoring Data; LQAS
		Moderate	Stable trends in all social barriers to accept OPV for all SIAs held in the past 3-6 months; OR if percentage accounts for 2-3% of all target children under 5 years of age.	
		High	Increasing trends in all social barriers to accpet OPV for all SIAs held in the past 3-6 months; OR or if percentage is ≥ 3% of all target children under 5 years of age.	
	Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	Low	≥90% of caregivers nationally and >80% of caregivers in high-risk areas are aware of the polio campaign prior to arrival of vaccinators	Independent Monitoring Data; LQAS
		Moderate	76%-89% of caregivers nationally and and >70% of caregivers in high-risk areas are aware of the campaign prior to arrival of vaccinators	
		High	≤75% of caregivers nationally and >70% of caregivers in high-risk areas are aware of the campaign prior to arrival of vaccinators	
	Source of information from those caregivers who report having heard any campaign message (Targets should focus on inter-personal communication, and higher trends in areas with commu-nicationstaff than those without)	Low	The proportion of parents in high-risk areas citing interpersonal communication as a source of information is higher in areas with communication staff than areas without; trends are increasing	Independent Monitoring Data
		Moderate	The proportion of parents in high-risk areas citing interpersonal communication as a source of information is the same in areas with communication staff as those without; trends are stable	
		High	The proportion of parents in high-risk areas citing interpersonal communication as a source of information is less in areas with communication staff that those without; trends are decreasing, or no data is collected	
Process	Social data are systematically used for communication planning	Low	≥90% of plans nationally and in high-risk areas reflect social data based on self-reporting and spot checking. Social data are utilized consistently in planning based on regular coordination meetings and data reflected in minutes	UNICEF Monitoring
		Moderate	76-89% of plans nationally and in high-risk areas that reflect social data based on self reporting and spot checking. Social data are utilized inconsistently in planning based on regular coordination meetings and data reflected in minutes.	
		High	≤75% of plans nationally and in high-risk areas that reflect social data based on self reporting and spot checking. Social data is not utilized consistently in planning based on regular coordination meetings and data reflected in minutes.	
	% of planned activities that took place in high-risk districts or Local Government Agencies (LGA's) that reported timely receipt of funding	Low	≥95% of activities identified in district-level communication plans have been completed and verified through independent sources	New monitoring forms/ system to be developed for some countries. Reporting in 2012.
		Moderate	86-94% of activities identified in district-level communication plans have been completed and verified through independent sources	
		High	≤85% of activities identified in district-level communication plans have been completed and verified through independent sources	
Inputs	Percentage of identified polio communication personnel in place in a country programme	Low	≥90% occupancy of designated GPEI communication posts, nationally and in the field, at the point of each reporting period	UNICEF Monitoring
	Percentage of identified polio communication field personnel in place	Moderate	71-89% occupancy of designated GPEI communication posts, nationally and in the field, at the point of each reporting period	
		High	≤70% occupancy of designated GPEI communication posts, nationally and in the field, at the point of each reporting period	
	Percentage of designated high-risk areas with polio communication field personnel	Low	≥60% of identified high-risk areas at sub-district level (UC, block, community, etc) have at least one communications officer working on behalf of the GPEI	UNICEF Monitoring. Should be possible for Q4 2011 Reporting
		Moderate	41-59% of identified high-risk areas at sub-district level (UC, block, community, etc) have at least one communications officer working on behalf of the GPEI	
		High	≤40% of identified high-risk areas at sub-district level (UC, block, community, etc) have at least one communications officer working on behalf of the GPEI	
	Percentage of HR areas that receive timely communication/ social mobilization funding	Low	≥95% of HR areas receive 100% of approved funding prior to the SIA for the past three SIAs	UNICEF Monitoring
		Moderate	86-94% of HR areas receive 100% of approved funding prior to the SIA for the past three SIAs	
		High	≤85% of HR areas receive 100% of approved funding prior to the SIA for the past three SIAs	


‘All of you are guardians, and all of you will be asked about the wellbeing of those who you are responsible for.’
The Prophet Mohammad (S.A.W.) speaking about responsibility for children’s health in the Hadith, Bukhari Kitabul Ahkam, Hadith 6605

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