Disclaimer

This publication is made possible by the generous support of the American people through USAID. The contents are the responsibility of the CORE Group Polio Project (CGPP), The Communication Initiative, and USAID’s Maternal and Child Survival Program (MCSP) and do not necessarily reflect the views of USAID or the United States Government.

March 2019


Photographs: Rina Dey, CGPP India Archive, and Unicef India

CORE
303, BESTECH CHAMBERS
B- BLOCK, SUSHANT LOK-1
GURGAON, HARYANA, INDIA
Pin: 122 002
EVERY BOOK IS DIFFERENT
BUT THIS ONE IS UNIQUE

In the past decade, one very important development has saved thousands of lives while also demonstrating various strategies and innovations that were effective and successful.

Not every strategy or intervention gets documented with its detailed processes included. This publication tries to do so by describing every step of the communication interventions used in a highly evolved programme: the Polio Eradication Initiative.

Since 1999, our team has been enriched by learning behavioural practices from communities and translating them into positive action.

These experiences are presented in this book called ‘INFLUENCING CHANGE’.

Hope you will enjoy reading the chapters and gain from this rich and creative publication.

DR. ROMA SOLOMON
Director
CGPP, India
India is polio-free — a remarkable achievement. Eradicating polio is a victory for every citizen in this country.

India had traditionally been considered one of the toughest places in the world to eradicate polio but the last case was reported in West Bengal on 13 January 2011 and the Southeast Asia region was declared polio-free on 27th March 2014. This was achieved due to a true and strong partnership between communities, government, and partners. India overcame huge challenges to stop polio transmission by implementing innovative strategies, rigorous monitoring, and evaluation that ensured all children are reached and vaccinated.

CORE Group, as one of the communication partners, played a crucial role in reaching and mobilizing communities to accept polio vaccination in high-risk areas and underserved communities. It is achieved through the implementation of quality communication interventions.

This book unfolds processes followed during the implementation of key communication interventions by the CORE Group. It is an overwhelming experience for a development worker to have the opportunity to read the steps followed in the implementation of communication activities.

I hope the readers will enjoy this publication and gain an insight into the details of very successful public health programs.

Happy reading!

Dr. Pradeep Haldar
Deputy Commissioner, Immunization
Government of India
Inspiring Communities.
Defeating Disease.

The SMNet, a hallmark of the CGPP India programme, has far exceeded USAID’s expectations. It was established out of frustration. A seemingly unbreakable reservoir of polio virus was circulating in parts of northern India. Children were being paralysed, families were refusing vaccination, community suspicion about the motives of door-to-door teams was abundant. Too many children were being missed in the campaigns, and the reasons were fuzzy. We needed the trust of communities. We needed local women who could answer the questions of mothers and fathers afraid to vaccinate their children. We needed a conduit for sharing information and experience from the grassroots to the policy-makers and back.

USAID counted on a vibrant network of non-governmental organisations (NGOs), with deep roots in their community, to overcome resistance and rebuild confidence in polio eradication and immunisation in general. USAID encouraged partnership, problem solving, and innovation. With these guiding principles, the project figured out locally appropriate ways to build a ‘people’s movement’ that turned naysayers into polio champions. The bonds between communities, health workers, elected leaders, and national public health policies has never been stronger, after decades of mistrust. SMNet mobilisers have mastered inter-personal communication and not only interrupted polio transmission, but also boosted routine immunisation and vaccinations given at birth through their child-tracking efforts.

More mothers are seeking antenatal care, breastfeeding, and practicing good sanitation and hygiene practices because of the SMNet’s integrated approach to polio eradication. The project’s goal to engage youth will have a lifelong impact on the health practices of a generation. Millions of children have been protected against polio and other vaccine-preventable diseases because of the project. Many members of the SMNet have advanced their careers due to the skills and capacity they acquired while at the project and are now serving India in numerous ways. More children are walking, running and excelling due to the persistence and dedication of the SMNet’s creative and compassionate volunteers.

Ellyn W. Ogden, MPH
USAID Worldwide Polio Eradication Coordinator

September 2018
Affirmations.  
For Life

Against long odds, the India polio eradication effort achieved a polio-free India in 2011. The CGPP was a major contributor to this singular accomplishment, working with dedication, ingenuity, creativity, and perseverance to achieve the seemingly unachievable. They established an unprecedented coordination mechanism in the SMNet; they engaged community members as mobilisers, change agents, and active supporters; they turned opponents into allies; they learned from their success and mistakes to create a stronger programme; they developed a host of creative behaviour change education materials; and they documented it all through a strong monitoring and evaluation system.

This programme is a shining example of what NGOs, communities, UN agencies, and governments can accomplish when they work together toward a common goal. There is much to be learned from the achievements of the CGPP in India, and this book lays it all out in a well-organised format. I am very proud to be associated with such an amazing accomplishment.

Lee Losey  
Deputy Director  
CGPP
Empowered Women and Community

My visit to the CORE Group Polio Project in India, was one of my personal highlights of CORE Group’s 20th Anniversary year. It was particularly important for me to see the work of this longstanding program that led the way for India to achieve polio eradication and be declared “polio free” by the World Health Organization in 2014. The magnitude of the impact for India of the CORE Group Polio Project and the hard work of the CGPP team could be seen on many levels.

I foremost was impressed by the personal dedication of everyone involved in the project and the multiple stakeholders that worked together - from the government officials to community level ASHAs and social mobilizers. The resistance to the vaccine throughout the many years of the project, and the myths that continued to circulate via social media, were huge obstacles to overcome to ensure every child was reached. The India project team recounted stories of having to demonstrate to the community that the vaccine was safe and not a sterilization method, by taking the oral vaccine themselves- the 2 drops ultimately led to 100s of drops to prove the resistance wrong.

The communication strategies that were employed to promote social behavior change reached levels of creativity that were astounding- barber shop skits, mobile promotion messages, dioramas, and engagement of every level of the health service and community. It was also remarkable how the CGPP approaches empowered the women in the community- from the discussion groups amongst community girls and women, to the community health mobilizer who was so respected in the community. This empowerment broke barriers of class and religion, to create a “safe space” for women to discuss their health needs and the health of their children and families. This opened doors to an integrated approach to immunization, nutrition, water and sanitation and beyond.

Through hard work, political will, creative communication and community engagement, and a strong commitment to polio eradication- the CGPP India team achieved remarkable outcomes. Their model of collaboration should be replicated in other countries, to extend beyond polio eradication.

Lisa Hilmi
Executive Director
CORE Group, Washington DC
CONTENTS

ACRONYMS 10

ACKNOWLEDGEMENT 11

1 INTRODUCTION 13
   STRATEGIES FOR POLIO ERADICATION IN INDIA

2 PARTNERING WITH THE GOVERNMENT 25
   COLLABORATING TO END POLIO

3 BEHAVIOUR CHANGE COMMUNICATION STRATEGY 39
   INNOVATIVE MESSAGES AND INDIGENOUS TOOLS

4 EMPOWERING WOMEN 59
   AND BUILDING COMMUNITY OWNERSHIP
   COMMUNITY MOBILISATION COORDINATORS

5 ENGAGING INFLUENCERS 73
   BUILDING TRUST

6 MESSENGERS OF CHANGE 85
   INVOLVING CHILDREN IN
   POLIO AWARENESS

7 MAKING INROADS WITH 99
   MOBILE POPULATIONS

REFERENCES 108
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADRA</td>
<td>Adventist Development Relief Agency</td>
</tr>
<tr>
<td>AFP</td>
<td>Acute Flaccid Paralysis</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>BDO</td>
<td>Block Development Officer</td>
</tr>
<tr>
<td>BMC</td>
<td>Block Mobilisation Coordinator</td>
</tr>
<tr>
<td>BTF</td>
<td>Block Task Force</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
</tr>
<tr>
<td>CDC</td>
<td>Centres for Disease Control &amp; Prevention</td>
</tr>
<tr>
<td>CGPP</td>
<td>CORE Group Polio Project</td>
</tr>
<tr>
<td>CMC</td>
<td>Community Mobilisation Coordinator</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CORE</td>
<td>The Child Survival Collaborations and Resources Group</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
</tr>
<tr>
<td>CRS</td>
<td>Catholic Relief Services</td>
</tr>
<tr>
<td>DM</td>
<td>District Magistrate</td>
</tr>
<tr>
<td>DMC</td>
<td>District Mobilisation Coordinator</td>
</tr>
<tr>
<td>DTF</td>
<td>District Task Force</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>GoI</td>
<td>Government of India</td>
</tr>
<tr>
<td>GPEI</td>
<td>Global Polio Eradication Initiative</td>
</tr>
<tr>
<td>HRA</td>
<td>High-Risk Area</td>
</tr>
<tr>
<td>HRG</td>
<td>High-Risk Group</td>
</tr>
<tr>
<td>IEAG</td>
<td>India Expert Advisory Group</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IPC</td>
<td>Interpersonal Communication</td>
</tr>
<tr>
<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
</tr>
<tr>
<td>IPV</td>
<td>Inactivated Polio Vaccine</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information Systems</td>
</tr>
<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NIDs</td>
<td>National Immunisation Days</td>
</tr>
<tr>
<td>NPSP</td>
<td>National Polio Surveillance Project</td>
</tr>
<tr>
<td>OPV</td>
<td>Oral Polio Vaccine</td>
</tr>
<tr>
<td>ORS/T</td>
<td>Oral Rehydration Solution/Therapy</td>
</tr>
<tr>
<td>PCI</td>
<td>Project Concern International</td>
</tr>
<tr>
<td>PEI</td>
<td>Polio Eradication Initiative</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
</tr>
<tr>
<td>PPI</td>
<td>Pulse Polio Immunisation</td>
</tr>
<tr>
<td>PRI</td>
<td>Panchayati Raj Institution</td>
</tr>
<tr>
<td>PVO</td>
<td>Private Voluntary Organisation</td>
</tr>
<tr>
<td>RI</td>
<td>Routine Immunisation</td>
</tr>
<tr>
<td>SEARO</td>
<td>South East Asia Regional Office of WHO</td>
</tr>
<tr>
<td>SIA</td>
<td>Supplementary Immunisation Activities</td>
</tr>
<tr>
<td>SRC</td>
<td>Sub-Regional Coordinator</td>
</tr>
<tr>
<td>SMNet</td>
<td>Social Mobilisation Network</td>
</tr>
<tr>
<td>SMO</td>
<td>Surveillance Medical Officer</td>
</tr>
<tr>
<td>SNIDs</td>
<td>Sub-National Immunisation Days</td>
</tr>
<tr>
<td>TTF</td>
<td>Tehsil Task Force</td>
</tr>
<tr>
<td>UIP</td>
<td>Universal Immunisation Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>U.P.</td>
<td>Uttar Pradesh</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WPV</td>
<td>Wild Polio Virus</td>
</tr>
</tbody>
</table>
Acknowledgement

The publication you are reading on screen or holding in your hands is a collaborative effort of The Communication Initiative and CGPP. It is the result of a lot of time, work, research, and dedication of many individuals. We would like to thank Ellyn Ogden, Frank Conlon, Lee Losey, Dr. Roma Solomon, and Warren Feek for their support and guidance. We would also like to thank Chris Morry and Rina Dey for initiating, managing, and reviewing multiple drafts of this document along with Manoj Choudhary and Jitendra Awale, who provided constructive and positive comments from time to time.

We would like to thank USAID for its financial support while acknowledging that the content of this publication does not reflect the views of USAID or the United States Government. A very special thanks to the programme team at MCSP who supported this initiative from the beginning and to their Global Engagement and Communications Office, who helped with the final edit. We also express our special thanks to all CORE India consortium partners and field staff of CRS, ADRA, and PCI, who directly or indirectly provided significant and essential support to complete this assignment. Our heartfelt thanks to all the children, religious leaders, influencers, and community members who gave us time and shared their insights of the programme.

Thanks to Anja V enth for providing extensive and always helpful comments, edits, and advice, and Sanjog Sharan, who designed this creative publication. This acknowledgement section would be incomplete if we didn’t save the last thank you for Vaishali Sharma Mahendra, who was the glue that held everything together — dedicating herself full time to researching, compiling, writing, editing, and assembling all the drafts.
This publication seeks to document the key strategies used by CGPP that contributed to eradicating polio in India. These involved strong partnerships with government structures and local and international non-governmental organisations (NGOs), as well as a variety of innovative communication activities with a particular focus on social mobilisation.
The World Health Organization (WHO) declared India polio-free on March 27, 2014. The country’s polio eradication programme now serves as a model for health programmes globally. CGPP played a key role in partnering with the Indian government and other agencies to achieve this goal. Lessons and tools that CGPP developed in India are now being used to support programmes in Africa and the remaining three polio-endemic countries: Pakistan, Afghanistan, and Nigeria. This publication seeks to document the key strategies used by CGPP that contributed to eradicating polio in India. These involved strong partnerships with government structures and local and international non-governmental organisations (NGOs), as well as a variety of innovative social and behaviour change communication activities, with a particular focus on social mobilisation.

Global Polio Eradication - Overview
The Global Polio Eradication Initiative (GPEI) was launched in 1988 to eradicate the Wild Polio Virus (WPV) that was endemic in 125 countries and had affected an estimated 350,000 children the same year the GPEI was launched (WHO, 2007). The availability and effective use of the Oral Polio Vaccine (OPV) and injectable Inactivated Polio Vaccine (IPV) made eradication of polio a possibility.

Polio or poliomyelitis is a crippling and potentially deadly infectious disease. It is caused by an entero virus that is transmitted from person to person via the faecal-oral route and can invade an infected person’s brain and spinal cord, causing paralysis.

The majority of cases occur in children.

---


2 Wild Polio Virus (WPV) is the naturally occurring causative agent of poliomyelitis and is present in three forms – WPV1, WPV2, WPV3. The last recorded case of type 2 was eradicated in 1999 and of type 3 in 2012.

3 The WHO defines polio eradication as “zero incidence of WPV transmission anywhere in the world”.

---
The four main strategies that formed the pillars of polio eradication were (GPEI, 2017):

1. **High Routine Immunisation (RI) Coverage:**
   Children receive all recommended childhood immunisations, including 4 doses of OPV in the first year of life in endemic countries.

2. **Supplementary Immunisation Activities (SIA):**
   National Immunisation Days (NIDs) conducted countrywide 2-3 times a year, and several Sub-national Immunisation Days (SNIDs) to cover every child under the age of 5 with OPV annually.

3. **Acute Flaccid Paralysis (AFP) surveillance:**
   Active surveillance for WPV through reporting and laboratory testing of all cases of AFP.

4. **Mop-up:**
   Targeted "mop-up" campaigns once WPV transmission is limited to a specific area.

Since the launch of GPEI, large-scale vaccination programmes resulted in over 2 billion children being immunised and caused a steep drop (By 99 percent) in WPV cases, from 350,000 in 1988 to 10 in 2017 (Source: GPEI website).

---

4 Additional doses of OPV are administered to each child aged < 5 years, regardless of their vaccination history, through mass campaigns. High frequency of campaigns is designed to immunise a high percentage of the population who need to have herd immunity to interrupt transmission.
Polio Eradication in India

During the 1970s and 1980s, India was one of the worst among the developing countries, affected by polio, with an estimated 200,000 to 400,000 cases annually (John, 1984). While vaccination against polio was first included in the Government of India’s (GoI) Expanded Programme on Immunisation (EPI) in 1978, the number of polio cases did not fall for about 10 years (MoHFW, 2001). It was only after the launch of the Universal Immunisation Programme (UIP) in 1985 that the immunisation coverage reached 95 percent. This resulted in a decline in polio cases from 28,757 during 1987 to 3,265 in 1995 (Ahuja, 2015).

To increase the immunisation coverage to 100 percent, the mass Pulse Polio Immunisation (PPI) campaign was launched in 1995 (GoI, 2001). When WPV transmission could still not be interrupted in the northern states of Uttar Pradesh (U.P.) and Bihar, immunisation efforts were intensified in 1999 by adding a house-to-house vaccination component, which followed an initial day of fixed site activity. However, India suffered a large polio outbreak in U.P. in 2002, and again from 2006-2009 (John & Vashishtha, 2013) (see Figure 2 below). It was only through an approach that emphasised working in partnership, as well as the development of an effective social mobilisation strategy, that India reported its last case of polio in 2011 and was subsequently removed from the polio-endemic country list on February 25, 2012 (CDC, 2012).

CGPP Partnering in Polio Eradication

The Indian government partnered with the government of Denmark and the US through CDC and USAID to establish the National Polio Surveillance Project (NPSP) to manage polio case detection and reporting. USAID contributed funds to WHO, the United Nations Children’s Fund (UNICEF), and the Rotary Foundation for surveillance and awareness-raising activities in India. In 1999, the USAID-funded CGPP joined the national polio efforts.

CGPP is a multi-country, multi-partner initiative providing financial support and on-the-ground technical guidance and support to strengthen host country efforts to improve the health and well-being of children and women. A US secretariat serves as a global partnership liaison and provides overall technical assistance and financial management in each country. Recognised for their expertise in working with extremely underserved, high-risk, and vulnerable communities, CORE group member organisations received funding from USAID and later from the Bill & Melinda Gates Foundation, also for CGPP in India. Their focus in India was to reduce the burden of polio and resistance among

---

5 The pulse vaccination strategy is a method used to eradicate an epidemic by repeatedly vaccinating a group at risk, over a defined age range, until the spread of the pathogen has been stopped. The high frequency of campaigns is intended to ensure that an extremely high percent of the population is immunised and thus have immunity to interrupt transmission.
communities by mobilising them to participate in PPI campaigns and RI.

The CGPP India secretariat is located in Gurgaon, Haryana and consists of a team of consultant advisors who provide technical guidance on the implementation of social mobilisation interventions. Implementation of the programme is done through a consortium of three Private Voluntary Organisations (PVOs) - Project Concern International (PCI), Adventist Development and Relief Agency (ADRA) India, and Catholic Relief Services (CRS) and their local grassroots NGO partners.

**Key Strategies of the Government of India’s PPI Campaign**

Stopping polio transmission was pursued through a combination of routine supplementary immunisation campaigns, community mobilisation, and surveillance of possible outbreaks. India was successful in reaching all children below 5 years of age using the following strategies:

1. **Polio booth strategy**: This one-day event was launched in 1995 to immunise all children below 5 years of age at fixed sites on fixed days. The booth had 2 vaccinators and a volunteer from the community, who was tasked with mobilising the community to attend.

2. **House-to-house strategy**: Launched in 1999, this strategy involved visiting each house by a polio vaccination team to immunise

---

6 A temporary kiosk or fixed site at or near clinics, markets, schools, and places of worship.

7 Usually held on Sundays, these immunisation days began to be better known as Polio Sundays.
OBJECTIVES OF CGPP

1. BUILD EFFECTIVE PARTNERSHIPS WITH PVOS, NGOS, AND INTERNATIONAL, NATIONAL AND REGIONAL AGENCIES INVOLVED IN POLIO ERADICATION.

2. SUPPORT PVOS/NGOs EFFORTS TO STRENGTHEN NATIONAL AND REGIONAL IMMUNISATION SYSTEMS TO ACHIEVE POLIO ERADICATION.

3. SUPPORT PVOS/NGOs INVOLVEMENT IN NATIONAL AND REGIONAL PLANNING AND IMPLEMENTATION OF SUPPLEMENTAL POLIO IMMUNISATION.

4. SUPPORT PVOS/NGOs EFFORTS TO STRENGTHEN ACUTE FLACCID PARALYSIS CASE DETECTION AND REPORTING AND DETECTION OF OTHER INFECTIOUS DISEASES.

5. SUPPORT TIMELY DOCUMENTATION AND USE OF INFORMATION TO CONTINUOUSLY IMPROVE THE QUALITY OF POLIO ERADICATION (AND OTHER HEALTH-RELATED ACTIVITIES).

6. SUPPORT PVOS/NGOs PARTICIPATION IN NATIONAL AND/OR REGIONAL POLIO ERADICATION CERTIFICATION ACTIVITIES.
unvaccinated children. Houses where children were immunised were marked “P”, and where children were missed (due to family resistance, child being sick, family not at home, or house being locked) with an “X”.

3. Identifying underserved and High-Risk Groups:
In its final stages, the polio programme placed added emphasis on reaching population groups at high risk for virus transmission.

The underserved strategy was launched in U.P. in 2003 to reach the marginalised sections of society, especially those living in poor Muslim communities. These communities lacked access to basic sanitary and healthcare services, and were often missed in OPV rounds, thus being most affected by polio8 (UNICEF, 2013). The strategy was later (in 2007) expanded to include hard-to-reach and migratory communities who had limited access to information or health services. These included groups like nomads, brick kiln and construction workers, slum dwellers, and seasonal labourers (Siddique et al., 2016; IPLE, 2017).

4. Transit teams: Vaccinators were deployed during the campaign in all railway stations, bus terminals, important crossings, highway checkpoints, toll booths on highways, important river bridges, ferry crossings, and airports to immunise the underserved mobile communities that were passing through these sites.

5. The 107 Block Plan was drawn up by the GoI in 2009 to address the last reservoirs of polio in the 107 highest-risk blocks in U.P. and Bihar. In these blocks, the programme tried to address the underlying causes of polio transmission by focussing on improving RI, lowering diarrhoeal rates, improving sanitation practices, and increasing rates of breastfeeding (IPLE, 2017).

Social Mobilisation – Context and Challenges
In 1999, the PPI programme was met with huge

---

8 In 2003, there was a disproportionately high percentage of polio cases among the Muslim community in U.P.- while accounting for 17% of the state’s population, the community constituted nearly 59% of polio cases.
resistance from communities. It not only introduced a house-to-house strategy but also a more intensive/repetitive vaccination campaign that required children to be immunised every month\(^9\) rather than only a few times per year. In the absence of any explanation about the need for these changes, families questioned the government’s motives and efficacy of the vaccine. In some instances, as the vaccinators were under pressure to achieve their targets, they forcibly vaccinated children (Chaturvedi, 2008). This exacerbated the situation, and parents who had earlier voluntarily brought their children to the booths for OPV started shutting their doors on the vaccinators. In many communities, vaccinators were chased away with sticks and stones, and in some cases boiling water was thrown on them. In some areas, the entire village boycotted polio immunisation and prevented vehicles carrying the vaccinators from entering villages (AIIMS, 2001). Where vaccinator teams were able to make headway into the village, parents would hide their children from them. Some parents hid their children on the rooftop, under the bed, under the carpet, and in other hiding places. Sending their children away to a relative’s home in another village or town to escape the polio campaign in their village was also a common tactic employed by some parents\(^{10}\).

The resistance to the polio vaccination was much higher among the Muslim population in U.P., who also accounted for more polio cases than other population groups (UNICEF, 2013). The reason for this disparity has been attributed by some researchers to the status of Indian Muslims as a sociological minority and associated structural

---

9 G0I recommended 8-10 doses of OPV for each child rather than the globally accepted 3 doses because the population density, low RI coverage, and the prevalence of diarrhoea cut the vaccine’s efficacy in half in India. Also, open defaecation and a lack of water treatment made it easier for a child to contract the polio virus (Source: Wikipedia: https://en.wikipedia.org/wiki/Pulse_Polio).

10 Personal experience shared by Dr. Roma Solomon (Director, CGPP India).
and environmental factors that made them more susceptible to the spread of polio (Hussain et al., 2015). The majority of poor Muslims lived in segregated areas that generally lacked infrastructure, had poor sanitary conditions, and had limited access to basic health facilities. Owing to the lack of basic services, these areas were seen as disease-spreading environments (due to the oral-faecal transmission of the virus) and documented higher infection rates in slums, particularly North Indian Muslim slums (Patriarca et al., 1991, Grassly et al., 2006, and Chaturvedi 2008). Many of the children visited by the teams on the polio rounds in these areas were found to be constantly sick, resulting in the families refusing vaccination for their already-weakened children. Also, families resisted the vaccine, as they were frustrated and angry with the government for compelling them to vaccinate their children against polio while general health and sanitation services were neglected. Some families resisted due to fatigue from the repeat doses of vaccination (Hussain et al., 2012).

In addition to these concerns, social resistance was linked to distrust of the government due to fears of sterilisation influenced by the Family Planning Programme of 1976-1977. Some members of the Muslim community believed they were specifically targeted for sterilisation during the Family Planning Programme, and they associated the state’s drive against polio as a means to once again control the fertility of the Muslims (Hussain et al., 2015). Soon, rumours started to circulate that OPV was designed to make their children impotent and infertile (MoHFW, 2000).

In some Muslim majority areas, Fatwas (Islamic religious decrees/orders) were issued by Islamic leaders declaring the vaccine as Haraam (against the tenets of Islam) because of ingredients used in the vaccine that caused more families to shun immunisation (Solomon, 2017). Polio immunisation numbers started to drop, and the number of children contracting polio in U.P. started to rise.

The programme recognised that there was an urgent need to introduce a social mobilisation component to the programme that would be designed to reduce family and community resistance. It also needed to respond to the fact that the plan to reach underserved and high-risk groups so that 100% coverage would be reached had not previously been achieved through other means.

To combine their efforts for a more coordinated and effective outreach, UNICEF, CGPP, and Rotary International started working together as the SMNet in 2003. USAID provided funding to all 3 organisations to help improve collaboration, foster partnerships, and play to the strengths of each organisation that each brought an important key to success. The organisation worked to improve the quality of the polio eradication programme and strengthen existing RI efforts by

---

11 The Government at the time launched the “Family Planning” programme, which promoted sterilisation as a means of population control. Muslim groups felt particularly targeted due to some incidents where young and old Muslim men were forced to opt for it. Though the policy was not supposed to be discriminatory based on religion, such incidents resulted in perceived discrimination and ensuing distrust in government supported/aided programmes (Gwatkin, 1978; Jeffery et al., 2008).
supporting behaviour change communication, which included: social mobilisation and the development of communication materials; capacity building of field staff; and establishing monitoring and reporting systems.

The social mobilisation strategy had two objectives: Firstly, to engage and convince communities, especially mothers/caregivers, about the benefits of vaccinating their children repeatedly for polio; and secondly, to ensure that families were motivated to vaccinate their children for other life-threatening diseases. Channels like interpersonal communication with mothers/caretakers and group meetings with religious and community leaders and other influential people were key to establishing proactive community dialogues about vaccination and dealing with resistant families. Over the years, the SMNet evolved, and the communication package and interventions were also revised to sustain community participation.

CGPP’s Lessons and Tools
Although the SMNet tried and adopted many innovative strategies for community mobilisation, the CGPP team identified six as the most effective in reaching the population, especially in hard-to-reach areas. These selected strategies responded to the needs and constraints of the programme with immediate solutions and made significant contributions to the overall goal of polio eradication. In this document, CGPP shares its experiences, challenges, and lessons learned by describing the process of each of these strategies as a guide for those who may want to design similar strategies for social mobilisation in other sites and settings. Each chapter describes the rationale, design, implementation, and achievements of the strategy and concludes with a statement from a CGPP team member reflecting on key lessons.

The chapters are:

**Partnering with the Government**
Collaborating to End Polio
This chapter details the design and implementation of the strategy adopted by CGPP to forge partnerships and strengthen collaboration with the Government. This partnership created an enabling environment to ensure people’s participation in and ownership of the polio immunisation programme.

**Behaviour Change Communication Strategy**
Innovative Messages and Indigenous Tools
In this chapter, a description is provided of CGPP’s individual- and community-level behaviour change approaches using creative and innovative communication activities and materials that reduced resistance and promoted vaccination awareness and safety.

**Community Mobilisation Coordinators**
Empowering Women as Agents of Change
This chapter documents the process of how cadres of community mobilisers contributed to reducing community resistance to vaccination by visiting households, promoting government-run immunisation services, tracking missed children, and mobilising local opinion leaders to break community resistance and promote vaccination.

**Engaging Influencers**
Building Trust
A strong network of community, cultural, and religious leaders were involved to act as a credible communication channel to help gain community support by responding effectively to fears and misconceptions. The description of how this network was developed and its role in supporting the efforts of the CGPP team are documented in this chapter.

**Messengers of Change**
Involving Children in Polio Awareness
One of the most innovative activities that the programme conducted in the community focused on harnessing the power of children as motivators. This chapter describes the process and achievements of involving children in the polio campaign.

**Making Inroads with Mobile Populations**
In this chapter, the process of designing strategic interventions for identifying and including transit areas and migrant communities is described.
2.

PARTNERING WITH THE GOVERNMENT COLLABORATING TO END POLIO

To ensure high immunisation coverage and to address the misconceptions and resistance that flared up in 2002 with the introduction of house-to-house visits and more intensive immunisation campaigns, the Government of India (GoI) needed to regain people’s trust by promoting people’s participation in and ownership of the polio immunisation programme. As this required that the government work more closely with communities, they looked towards partnerships with NGOs to undertake rigorous social mobilisation at the community level.

Designing the Intervention
CGPP was one of the larger NGO partners and, as an organisation that was recognised for its work with extremely under-served, high-risk, and vulnerable communities, it was mandated to accelerate polio eradication efforts by supporting social mobilisation and addressing resistance and misconceptions. After consultations with the Ministry of Health and Family Welfare (MoHFW), the WHO, and USAID, CGPP developed a “bundled” proposal that involved working with a range of participating partners at the community and household level. The basis of the project was partnership, where various civil society organisations came together for a common purpose, that of polio eradication (Dyalchand, 2015).

Implementation of Intervention Activities
Research to Understand Community Needs and Concerns
In the early days of the polio programme, the maximum opposition to its implementation was in the state of U.P., which was also home to the majority of polio cases in the country (WHO, 2010). CGPP worked at the community and household level to better understand the concerns and needs of the people. Later, a continuous research process was initiated, the results of which were used to tailor the programme to community needs. Research included household surveys; discussions and interviews with community members; feedback from knowledgeable informants such as local NGOs, health offi-
cials, and community leaders; findings from government reports and academic research studies; and information from the India Expert Advisory Group (IEAG)¹ for polio eradication. CGPP’s main focus was to understand the people and the circumstances under which they lived. They also undertook systematic enumeration and tracking of children under 5 years old in high-risk areas (utilising MoHFW lists and forms) to discover the reasons why children were not being vaccinated.

**Setting up the Social Mobilisation Network (SMNet)**

UNICEF, which was mandated to coordinate Pulse Polio activities with the government, was working in the same districts as CGPP, which resulted in duplication of efforts and confusion about roles and responsibilities. In order to minimise overlap and capitalise on their strengths and capacities, CGPP and UNICEF, along with Rotary International, collaborated to establish a multi-agency Social Mobilisation Network known as SMNet.

---

¹ The India Expert Advisory Group (IEAG) was constituted in 1999 by GOI to review progress and guide ongoing and future activities. The private sector, including representatives from civil society organisations, academic bodies, and independent polio experts, were included in this technical group.
that comprised a cadre of mobilisers who reached out to resistant or left out families to ensure polio immunisation. They jointly approached the U.P government with the proposal of forming SMNet in August 2003. Mobilisers of both agencies were given the same nomenclature and key responsibilities and were supervised at block, district, and regional levels. SMNet partners collaborated with each other and coordinated with local government officials to support polio eradication activities and reduce duplication and overlap (Coates et al., 2013).

Structure of the SMNet

The Network consisted of 4 tiers at the community, block, district, and state level. In each tier, mobilisers were deployed who were trained in communication skills, armed with materials, and supported by a mentor. At the first tier, Community Mobilisation Coordinators (CMCs) interact with families and community members at the village level to provide correct knowledge about polio by addressing myths and misconceptions, with the ultimate goal to mobilise families to immunise their children. They belong to the communities they serve. At the second tier, Block Mobilisation Coordinators (BMCs) were responsible for social mobilisation activities at the block level and for providing mentorship and supportive supervision to CMCs. At the third tier, District Mobilisation Coordinators (DMCs) were responsible for supervising the BMCs and for conducting mobilisation activities and forming partnerships at the district level. The District Underserved Coordinator was responsible for focussing on underserved communities and for providing mentoring support to BMCs and CMCs. The District Management and Information Systems (MIS) Coordinator monitored and managed the programme data. A Sub-regional Coordinator provided regional leadership and is appointed by each of the partner PVOs (ADRA, CRS, PCI) (Weiss et al., 2013b; Siddique et al., 2016).

Liaising with Government Agencies at National, State, District, Block and Community Levels

As political ownership was a key determinant of the success of polio eradication efforts, the government formed core groups and task forces at every administrative level. All the meetings, with government agencies were called Partners Meetings, and CGFP was invited to participate in all these meetings. The purpose of these meetings was to sort out operational issues in the field, if any, and to update everybody about them. Throughout this process, the CGFP Secretariat liaised with health officials at the various administrative levels, and with government vaccination teams.

National Level

Under the leadership of the MoHFW, the CGFP was set up to share experiences and address challenges faced by the partners in the field. In addition, planning and discussing how to share and delineate responsibilities for upcoming polio campaigns was an important aspect of these meetings. In these meetings, the key participants were WHO, UNICEF, donors such as USAID and Rotary, and civil society organisations (CSOs). Initially, the CGFP met every week, and helped polio partners come together and work proactively to respond to programme needs in a timely manner.

CGFP was also invited by the MoHFW to all monitoring and evaluation processes relating to the Polio Eradication Initiative (PEI) and the Expanded Programme on Immunisation (EPI). Along with the MoHFW, the National Polio Surveillance Project (NPSP) and the polio partners, eradication efforts were intensified with careful monitoring

---

2 Block is a district sub-division for the purpose of rural development.

3 States and territories (or divisions) are subdivided into districts. Each district is headed by a District Magistrate.

4 DMCs, BMCs are PVO staff, while the CMC is paid an honorarium by the PVO partner.

5 National Polio Surveillance Project (NPSP) - a collaboration of WHO and the GoI - was established to conduct AFP surveillance until global certification. It was engaged in Supplementary Immunisation Activities (SIAs) for planning and monitoring of the campaign.
and implementation of immunisation and surveillance activities. Surveillance data were used to systematically map and identify pockets of underserved and high-risk areas (HRAs) to determine areas for the SMNet operation. The criteria for HRAs were refined periodically as per the need. Once an area was identified as an HRA, mobilisers would be designated to work in that community/area (Weiss et al., 2013a).

CGPP was also invited to participate in IEAG meetings. During these meetings, the polio partners would provide updates about the current status and strategy, and recommend strategy changes, if needed. At the same time, a national level Social Mobilisation Working Group was set up by UNICEF to strategise around communication issues that were emerging from the field and from the data shared by WHO. This Working Group met every month, though meetings were gradually reduced as the need became less. CGPP was also a member of the Routine Immunization Working Group (consisting of MoHFW, UNICEF, WHO, and other international and national NGOs).

State Level

The states were proactive in taking ownership of the polio eradication programme, with chief ministers of key endemic states taking charge of the programme in their own states. The cabinet secretaries were instructed to directly coordinate and review the programme implementation through monthly video conferencing with district authorities (Thacker, 2016).

CGPP was a key member of the Polio Partners Meetings, which included representatives from the state government, usually the State Immunisation Officer or the Manager-Routine Immunisation. In addition, there were partners from USAID, WHO-

---

6 HRA criteria were based on the following information: number of wild polio virus (P1) cases during low-transmission seasons (since 2003); number of AFP cases in last 2 years; if the area was a Muslim-majority slum (see chapter 1 for details); presence of High-Risk Groups (HRGs) like slum dwellers and nomads; and the percent of households that had unvaccinated children (X houses).
NPSP, UNICEF, Rotary International, World Bank, and other stakeholders. Partners meetings were initially held every month, though as time went on, these meetings were convened bi-annually.

**District/Tehsil/Block Levels**

During the campaign, District Task Force (DTF) Meetings, Tehsil Task Force (TTF) Meetings, Block Task Force (BTF) Meetings, and evening feedback meetings were held on a regular basis. At the district level, the District Magistrate (DM) and Chief Medical Officer (CMO) were accountable for the quality of polio eradication efforts in their respective districts. The DTF was chaired by the DM. Critical members included the CMO or District Immunisation Officer, Sub-divisional Commissioners, the District Panchayati Raj Officer, the Chief Development Project Officer (official representing the Integrated Child Development Scheme (ICDS)), community/religious leaders, an urban area planner, an education officer, and a district transport officer. Attendees also included members from CGPP, UNICEF, WHO-NPSP, and Rotary International.

These meetings involved all partners and focused on the larger picture in terms of coverage and gaps. During these meetings, programme progress was discussed, preparations were made for the next campaign, and the roles and responsibilities of each partner were delineated to ensure the programme runs smoothly. In addition, vaccination coverage and gaps (both administrative and operational) were reviewed, and strategies for the next round, to avoid identified problems, were planned. See Figure 3 for activities undertaken in these meet-

---

**Figure 3**

**Percent activities undertaken in District Task Force Meetings in 2010**

Source – CGPP, 2011

---

7 The administrative divisions of India are composed of a hierarchy of sub-divisions – States & Union Territories are subdivided into Districts (zillas), which are further sub-divided into Tehsils/Taluks and then Blocks. Villages are the lowest level of sub-division, and the government bodies are referred to as Gram Panchayats.

8 The District Magistrate (DM) is the highest government representative in a district.

9 Integrated Child Development Scheme (ICDS) is a programme of the Ministry of Women and Child Development that provides food, preschool education, and primary healthcare to children under 6 years of age, as well as health care for their mothers.
ings. The SMNet would also make a presentation in this meeting to seek support needed in the upcoming rounds from departments other than health, such as education and transport, representatives from which were also present. For example, problems such as vaccines not reaching communities on time and religious resistance in the community were discussed in order to find ways to address them with the help and support of the various partners present in this meeting. Also, the DM’s support was needed to enlist other agencies to provide essential services demanded by the communities, such as water supply or electricity connections.

Partners also discussed the support provided by them to the programme and how that helped in solving problems. At the Block level, the Block Medical Officer (BMO) chaired the meetings. If there were any problems or gaps that could not be addressed at the Block level, they were documented and shared with the DTF in order to receive the required support and action.

Evening ‘feedback meetings’ were organised during polio campaigns at the office of the CMO to review the coverage, gaps, and problems faced during the day. These meetings were attended by representatives of WHO, UNICEF, Rotary International, and CGPP. They also discussed and planned the schedule for the next day’s activities.

**Community Level**

CGPP’s support to the programme ranged from micro-planning to community mapping, the provision of information, education, and communication (IEC) materials, community mobilisation, logistics, and monitoring. CGPP partner PVOs (ADRA, CRS, and PCI) identified the CMCs, who are volunteers from the hard-to-reach and resistant communities. It trained them in interpersonal communication (IPC), and on how to develop social maps and tackle the most ‘difficult’ areas — both in urban slums and villages (more detail to follow in Chapter 4).

At the community level, CGPP networked with various government functionaries representing different ministries and departments to seek their support for day-to-day activities. Some of these included the Angan Wadi Workers (AWW) from ICDS, principals and teachers from schools, Pradhan/Ward members from Panchayati Raj Institutions (PRIs)\(^\text{10}\), and Auxiliary Nurse Midwives (ANMs) from the health department.

Village-level meetings, also called interface meetings, were held regularly. These meetings involved many partners like the ANM, teachers, Pradhan/Ward members from PRIs, AWW and representatives of WHO-NPSP, UNICEF, Rotary International, and the BMcs/CMcs of CGPP. In addition to these, ration dealers, brick kiln owners, religious leaders, and other community-based influencers were also invited.

**Integrating Activities with the Local Health System**

CMCs and BMcs extended the reach of government health facilities by aligning their social mobilisation activities to promote polio immunisation and routine immunisation (RI). This alignment included timing, content, and materials. They coordinated their work with local ANMs and the new cadre of Accredited Social Health Activists (ASHAs) and enhanced the training by adding new skills. For example, when ANMs trained the ASHAs to give immunisations, CGPP staff led sessions on IPC.

CGPP provided assistance for cold chain logistics for RI and gave feedback on ways to improve the quality of supplementary immunisation activities (SIAs). MoHFW and CGPP merged their lists of missed children and shared tracking forms. CMCs assisted the vaccination teams by monitoring coverage during SIAs and following up with RI defaulters. They also referred caregivers to local health posts for other life-saving child health interventions and reinforced health workers’ messages about hand washing, sanitation, and oral rehydration therapy.

\(^{10}\) Panchayati Raj Institutions (PRIs) are tiers (3 level) of self-governance below the state level.
Achievements/Impact

- Participation and collaboration between various ministries such as Health, Women and Child Development, Human Resources, Education, and Railways & Transport, as well as international and national organisations, was a big achievement of this partnership, and helped transform the polio programme into a people’s programme. By building community trust in the government programme, the NGO partners were able to ensure that household doors were opened for the campaign every 6 weeks. This also made the government feel good about their success. The GoI started viewing NGOs as equal partners who had something valuable to contribute, rather than as agencies working at cross-purposes with them.

- Teams of CMCs cooperated with the government vaccination teams and, subsequently, uptake of polio, and RI increased significantly. Over the years of this partnership, the polio cases started to drop consistently.

- The various meetings with government agencies were an effective feedback and sharing mechanism. They led to better relationships, as many operational problems could be solved by working together. CGPP’s participation in these meetings helped improve networking and coordination with all partners, which led to support for improving service delivery to the community. For example, to address the concerns of the community about lack of health services other than polio immunisation, CGPP and other agencies were able to convince the government to hold general health check-up camps (such as antenatal care, eye care, RI, etc.) in resistant areas prior to the polio round. The Block Medical Officers (BMOs) were requested to send staff, drugs, and vaccines for the camp, and the CMCs organised the venue, provided transport to medical personnel, and sometimes even arranged for a female doctor to be contracted for a day so that antenatal or other gynaecological cases could be seen. Following the delivery of services to the community, trust was built between the community and CMCs that led to greater acceptance of polio vaccines.

- The gaps, which were reported during the various meetings, were addressed immediately, especially when they were backed by data and reports from CGPP field staff.

- Another key achievement and a key to the success of this effort was the coordination between partners, which led to more effective use of human resources, as well as coordination around the development of communication materials to ensure that messaging was consistent.
Reflecting on the Partnership

The Director of CGPP India, Dr. Roma Solomon, mentioned that partnership was possible because “the virus brought us all together with one single purpose – to work together to protect our children from it. We were forced to look at the disease from a human angle…and from the parents’ point of view”.

Talking about establishing and maintaining a good relationship with the GoI, she said it was important to “not refuse the government anything they asked for…and we never questioned their leadership.” This ensured that the working relationship was one of respect and trust. At the same time, it was very important that a secretariat that was coordinating the efforts of international NGOs, central and state government officials, and multinational organizations have a distinct legal status and identity.

She also felt that “not being prepared was transformed into a strength as otherwise we would have gone into this with pre-conceived notions”, which may have led to the team not being open to modifying and re-designing the programme and interventions.

Dr. Solomon felt very strongly that “unless we involve people for whom this programme is intended, it will not work. It is a people’s programme.” She stated that CGPP was able to help achieve this, as it acted as the “bridge between the government and civil society.”
कुकडू कँौं रैली
हम गाँव जनों ने ठाना है,
सभी को पक्के शौचालयों में शौच जाना है।
सोसाइटी फॉर आल राउंड डेवलपमैन्ट (सार्थ) मेरठ।
FOR OUR CHILDREN
Until 1998, the thrust of the polio eradication programme was on encouraging parents to bring their children to fixed booths/sites for vaccination. The communication strategy focused on using mass media to promote awareness of dates when the vaccination booths would be functional. When house-to-house visits were introduced, the focus of the communication campaign was intended to inform families about polio transmission and prevention and the need to give their child the oral polio drops. For this, there was widespread distribution of information materials and outreach activities just before and during the campaign. As per CGPP’s BCC Advisor, Rina Dey, “this prescriptive one-way messaging, which focused only on changing one behaviour without addressing other health needs, resulted in families questioning and doubting the intent of the vaccination efforts and soon transformed into resistance to the vaccine and vaccinators”. Thus, mobilising the community was very essential for winning their trust in order to break the resistance to the polio vaccine that had become a barrier in achieving polio eradication.

In order to do so, the programme had to understand the communities’ needs and concerns and develop messages and materials that were not only technically sound, but also respected their attitudes and beliefs.

**Designing the Intervention**

With increasing resistance to polio vaccination, CGPP and their partners met to share the experiences that their mobilisers faced in the community. These data from the field helped improve understanding of social and cultural beliefs and concerns of the communities and brought greater focus and efficiency to planning communication activities. In order to communicate to families that the only way to eradicate polio was to immunise all children under the age of 5 every time there is a polio round, CGPP started innovating and expanding its BCC strategy. With improved data collection and behaviour analysis, they carefully segmented their audiences, designed and developed messages and materials, and used a mix of methods to achieve their defined objectives that...
sought to promote immunisation and bring about behaviour change related to polio and convergent health issues. Key elements of CGPP’s BCC strategy were (Dyalchand, 2015):

1. Sharing information with individuals and families to enable an informed choice;
2. Motivating households and small groups;
3. Identifying and involving influencers and communication networks to generate social pressure and motivate resistant families to vaccinate their children; and
4. Involving community groups through participatory strategies (social mobilisation).

Over the years, the BCC strategy saw modifications and refinements to address the needs of the community. The following section will discuss some of these changes and how they were implemented.

Identifying the Audience
Based on research findings and behaviour change objectives, the audiences for the communication efforts were segmented into:

Primary audience – This segment included the mothers, fathers, and other caretakers of children below 5 years of age.

Secondary audience – These included influential people in primary audiences’ social networks who can influence their knowledge, attitudes, and practices to adopt and continue with healthy behaviours. These members included relatives, neighbours, and community members such as leaders, teachers, medical professionals, religious leaders, etc.

Prioritising Behaviours and the Evolving Communication Package
The CMCs, who were tasked to break the resistance in families and communities towards polio immunisation, initially used communication messages and tools developed by the GoI and WHO on polio. However, following initial interactions, the influencers and families reverted to being resistant during the next rounds of polio immunisation campaigns. This prompted CGPP to re-examine community practices and needs in order to develop focussed messages that would contribute to sustainable change. As families asked “why focus only on polio and not our other health needs?”, it became evident that long-term change could not be brought about by only focusing on polio and polio vaccination messages. In addition to the polio messages, messages on RI, exclusive...
breastfeeding, diarrhoea management, open defaecation, and hand washing were therefore also included in CGPP’s ‘communication package’ or package of communication messages (Dey, 2017).

Some of the health messages incorporated into the CGPP communication package included:

- A component on risk perception - messages focussed on making families understand why their children were at risk of polio infection, and how important it was to get all the children in their community immunised against polio.

- Information on RI as one of the pillars of polio eradication.

- Information on the prevention and management of diarrhoea — a need expressed by mothers.

- Messages on hand washing to ensure hygiene and cleanliness.

- Information on the importance of breastfeeding and colostrum to ensure improved immunity for newborns.

- Messages on links between the spread of polio and open defaecation and encouraging use of toilets for defaecation.

- Since 2014, when India was declared free from polio by WHO, the GoI’s focus turned to sustaining the achievements, and along with CGPP and polio partners, they promoted the

---

**STRENGTH OF THE WOMAN**

Women have been at the core of the success of the CGPP in India. A woman-led movement, starting from the mothers of infants and little children to our eminently resourceful and inventive mobilisers, our success is a salute to their combined inventive energies.
message “Do boond har baar, jeet rahe barkarar” (Two drops every time, victory (against polio) should stay forever).

- When the injectable polio vaccine (IPV) was introduced in 2015, another message was added to the communication package to promote the acceptance of the injectable vaccine. The message was “Polio sé double suraksha, do boond aur injection” (Double the protection for polio with two drops and injection).

**Implementation of BCC Activities**

CGPP and its partners used a multipronged communications approach that encompassed (i) interpersonal communication (IPC) (client-provider interaction); (ii) group meetings and community gatherings engaging community influencers, religious leaders, children, and mothers; and (iii) use of key community sites such as mosques, schools, or festivals to disseminate their BCC package and generate demand for health services.

The CMCs through IPC visited households to allay family members’ misconceptions and fears. They achieved this by disseminating facts and information about polio and how it spreads and can be prevented, and they encouraged them to immunise their children. They also assessed the perceptions and needs of mothers and adapted BCC activities accordingly.

Group meetings were conducted with 5-10 individuals belonging to different groups of stakeholders with a common agenda and objective. During these meetings, the CMCs would conduct a needs assessment, disseminate information, and together with group members discuss solutions and decide on actions to be taken (Dyalchand, 2015). There were different kinds of group meetings. There were “Mothers’ Meetings,” also known as mata baithak, which were organised with mothers of children below 5 years of age. Meetings with influencers like community leaders, religious leaders, ration dealers, and shopkeepers were also held, as they
Mothers’ United
helped to reinforce positive perceptions, attitudes, and behaviours before every Pulse Polio round.

Group meetings were also organised through religious leaders. For example, during Ijtema — a meeting organised by Muslim women where religious topics are discussed based on the Islamic scholars’ interpretation of the Quran and Hadiths — CMCs introduced health topics, resulting in both religious and social approval for polio and RI.

Rallies encouraged child participation: Calling brigades (Bulaawa Tolies) would conduct a walkabout rally in their neighbourhood with banners and music prior to each polio vaccination round and on the vaccination day. Rooster rallies were also organised, where children would loudly sing “cock-a-doodle-do” (Kukuru-ku), a slogan accompanied by pictorial placards that were developed for promoting messages to discourage open defaecation, which is linked to polio transmission. CGPP designed name plates, which were given to families whose members were all using the toilets in their homes, as a sign of support and encouragement for discouraging open defaecation.

Fun Classes (Masti Ki Kaksha) were held in schools with children using materials developed by CGPP such as colouring books and games to disseminate information about polio, immunisation, hand washing, and sanitation issues.

Mosque announcements were made by the local Imaam or Maulvi (local Islamic religious leader/cleric) about the date of the Pulse Polio immunisation round through loudspeakers that were traditionally used for prayers.

**BCC Materials and Tools**

With the need to address the growing resistance to polio-only information and the community’s need for messages on other health problems, CGPP developed a set/kit of innovative IEC tools that were participatory and fun. A mix of print and electronic materials, games, and mid-media tools were developed and used in different activities/settings (such as IPC, group meetings, rallies) and with different audiences (such as mothers, children, influencers, mobile populations, and the general community). These materials and tools were used by the CMCs and formed a part of the CMC Communication Kit.

1) **Materials for community mobilisers**

A booklet provided community mobilisers with detailed project messages in a convenient 8-frame, 1-page pamphlet that served as an easily accessible reference guide for mobilisers as they carried out activities in their communities. It contained key messages on polio immunisation, vaccine-preventable diseases and RI, diarrhoea management, hygiene and sanitation, and breastfeeding.

In addition, a film on mobilisation activities was provided to the CMC for her reference. This film was ‘for the CMCs by the CMCs’ to support skills development on the Polio Communication Kit. The film shows community mobilisers demonstrating interactive group meetings and individual household sessions using various IEC tools and materials. The CMCs were also provided with all the IEC materials that were developed for use with various audiences. Mobilisers were provided training and skills on the use of this booklet and the IEC materials during their training sessions (discussed later).
2) **Materials for interpersonal and group meetings with mothers, fathers, families, and community members**

i) **Flash cards and flip books** with illustrations on one side and messages on the other side on polio immunisation, RI, diarrhoea, hand washing, and breastfeeding.

ii) **Leaflet** - a 1 pager with pictorial representation and written messages on RI, breastfeeding, diarrhoea management, hand washing, and children’s rights.

iii) **Behavioural charts** that were used by the CMC to seek information about the current practices of the individual member and the group on polio immunisation, RI, and hand washing.

iv) **Immunisation Card Holder and Congratulatory Card for Newborn Immunisation** - Recognising that most families had misplaced or damaged the government immunisation cards of their child/children, the CGPP team developed an innovative and attractive plastic pouch for keeping these records safe. At the same time, they developed congratulatory cards for mothers of every newborn in the community that included pictorial reminders of timely immunisation. It also included space for registering the child’s basic information, a photograph, and date(s) of immunisation. Community mobilisers started to give the plastic card holders to mothers of newborns along with the congratulatory card, as the card holder has enough space to keep both the government immunisation card and the congratulatory card safe.

v) **Snakes and ladders board game** to promote learning while playing. This game was adapted from the ‘Snakes and Ladders’ board game played widely by children in India. The board illustrations included immunisation and other healthy practices, as well as unhealthy practices. Squares with positive health messages are linked with a ladder that gives the player a ‘boost up’ closer to the winning square, while the squares with unhealthy behaviours are linked with snakes that pull the player down to positions away from the winning square (Coates et al., 2013). During the course of the game, the players discuss the messages depicted in the illustrations to promote group learning and sharing.

vi) **No-cost communication tools** - These indigenous tools and methods were used to promote group learning and included:

a) **Soil, water, turmeric, chart paper, and drawing pens** - These were used to depict how open defaecation and unsanitary conditions could result in spreading the polio virus. The facilitator asks the group to map their community on a chart paper. Then the group members are asked to place soil on the map to depict open drains and garbage dumps and to put turmeric on the drawing to mark places where people defaecate openly. The facilitator then pours/sprinkles water on the drawing to recreate monsoons and to show how the dirt and faeces mingle and result in unsanitary conditions that promote the spread of the polio virus.

b) **Glasses, jugs, paper strips, and water** - These were used with a group to create a story about the importance of RI, polio vaccination, and immunity. The two glasses depict the children who have to get their vaccinations. Water is filled partially in both the glasses to show that the children have got their first dose of vaccination. Then, water is poured into one glass till it fills up, and not in the other. A full glass of water depicts complete immunisation and enhanced immunity. Then, strips of paper (that signify virus) are put into both the glasses. When water is poured into the full glass, the paper strips flow out of the glass, whereas in the half-full glass they continue to float. This signifies that if the child has full immunity due to a complete schedule of vaccines, the virus cannot enter his/her body.
3) **Materials for community influencers**

CGPP developed specific materials to share during meetings with community opinion leaders who had the influence to change resistant mindsets within their communities. These included:

i) ‘Science of Polio’ film - This 6-minute film was made in Hindi and also included animation to explain complex concepts about how polio is transmitted and the importance of polio vaccination in a simple and appealing manner to reach both illiterate and less-literate audiences.

ii) Butterfly booklet - This was distributed to community influencers to remind them of the importance of disseminating the “polio plus” message (see image below). The ‘polio plus package’ includes messages on exclusive breastfeeding, RI, diarrhoea management, and hand washing, in addition to existing polio prevention, and transmission messages (Source: CGPP).


iv) A certificate of appreciation - This was awarded to all influential people in the community to recognise their support for and contribution to the polio eradication programme.

v) Specific materials were developed for community barbers to increase male support for polio and RI. These included:

a) A sticker for fixed barber shops with a key message about safety from polio for a disease-free future for children.
b) Rate cards for barbers containing pictorial information on polio and other vaccinations. The card also had messaging about “anywhere you go by train or bus give two drops and injections”.

c) An apron for stationary and mobile barbers that displays a slogan to promote immunisation.

4) Materials for children and schools

Materials for involving children and school teachers in activities such as rallies and classroom talks included:

i) Colourful banners for children’s rallies, which were conducted prior to each polio vaccination round, and on the vaccination day.

ii) Bright aprons, badges, and caps for child mobilisers - Children wear these during rallies and on booth day, which helps highlight their presence and role as child mobilisers.

iii) Placards for children’s rallies with messages on immunisation, toilet use, and hand washing.

iv) Polio fun class colouring book - The colouring book had pictures with polio messages and polio behaviours. These polio-related images provided a creative way for children to learn about polio, open defaecation, and hand washing.

5) Materials for mobile populations

Specific materials for mobile populations were also developed by CGPP, such as banners that were posted at polio booths and immunisation sites to remind migrant populations to immunise children no matter where they are.

6) Materials for polio booths, health camps, congregations, and group meetings

CGPP developed bright and colourful IEC materials for polio booths, health camps, congregations, and group meetings to announce the date and location of the booths.

i) Polio booth planners - This informative dangler was used at polio booths and immunisation sites and contained information on the
total number of eligible children and the number of children due for polio and other immunisation.

ii) Streamer (Toran) - To decorate polio booths, RI sessions, and group meeting venues, this streamer contained attractive messages on RI, polio immunisation, exclusive breastfeeding, diarrhoea, and hand washing.

iii) Banners for immunisation sessions and meetings - These contained a message welcoming people to the session, as well as a pictorial representation about the importance of immunisation.

iv) Banners for congregations such as the Muslim religious Urs – These banners, with a welcome message and information about RI and polio drops, were displayed in prominent places for greater visibility.

7) Mid-media tools

These were used to convey information about polio prevention and booth day to a wider audience. Methods included street theatre, magic shows, video-vans, information-vans, and electronic rickshaw rallies.

**Capacity Building of CMCs for BCC**

To ensure CMCs have the knowledge and skills for conducting quality community-based activities, they required training. CGPP conducted annual trainings for building CMCs’ capacities to dispel misconceptions and fears around immunisation within their communities.

The trainings followed a cascade model, where master trainers were identified and trained at Training of Trainer workshops. Master Trainers were selected from among the District Mobilisation Coordinators and Block Mobilisation Coordinators. The CGPP Secretariat trained these trainers who in turn, trained the rest of the staff, including the CMCs. The training modules and other tools that CGPP and its partners developed and used are as follows:

**3-Day Training Module for CMCs**

Trainers used this intensive 3-day capacity-building programme to share knowledge and skills in social mobilisation activities for polio eradication. The training was highly interactive and used a variety of training methods, including group work and participatory sessions, problem-solving exercises, games, and role plays. The training module had 4 parts:

1. The basics of polio eradication and its vital link with RI.

2. Communication and counselling skills theory and practice focusing on the principles of health education, counselling for behaviour change, and strategies for recalling appropriate messages and dispelling myths.

3. The practical use of programme-specific tools and methods for social mobilisation activities and IPC.

4. The use of registers for recording up-to-date information on households and institutions in a mobiliser’s catchment area to be used for planning and implementing social mobilisation activities.

An expanded 4-day version for training trainers also covered participatory training methods, facilitation skills, and needs assessments.
**CGPP INDIA BCC FRAMEWORK**

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>AUDIENCE</th>
<th>BEHAVIOUR TO PROMOTE</th>
<th>ACTIVITY</th>
<th>SUPPORT MATERIAL</th>
<th>INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating enabling environment for polio immunisation</td>
<td>Community and children</td>
<td>It’s my responsibility to immunise my child at the booth</td>
<td>Formation of Bulawwa Toles [Calling Brigade]</td>
<td>Badges, aprons, caps, streamers, danglers</td>
<td>No. of Bulawwa Toles formed</td>
</tr>
<tr>
<td>Linking lack of hand washing with polio</td>
<td>Children</td>
<td>Hand washing will prevent you from illnesses like diarrhoea and polio</td>
<td>Fun Class [Masti ki Kuksha]</td>
<td>Pictorial colouring book</td>
<td>No. of schools conducting fun class &amp; demonstrating hand washing</td>
</tr>
<tr>
<td>Linking use of toilets with washing with polio</td>
<td>Community and children</td>
<td>Regular use of toilets will prevent you from polio and other illnesses</td>
<td>Rooster Rally [Kuk-ru-ku rally]</td>
<td>Placard</td>
<td>No. of Rooster Rallies conducted, No. of nameplates pasted on doors</td>
</tr>
<tr>
<td>Promotion of RI, breast-feeding, ORS, zinc and immunisation of missed children in RI sessions</td>
<td>Mother of caretaker [mother-in-law] of children under 5</td>
<td>Exclusive breastfeeding. Timely immunisation [including keeping the card for 5 years] &amp; intake of ORS and zinc tablets will prevent your child from getting diarrhoea and polio</td>
<td>One-on-one interaction and mothers’ meetings Health camp congregations</td>
<td>Butterfly booklet Congratulations card / Badhai card &amp; carry bag / Banners and streamers</td>
<td>No. of children given ORS &amp; zinc tablets, No. of children immunised under RI</td>
</tr>
<tr>
<td>Ensure immunisation against polio and other vaccine preventable diseases, anywhere you go</td>
<td>Migrant population</td>
<td>It is safe to immunise anywhere, anytime against getting diarrhoea and polio</td>
<td>One-on-one interaction and mothers’ meetings</td>
<td>Leaflet / soap strips / waterproof board / danglers</td>
<td>No. of children immunised against polio and RI</td>
</tr>
<tr>
<td>Sustain motivation</td>
<td>Mobilisers and influencers</td>
<td>It is important to immunise all children against polio and other vaccine preventable diseases till the country is declared polio free</td>
<td>Jamborees / group meetings Big ceremonies</td>
<td>Memento/Appreciation certificates</td>
<td>No. of jamborees conducted, No. of influencers’ meetings conducted</td>
</tr>
</tbody>
</table>

**Recognition and Appreciation of CMCs’ Work**
This was done periodically through a full-day information programme designed to acknowledge the contribution of field staff. The event consisted of a cultural programme where awards were presented to well-performing grassroots workers and volunteers. The function was presided over by the District Magistrate and Chief Medical Officer, who are the most senior government officials at the district level and thus provide an element of prestige to the event.

**Achievements**
- Due to the implementation of the enhanced package of messages and information, the polio programme was perceived by the community as being interested in and committed to improving the overall health of children.
- In a study of CMCs’ perceptions about the effectiveness of BCC materials, the behavioural (Vyavahaar) charts on RI and hygiene, and the Snakes and Ladders board game were identified as the 3 most effective materials (see Figure 4) (Synovate, 2009).
- Implementation of the BCC intervention by CMCs had a positive impact on the level of mothers’ knowledge about polio. As per Figure 5, a survey of mothers in 8 districts of U.P. (Baghpat, Bareilly, Mau, Meerut, Muzaffarnagar, Saharanpur, Shahjahanpur, and Sitapur) clearly showed that the percentage of those mentioning the CMC as a source of information on polio, as well as on the vaccination campaigns, increased over time (Coates et al., 2012).
- A survey of 1,786 mothers showed that the majority (78%) of them reported exposure to at least one IEC material provided by CMCs. Data showed that there was a high retention of the immunisation card (Weiss et al., 2015).
- When the last case of polio was reported in Howrah, West Bengal, CGPP was invited to be part of the emergency response. They spent 2 years in that state from 2012, and due to the success of the tools in U.P., they used the same BCC structure and tools.

The tools were translated into Bengali, and the ‘Science of Polio’ film, which was also used during the training with CMCs and influencers, was given a voice-over translation.
THE CORE GROUP

INFLUENCING CHANGE

GATHER. TOGETHER
Community Mobilisation Coordinators (CMCs) were key to the success of the social mobilisation activities and the polio campaign as a whole, in particular in overcoming the challenges of resistance and lack of immunisation coverage. They addressed parental concerns, built faith in the polio programme, created trust between polio eradication personnel and local residents, and helped identify and track missed children.

**Designing the Intervention**

The involvement of CMCs was designed to: (i) ensure that children most at risk were adequately protected from polio, and (ii) increase the total number of children attending polio booths and being immunised. To achieve these objectives, each CMC was tasked to conduct communication interventions and mobilise communities using one-to-one and group meetings as the main tools for behaviour change. Each CMC was provided with a monthly stipend and was responsible for the immunisation status of all children below 5 years of age in about 300 to 500 households in their assigned community/area (Coates et al., 2013). The CMCs were given mentoring support by the Block Level Mobilisation Coordinators (BMCs) and the District Level Mobilisation Coordinators (DMCs).

Over the years, the CMCs’ role underwent many modifications owing to the changing epidemiological situation and evolving polio eradication programme. The modifications are described below.

**Implementing the Intervention**

Identifying and recruiting women CMC candidates

At the start of the initiative, male CMCs were recruited; however, it was hard for male mobilisers to engage or communicate with women, as women refused to allow these men entry into their households due to cultural or religious reasons. Knowing that it was crucial for programme success to gain access to households and counsel mothers, the programme then sought ways to recruit women from the local community.
CMC candidates were identified with the help of CGPP partner PVOs (ADRA, CRS, PCI) working in the area, and in some areas, the medical officers and other government aid workers suggested possible names. The criteria for selecting CMCs were that they had to be residing in the community, had to have completed a minimum of 8th grade in school, and had to have good communication skills. However, due to prevailing social norms, particularly in Muslim communities, it was not an easy task to convince their households to let women from their families engage in work that required them to interact with outsiders, as well as travel outside their community. Moreover, the fact that they would be working to support a government-aided programme meant standing up against the fatwas that forbade acceptance of the polio eradication programme. To address this challenge, the NGO partners and CGPP workers approached the home of the potential CMC to convince the household heads to allow their daughters/sisters/wives to work with the programme. Some households relented and agreed, and thus female CMCs were recruited for the programme.

During the initial phase of the programme, the female CMCs were Dais (traditional birth attendants) and Aapas, who were well respected in the community and were allowed easy access to households to engage with families. However, most of these CMCs were illiterate and thus were not able to keep records. On the other hand, the literate CMCs were younger than the Dais and Aapas and therefore not easily accepted by their community. In fact, many of them faced humiliation and discrimination on a daily basis because the elders in the community believed they were defying their religious diktats. Ensuring the support of local influencers, such as community and religious leaders, was therefore important for CMCs to make inroads into the community and households (more about this in Chapter 5 on Working with Influencers).

It was also very essential that the selected CMCs had the ability to develop and maintain relationships with different members of their community, be they parents of children, community leaders and other influencers, or children themselves. At the same time, they had to ensure they did not come across as if they were talking down to community members and in turn alienate the people they needed to work with.

Once recruited, there were additional challenges related to CMCs that had to be overcome. Despite
all efforts by the CGPP to retain the CMCs in the programme, some of them were unable to work after they got married, as their spouse or in-laws objected to their work outside of the home. In some areas, there were long distances to cover to reach households and families, which also posed a challenge for CMCs who worked alone. Ingenious methods were devised to address these challenges, such as taking along a family member for company or enrolling the help of an influencer.

The Expanding Role of CMCs
When CMCs were first recruited, it was envisaged that their role would be to support the vaccinator teams during their home visits and follow-up visits with families who were missed during a vaccination drive. They were thus hired for 15 days a month and had to work a week prior to the polio round, during it, and a week afterwards. However, it was soon realised that this level of involvement was not enough to mobilise households and the community to accept polio vaccination. Not only did CMCs need to be involved full time, but their role and reach had to be broadened. Over the years, the role of the CMC therefore grew to promote a larger package of services that included a focus on RI, as well as sanitation and its link to polio eradication. They also visited households to not only raise awareness about these services, but also to track missed children and ensure that they get vaccinated. In addition, CMCs were tasked with mobilising influential people to make home visits, and to maintain immunisation status records for all of the under-5 children in their assigned areas and for those participating in vaccination campaigns.

The activities undertaken by the CMCs before and during polio campaign/rounds are detailed below.

CMC Activities before Polio Campaigns/Rounds
When no immediate polio campaign activities were taking place, CMCs were involved in the following activities:

- They prepared detailed maps of their communities and visited their assigned households once a month or more, as needed. During the household visits, they provided information about vaccination, addressed myths and misconceptions about OPV, and collected detailed information in a field book, tracking
the names, ages, and immunisation history of all children under 5 in their area (Coates et al., 2013).

- The CMCs prepared ‘child maps’ to identify all eligible and missed children. They marked out priority areas including households with newborns and children under 3 years of age, as well as areas that have had repeated refusals and missed children. They also collected additional data for microplans to monitor children in the age group 0-5 years. The microplans\(^1\) included a 5-day plan for household visits and immunisations.

- CMCs held regular meetings with mothers’ groups to advocate for repeated polio immunisation.

- They identified and organised meetings with local leaders and influencers, such as religious leaders, practitioners of alternative medicine, shopkeepers, and owners of businesses, to obtain their cooperation and support for polio vaccination efforts. During these ‘influencer meetings’, CMCs would convince them to make house visits during the campaign to allay the fears of families who were reluctant to immunise their child/ren.

The CMCs also convinced religious leaders to make mosque and temple announcements about the immunisation campaign prior to the campaign (more detail in Chapter 5 on Working with Influencers).

- CMCs prepared a mobilisation plan, which would identify areas for placing posters, as well as identify influencers who could accompany the CMCs and vaccination teams to households where there were repeated refusals.

---

1 Microplan is a widely used tool in the polio programme to plan immunisation activities in detail. It is a map that includes the number of houses and children to be reached, area to be covered from start point, route to be taken, end points, and landmarks such as schools and playgrounds to ensure all children in the area receive the vaccine.
They worked closely with schools and madrassa (schools attached to a mosque for the study of Islam) to engage children in polio eradication efforts. They organised children’s brigades (Bulawwa Tölı́), fun classes (Masti ki kaksha), and Rooster or cock-a-doodle-doo (Kuku-ku) rallies to encourage children to promote awareness about polio vaccination, and to motivate their families to practice good hygiene at home and in the community (details in Chapter 6 on Children as Mobilisers).

CMCs also worked with key informants such as brick kiln owners and barbers to help locate and reach migrant workers who were often missed during campaigns (details in Chapter 7 on Making Inroads with Mobile Populations).

One key goal of CMCs was to convert missed houses marked as ‘X’ to accepting or ‘P’ houses. Over the years, the ‘X’ code was expanded to provide information about various types and causes for children being missed. The expanded ‘X’ code allowed for identification of households that were resistant, and also where children had not been immunised for other reasons, which could be that the child was not at home or not in the village, the child was sick, or the house was locked (See Figure 6 for more information about the different codes). This additional information facilitated more targeted responses, strengthened the polio eradication effort, and promoted local ownership by the CMCs (Deloitte, 2014).

CMCs also counselled pregnant women on the importance of exclusive breastfeeding and Colostrum feeding, and helped to integrate newborns into the RI system.

CMCs’ Roles and Responsibilities During the Polio Campaigns/Booth Days

- CMCs helped vaccinators set up and decorate the vaccination booths to attract families and children.
- They organised mosque/temple announcements by the local priests to promote booth
day activities and encourage families to take their children for vaccination.

- Children rallies were organised to attract the communities’ attention to the booth day activities and encourage families to bring or send their children for vaccination.

- CMCs went from house to house with the government vaccination team, using their field book to ensure that no child was missed. If a child was not at home, or a parent refused the vaccine, the team marked the house with an ‘X’ and returned twice in the next week, attempting to either find the child at home or tackle the parents’ resistance.

- CMCs involved their network of influential local people to accompany them to the ‘X’ houses with the vaccination teams to help persuade those refusing to vaccinate.

### Codes used for Reason for Missed Child

<table>
<thead>
<tr>
<th>Codes</th>
<th>Reason for Missing Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>XR</td>
<td>Resistance to vaccination</td>
</tr>
<tr>
<td>XS</td>
<td>Sick children</td>
</tr>
<tr>
<td>XL</td>
<td>Locked houses</td>
</tr>
<tr>
<td>XH</td>
<td>Children were not home but were expected to return later that day</td>
</tr>
<tr>
<td>XV</td>
<td>Child had travelled out of the village or the city, often because the mother had taken the child or her children for a visit to her parents or other relatives</td>
</tr>
</tbody>
</table>

### Capacity Building of CMCs to Catalyse Change

As the polio programme relied on CMCs for social mobilisation, they were required to be effective communicators with sound knowledge of polio eradication and the social and cultural norms that existed in the community. Therefore, it was imperative to equip the CMCs with appropriate skills to build rapport and conduct interpersonal counselling with caregivers. In addition, they had to be trained on how to approach and work with leaders, mothers-in-law, and other influencers in the community. They were also trained on how to systematically collect data and use it for planning communication interventions, and on how to conduct surveillance of Acute Flaccid Paralysis (AFP).

A cascade model of training was developed wherein the CMCs received training, coaching, and supportive supervision from BMCs, who in turn were guided and supervised by the DMCs (Murphy, 2012). The training of CMCs was based on adult learning principles, where trainers adopted a participatory approach to a mix of lectures, games, role plays, and field visits to facilitate learning. During these trainings, they also learned how to use practical demonstration techniques and interactive materials that were developed by CGPP for use in the community (for details, see Chapter 3 on Behaviour Change Communication Strategy). Periodic training needs assessments and refresher training helped address gaps and reinforce IPC skills (Murphy et al., 2012).

In addition to training and supportive supervision, the programme focussed on recognising and motivating CMCs, considered to be the back-bone of the polio programme. Special events such as day-long jamborees were introduced to boost their morale, and they were also awarded certificates and trophies to honour their hard work and contributions to polio eradication in their communities.

### Achievements - Creating Trust and Improving Outcomes

At first, CMCs were met with hostility, and people were reluctant to engage with them. Parents hid
their children when they made house visits and, at times, they were even abused and had stones thrown at them. Acting as a single point of contact for the community on all issues related to polio, combined with house-to-house counselling and regular monthly meetings, helped the CMC build trust and faith amongst the people. They built relationships with their community that earned them respect as dedicated health workers. As the CMCs’ credibility grew, people started reaching out to them to seek information on polio vaccination, schedules for the next round of vaccinations, and other immunisation-related information. The acceptability of the CMC, which was aided by the fact that she was part of the community in which she sought to create positive change, was key to the success of the SMNet. In a CMC’s own words:

“It took time to gain acceptance of the community and now we have a very good relationship with people here, they are like family and trust us completely. Now there is no resistance to polio vaccination in the community. People consult us whenever their children are not well. The children see us and greet us as ‘polio-wali’ Aunty.”

Increased Number of Children Vaccinated
The effectiveness of the awareness raising and mobilisation efforts of the CMCs was linked to the increase in the number of children immunised at booths in U.P. Research showed that booth coverage in CMC areas was clearly higher than in non-CMC areas (CGPP, 2012) (See Figure 7).

CMC Impact on Reducing Resistance to Vaccines
The CMCs’ impact on reducing household resistance to vaccination was tremendous. An assessment of reasons for missed vaccination during SIA campaigns in CMC areas in 2012 showed that only 0.5% of households resisted vaccination (CGPP Annual Report, 2012) (See Figure 8).
Empowerment of CMCs

Many CMCs described their involvement in the programme as life changing, as it gave them access to a platform for growth and learning. They expressed pride in contributing to improving the health of the children in their communities and the country. They also reported gaining valuable life skills and self-confidence.

As a secondary result of the intervention, women were empowered and became active decision makers in their households. In their own words, the CMCs talked about their increased mobility and social recognition because of their involvement in the polio programme.

“Working as a CMC gave us so much confidence and belief in ourselves. Where earlier I would not step out of the house alone, now I can go anywhere, talk to anyone and feel very satisfied that I am helping children get a better life and future for themselves as health individuals.”

“My children tell me that I am better known and respected in the community as compared to my husband.”

A decade ago in northern India, many women who are now CMCs were not allowed to leave their homes. Now, some have gone on to full-time paid employment in government jobs, with NGOs, or even as local elected representatives.

“In my family, women were not allowed to go out and work. My husband encouraged me when I told him about my desire to work. He supported me when family elders expressed their displeasure and anger. Over time they started accepting and..."
appreciating my work. This work changed my life. I now have an identity and respect in my family as well as community.”

“The skills and confidence I gained as a CMC have been a big help to me in my work with the government” (former CMC employed as ASHA worker).

**Broader Social Change**

Some community mobilisers discussed how the polio programme helped bring about broader social changes, such as bringing religious communities together.

“Working as a CMC has broken so many barriers for us…it helped us learn about other religious communities and made us change our views and beliefs about them. Where earlier I would not even interact with them, now we work together, support and help each other. Most importantly, I feel that we have been able to bring religious communities closer together in our area through our work.”

One CMC described how the Imam in her community asked her to make mosque announcements about polio vaccination despite her being Hindu. She was the only female and only non-Muslim person to do so.

“I have been making announcements from the mosque in my community for the past two years. I am the first woman and first Hindu who has ever done this in our community. No one in the community has objected to my doing so and I must give credit to the Imam for giving me this respect and reposing such faith in me. This has been made possible only because of the polio prevention work…it has given us such a big platform to bring about change in our communities.”
Reflections

Working with such a large workforce at the community level is a resource-intensive effort. If programmes have limited resources, careful thought and planning is needed to adapt/replicate this effort in different settings. Some members from the CGPP India team reflected on and shared insights about involving community mobilisers as frontline workers in health promotion.

Rina Dey, BCC Advisor, CGPP India, said, “I would design the deployment of CMCs to complement the work of government health workers in order to implement quality interventions.” She added that it was also very important to provide supervision and support to these functionaries for them to perform their role to the best of their abilities.

Manoj Choudhary, Monitoring & Evaluation Advisor, CGPP India, mentioned that community-based workers are needed the most in areas where communities are not aware and/or are resistant to large public health efforts. He said, “As CMCs are frontline workers, they are most effective in hard-to-reach areas where mobilisation efforts are needed and where the existing cadre of government workers are unable to manage or need support.”
“Working as a CMC gave us so much confidence and belief in ourselves. Where earlier I would not step out of the house alone, now I can go anywhere, talk to anyone and feel very satisfied that I am helping children get a better life and future for themselves as health individuals.”
FRIEND
PHILOSOPHER
GUIDE
As mentioned in the previous chapter, CMCs were initially hired for a period of 15 days to mobilise the community and to carry out rallies to create awareness about the vaccination day. Together with the vaccinators, these volunteers would visit houses where there was resistance to vaccination. However, despite these efforts, the resistance persisted. In some communities, due to misinformation about the polio vaccine, elders and local leaders discouraged participation in immunisation programmes, or simply did not support it.

Following meetings and discussions with various community members and NGO partners, it became clear that an effort needed to be made to involve community leaders to champion the cause for polio immunisation. This strategy has been used effectively for behaviour change in public health programmes globally (Murphy, 2005) and proved to be a key to the success of the Polio Pulse Programme.

**Designing the Intervention**

One of the key social and behaviour change strategies therefore involved identifying and involving influencers – members of the community who had social, political, and economic influence in their community. They sanctioned behaviours and actions, were a source of credible information, and would therefore be able to apply social pressure to motivate their community members to change their resistant attitudes towards polio. With this understanding, the CGPP team used their existing networks to identify influencers in the community.

**Identifying Influencers as Partners**

The influencers included in the programme were not a homogenous group and comprised the following categories of individuals, who were respected and had a mass reach in their communities:
• Local political leaders, such as past and current members of the Panchayat (village council), Sarpanch and Pradhan (village heads), and ward members from local political parties.

• Local religious leaders, such as priests/heads of places of worship across all faiths. These included: Hindu Pujaris, Christian Padres, Islamic Maulanas or Imams (male scholars who conduct religious teachings in the Madrassas and/or lead prayers in the mosques), and Aalimahs (Islamic female scholars who teach the Quran to women), as well as Jain Muni.

• Local ration (grains/pulses) suppliers and dealers, who come into contact with almost all community members when they come to purchase their household supplies.

• Local healthcare providers and traditional healers, who are the first point for health care.

• Shop owners, paan kiosk owners, barbers, etc., as most community members come into contact with them on a regular basis for their various needs.

• Family-based influencers who are well respected people within a family such as elders, fathers-in-law and mothers-in-law, parents, or even an outsider close to the family.

• Government community workers, such as Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs), and Accredited Social Health Activists (ASHAs), who are well respected in the community. Their social interaction skills enhance their acceptability to meet and convince resistant families.

• Schoolteachers, who were critical in coordinating activities with schoolchildren to promote polio immunisation. They helped
in informing, motivating, and organising schoolchildren to become involved in the Pulse Polio and RI programmes through polio classes and rallies.

- Brick kiln owners, who were also instrumental in reaching out to mobile populations, as well as in providing a space for setting up immunisation sites in their community.

- Other occupation-based leaders, such as large contractors and suppliers, who occupy an important position in the community because they are seen as a main source of livelihood. In some of the districts, the main income source is through brass and bangle industries, weaver associations, slaughter houses, etc. The contractors and suppliers who manage these trades have a big role in influencing attitudes and practices of community members employed with them.

Implementing the Intervention
Initially, the involvement of influencers only produced short-lived results, as the resistance was broken only for one round of immunisation. By the second round of vaccinations, people once again resisted the effort to immunise their children. Realising that this may be due to the fact that the influencers themselves were not convinced of the reasons and benefits of immunisation, efforts were made to work in a more structured way with them to bring them on board. The influential leaders were then involved in supporting community mobilisers during group meetings and house visits to influence attitudes and practices.

- Community mobilisers would begin by identifying households that were known to be resistant to polio vaccinations. Once they identified such families, the mobilisers then mapped and identified influencers in the
The selected influencers were trained about the importance of polio immunisation. They were provided with adequate information to allay any concerns and fears they may have had about participating and supporting the vaccination drive. The influencers were also oriented to their role as motivators of community members to accept the polio vaccine.

In some cases, influencers outside the community were also identified and approached. For example, to address the resistance towards polio immunisation among Muslim communities, CGPP and its partners identified the Shahi Imam (spiritual and political leader of the Sunni Muslim community in India) of Jama Masjid in New Delhi as a key influencer.

The CGPP Director, Roma Solomon, approached the Shahi Imam to discuss the resistance they were encountering in the Muslim communities in Western U.P. and to seek his advice and intervention. Facts and figures were presented to him about the dangers of polio, its transmission risk, the need for prevention, and challenges they were facing in trying to protect children from this disease. When presented with this data, the Shahi Imam promised to support CGPP’s efforts by providing the names and contact details of some influential Islamic religious leaders who could also be approached to help in gaining an entry into resistant communities. Over time, with support from the religious gatekeepers and influencers, CGPP was able to convince Maulanas, Imams, and Aalimahs within each community to support the immunisation efforts.

• Meetings were held with the identified influencers to motivate and sensitise them to join the immunisation efforts. They were shown the film ‘Science of Polio’ to provide information about the virus and its prevention in order to allay any concerns and fears they may have had about participating and supporting the vaccination drive.

• The selected influencers were guided into their role as motivators through group meetings and personal interactions organised by the CMCs. Communication materials were developed to provide influencers with information about the problem of polio and how vaccination efforts reduced the burden of the disease.

• Interface meetings were conducted prior to each polio round, and those invited included influencers from the village, vaccination team supervisors, WHO/GoI representatives, and block-level staff of CGPP. Resistant families in the village were identified, and attendees took responsibility to talk to them and persuade them to get their children immunised at the next round. Strategies for conducting the polio rounds and door-to-door campaigns were also shared during these meetings (CGPP, 2012). For example, Pradhans would encourage their

---

1 The Shahi Imam is the Imam of Delhi’s Jama Masjid (one of the largest mosques in India). The current Imam, Syed Ahmed Bukhari, is the 13th Imam and descendent of the first Imam who was appointed by the Mughal Emperor Shahjahan (who built the Jama Masjid between 1644 and 1656) in a long line of family dynastic appointments. He is one of the most visible and prominent faces of the Muslim community in India.
constituencies to immunise their children and also visit homes of caregivers when necessary.

“I used to speak at meetings when the community mobilisers would tell me to. I have visited many households with the mobilisers and vaccination teams...these were the families that had refused to have their children vaccinated. I would talk to them and convince them to give their children the polio vaccine. Most people would do as I would request them as being the Pradhan they would all listen to me.” (Former Pradhan of a village in Meerut)

- Some of the influencers provided logistical support and a venue for the vaccination teams to hold their meetings, and for setting up vaccination booths. In some communities, influencers were invited to inaugurate and address polio booth day activities.

- Religious leaders would speak in favour of immunisation in their sermons, from the pulpit (minbar) and in other religious and social gatherings. Announcements of vaccination drives/days were made by Imams from mosque loudspeakers, providing information about booth venues and timings.

Overcoming Religious Resistance by Partnering with Imams, Maulanas, and Aalimahs

The WHO and GoI’s 2002 surveillance data showed that children in western U.P., primarily those in Muslim communities, were for some reason being consistently missed during immunisation rounds (UNICEF, 2004). The immunity gap among Muslim children in western U.P. was 29%, compared to 14% among Hindu children (See Figure 9) in 2002; and for the entire state, it was 40% for Muslim children and 20% for Hindu.

The gap showed that there was a sizeable pool of non-immunised children who could easily become the source of transmission for other children with poor immunity (MoHFW/WHO-NPSP, 2002).
As explained in Chapter 1, many structural and environmental factors were associated with resistance to and a low level of acceptance of the polio vaccine. In addition, during the early years of the polio programme, some religious leaders had issued fatwas (religious decrees issued by Islamic scholars) against child immunisation (Coates et al., 2013). Despite efforts by various agencies and their workers, religious resistance to the polio eradication programme could not be challenged effectively. As detailed earlier, with the support from the Shahi Imam, CGPP relied on the Imams, Maulanas, and Aalimahs to support immunisation efforts in communities with majority Muslim populations. The social standing of these religious leaders and scholars enabled them to bring people together, dispel myths and misconceptions around vaccinations, and promote positive changes. When the Government introduced polio immunisation for Muslims going on the Hajj to Mecca, it provided additional proof to resistant families that immunisation was necessary to prevent polio.

The CGPP team and community mobilisers responded to this resistance by holding several meetings with religious leaders, during which they shared data and research findings on the advantages and safety of polio vaccination. Slowly, the leaders became convinced about the benefits of polio immunisation and started to promote participation in routine and campaign immunisation services. In some instances, counter fatwas were issued in favour of polio vaccines. Mass appeals to immunise their children against polio were also made from Madrassas (Islamic schools for the study of religious sciences and other related subjects).

“I told the community members that we should be grateful to all the agencies who have thought about us and are helping us. It is our duty and responsibility to see that this work is a success as it is our programme that is for protecting our children’s health and improving their future.” (Imam in Meerut)
Another avenue to reach the community was through the religious group meetings called *Ijtemas*, which were held separately for men and women. In these meetings, male and female leaders used exhortations from the *Quran* and the *Hadiths* to stress the obligation of parents to protect the health of their children (Murphy, 2012). To integrate polio messages into religious discourse/teachings required a lot of thought and planning, as well as sensitivity to ensure religious sensibilities were not hurt or offended. The monthly religious discourses or *Ijtemas* served as an ideal space to inform and influence women attendees about polio vaccination. While the men were reached by *Maulanas* and *Imams* in mosques and madrasas, for women, *Aalimahs* (women scholars), also referred to as *Aapas* (title of respect used to address an older sister), were involved.

The *Imams* and *Maulanas* introduced the CMCs to the *Aalimahs* in their community. They held meetings with the *Aalimahs* prior to *Ijtema* to inform and sensitize them about the importance of polio vaccination so they could in turn convince the women attendees. Along with *Aalimahs*, the community mobilisers identified ways that polio vaccination messages could be integrated with religious teachings. *Aalimahs* selected a *Hadith* from the Holy *Quran* that would relate to the well-being and health of families and then incorporate information on the benefits of polio immunisation in protecting the health of the children. With the support of the *Aalimahs*, the CMCs also attended *Ijtema* meetings to gain trust and build rapport with the women attendees.

**Motivating Influencers to Sustain Their Involvement**

Long-term involvement of influencers was a major challenge. At first, the influential leaders were motivated to become involved in the programme by their desire to do good in their community. However, over the years, their enthusiasm waned, and they stopped coming for meetings and lost interest in the programme. The CGPP team worked with other partners to develop a strategy that would sustain the influencers’ interest in the project.

CGPP partners realised that the role and efforts of these community leaders needed to be appreciated and recognised in a formal and structured manner. To motivate and sustain the influencers, meetings were therefore held regularly to reward their participation and achievements. They were given certificates of appreciation and were also involved in district task force and community-level planning meetings (See Chapter 2 on Collaboration and Partnership with the Government for details). This went a long way in keeping them interested in continuing their association with the programme.

“In a meeting in the community where the District Magistrate was the special invitee, we distributed trophies to all our influencers in recognition of their work with us in polio eradication. This has helped boost their interest and motivated them to stay involved with us. Now they are always ready to participate in our community meetings with resistant families and speak very highly about our programme to all.” (BMC, Block - Sardhana)

“Because of this Polio programme I achieved a lot of satisfaction knowing that I was part of such a big achievement – we eradicated polio from our nation. The certificate that I received for being a part of this programme has been displayed prominently in my office for everyone to see.” (Local medical practitioner, Meerut)
Achievements
Improving Programme Coverage

- Involvement and support of influencers helped to build positive perceptions, attitudes, and behaviours, and provided credibility to the polio programme. In addition, the participation of community leaders, medical practitioners, religious leaders, ration-dealers, shop-keepers, etc., demonstrated that the goal of polio eradication was not imposed from the outside, but was owned by the community.

“I told the Ration Dealer that I needed his help as there were some people in the community who were refusing to get their children vaccinated. I gave him the names of these people so when the next time they visited his shop he could emphasise the importance of the polio vaccine and convince them to get their child/children immunised. He agreed. In fact, he went ahead and added his own messaging. He would tell the parents that not getting their children vaccinated meant they were depriving them of their chance to be healthy and how would they like it if they were deprived of their rations. In this way he was able to convince many families to convert from resistance to polio vaccination accepting families.” (Community mobiliser, Meerut).

- As per recorded social mobilisation activities undertaken by CGPP partners in U.P. over a year (Oct 2011-Sept 2012), more than 15,000 mosque announcements were made during SIA about polio immunisation and when and...
where children can be vaccinated. In addition, over 8,000 meetings were held with influencers during the same period (CGPP, 2012).

- Households resistant to polio vaccination reduced significantly in areas covered by CMCs. In most of these areas, local influencers visited resistant households with the community mobilisers in an effort to convince them to get their child vaccinated. In a review by Singhal (2013), local influencers who accompanied mobilisers and vaccination teams during house-to-house activities more than doubled over a 2-year period (from 37% in January 2006 to 85% in February 2008). The author stated that, therefore, any change in resistance should be attributed to combined efforts of the influencers and mobilisers.

The mean percent of “X” households (not all eligible children vaccinated) that were converted to “P” (all eligible children vaccinated) during the vaccination campaign was higher in CMC areas, on average, than in non-CMC areas (see Figure 10). (Weiss et al., 2011).

**Reflections**

As the role of influencers played an important part in allaying the fears and resistance of communities and families, this approach should be replicated or adapted in other settings.

Key CGPF staff were asked about their insights around involving influencers for those wanting to use this particular strategy. Rina Dey, BCC Advisor, stated, “One has to first assess the needs and then identify the appropriate influencers. Moreover, influential leaders need to be selected with care as they have to be acceptable to the community. Therefore, involvement of the community is important in identifying these influencers”. She also mentioned that it is essential to recognise that there are influencers at various levels – at the community level and also at the household level, such as husbands, mothers-in-law, and other family elders. To identify these household-level influenc-
ers, the programme needs to not only know their community very well, but also to have the trust of and access to households/women, before proceeding. Once identified, the community level influencers can be tapped to work with household-level influencers to change attitudes and adopt healthy and safe practices.

According to Manoj Choudhary, M&E Advisor, “Use of programme data such as number of polio cases and missed children in the community or neighbouring community made the potential risk look real and closer to home. This convinced and galvanised the influencers to provide support to the programme. Thus, it is very important for data to be used to drive programme efforts and innovations.”

He added that, “instead of involving the influencers on a regular basis, they should be engaged when there is absolute need. Otherwise, their influence may wane and people may not listen to them after some time”. Furthermore, sustaining the interest of the influencers for the duration of a programme is challenging. There is a need to plan how to motivate and keep their interest going through the life of the project.
The CMCs were located in the most difficult areas with the lowest levels of immunisation and communities/families resistant to immunisation.

Source: Weiss et al., 2011
When CGPP got involved in the Pulse Polio Programme in 1999, the first major activity they undertook was to try to involve the community in order to understand and address their concerns about polio and OPV. Recognising that public awareness through mass media campaigns was not sufficient to bring about behavioural and social change, the communication strategy also sought to meaningfully engage affected populations through social mobilisation and interpersonal communication. Early in the programme, CGPP was convinced that by encouraging the participation of children, they would be able to extend their reach in the communities. Children could operate as messengers of change and encourage their parents to vaccinate their younger siblings. In addition, involving children as mobilisers would be a colourful and effective way, not only to increase coverage, but also to educate the next generation and instil a spirit of community service that can be tapped for other child health problems. It was as early as 2000 that CGPP adopted the child-to-parent approach to disease education and prevention (Coates et al., 2013).

**Designing the Intervention**

CGPP saw the meaningful involvement of children as an opportunity to innovate and make changes to their communication campaign. The strategy was designed to partner with local schools and Madrassas in order to engage teachers and students in the polio effort. The schools would help identify children who in turn could organise rallies to spread awareness about the polio campaign, both before and during the immunisation days. Children were seen to be effective ambassadors for change, as they were enthusiastic and were perceived by the community as non-threatening.

Over time, the role of children’s rallies increased to providing support to the CMCs during their scheduled house visits by ‘calling’ parents and their children to the booths for immunisation. As their main role was to ‘call’ parents and their children for immunisation, these groups of children were known as ‘Bulawwa Tolies’ (Bands of Children or Calling Teams). They helped in disseminating polio messages, identifying small children, and even carrying them to the polio booth. Gradually, the polio rally was transformed into a ‘Kukuru-ku’
(Cock-a-doodle-do, the morning wake-up call of a rooster) or Rooster Rally, which was conducted to promote not only immunisation, but also hand washing and the use of household toilets for defaecation.

CGPP’s work with the school authorities also expanded. Before each polio campaign, CMCs conducted a ‘polio class,’ where primary and middle school children learned about polio transmission and its link with sanitation.

Over the years, these classes/sessions were modified to incorporate more fun activities, using entertainment formats like colouring books, games, etc., to discuss polio, immunisation, hand washing, and sanitation issues. These classes came to be known as ‘Masti ki Kaksha,’ or fun classes.
Implementing the Interventions

**Bulawwa Tolies (Calling Brigades)**

The children’s programme was conducted over a period of 3 days – ‘polio classes’ were organised on Friday, rallies were held on Saturday, and *Bulawwa Tolies* took to the streets on booth day on Sunday. The activities, which took place before polio booth day and during polio booth day, were as follows:

**Prior to booth day:**
- **Involvement of Schools/Madrassas** - CGPP consulted WHO and other partners to identify priority areas based on available data on where children were being missed during vaccination drives. Having identified these communities, CGPP then approached the local schools and Madrassas for their approval and support for engaging their schoolchildren in spreading awareness about polio. It took a lot of planning and meetings, as well as time and effort, to convince the Madrassas to allow students to participate in the programme. In most cases, the CMCs needed support from the BMCs and DMCs to convince the Madrassa Maulvis to participate in the programme. Schools were also reluctant to send their children to communities far from their homes due to concerns about their security and safety. To address this, it was decided to involve them in their own communities and in lanes that were close to their homes. However, once the Madrassas were on board, there was no problem in conducting the polio classes and in organising rallies with the Madrassa children.

- **With the support from the Madrassas**, ‘polio classes’ were conducted to educate children about the importance of polio immunisation, RI, and other childhood diseases that affect children in their communities. While the school authorities were welcoming and open to CGPP, their concern was that the teachers may not have the skills or the time to conduct the polio classes/sessions. They preferred that these classes, instead, be conducted by the community mobilisers. During the classes, CMCs related simple stories about the causes and symptoms of polio and the ways to avoid transmission. To sustain the interest of schoolchildren in these classes, they also organised essays and art contests on polio themes. At the end of this class, the mobilisers and teachers would identify children aged 5-12 years who showed leadership skills and were interested in becoming a member of the *Bulawwa Tolies*, which usually had between 8-10 members. The selected children were informed about the polio booth date, as well as the venue to which they were supposed to send parents and children for vaccination. Each CMC had one or two such groups per polio booth.

- To encourage a greater sense of involvement in the polio programme, schools were also involved in preparing slogans and taglines for the polio awareness rallies.

- A day before the booth day, a polio rally would be held by the *Bulawwa Tolie* members, who were asked to come wearing clean clothes and have neatly combed hair and cut nails in order to be seen as role models for personal hygiene. They were then geared up in project caps, badges, and aprons and were given flags/banners to wave during their walk through the community. The children would march through the community, beating drums and shouting slogans, to create a celebratory atmosphere and to generate interest in the vaccination campaign on the following day.

“*Bulawwa Tolies* were a big help and support to our work. When the children would beat their drums and create a festive scene with their slogan shouting, people would come out of their homes to see them and get energised and encouraged to participate in the programme.” (CMC from Meerut)

**On booth day:**
- On the polio booth day, the *Bulawwa Tolies* would call out to the mothers, wave their flags, sing songs, and shout slogans about immunisation and would go from house to
house, according to the plan shared by the mobilisers, to bring caregivers and children to the immunisation booths in their community. They were able to not only persuade mothers to take their children to the booths, but were sometimes even given permission by parents to take children below the age of 5 years to the booth themselves. To appreciate the efforts of the children in the Bulawwa Tolies, a token reward was given to children who brought the most children to the booth to be immunised.

“The Bulawwa Tolies were asked to come wearing clean clothes, neatly done hair, and cut nails in order to be seen as role models for personal hygiene. In addition, they would wear project caps, badges, and aprons and carry flags/banners during their walk through the community.

On booth day, Bulawwa Tolies play a big role. At the start of the Pulse Polio Programme, very few children would come to the booth for polio drops. It was then thought that why not involve children to call parents to bring their children to the booths. Children were seen as non-threatening. Thus, this is how people started sending their children to the booth.” (CGPP, Baghpat).

“Masti ke Doot were a big help to us. They would go to the homes and bring children to the booth. Parents were comfortable in sending their children with them. If they were not there, then we would have to go to the homes and it would have taken much longer for us to achieve the results that we did.” (CMC, Meerut)

During booth day, the children also participated...
in art competitions, and their art was used to decorate the booths. At the end, all the children who participated in the Bulawwa Telies were given a small gift and refreshments for their enthusiastic participation. The schools also encouraged these children by recognising their contribution at special functions and school assemblies.

**Masti Ki Kaksha (Fun Classes)**

The class-based mobilisation activities were changed during the course of the programme from polio class to ‘fun class’, or *Masti Ki Kaksha*. These classes were run by CMCs with the help of class teachers, and included 25-30 children (aged 5-12 years). The CMCs used a toolkit containing creative and fun activities for children, which were designed to teach them about polio and safe hygiene behaviours, such as the use of toilets for defaecation, hand washing with soap, and keeping the environment clean.

- The fun classes were conducted once a month, whether the polio campaign was being held or not. The CMC and teachers would give children a colouring book that had black and white line drawings of activities and behaviours depicting healthy and unhealthy behaviours. Children were handed colour crayons/pencils and were asked to colour in one of the drawings. The mobiliser would then ask the following questions:

  1. What have you coloured in today?
  2. What have you understood from the colouring sheet?
  3. What have you learned today?
  4. What will you do with this information from now onwards?

- The community mobiliser would then identify some children as fun messengers or *Masti ke Doot*, who were made responsible for ensuring that the school premises were kept clean and dustbins were provided and being used. The *Masti ke Doot* were also tasked with ensuring that children washed their hands with water and soap before midday meals, and for checking the nails of children during school assembly. To support this, school authorities were requested to ensure that there were functional hand pumps or water facilities, and soap for hand washing.

- The children were urged to share the health and hygiene information with their families and neighbours and to encourage them to maintain health and hygiene in their homes and in their surroundings.
Another adaptation that was implemented during the course of the programme was the move from Polio Rallies to the Kukuru-ku rallies to promote immunisation, hand washing, and the use of toilets for defaecation.

- To establish a link between open defaecation and the spread of the polio virus, the idea was to organise a rally early in the morning when people go to defaecate in the open fields. However, the CMCs objected because it was too early for them, so it was decided to hold the rallies after 9 a.m.

- These were rallies with a difference, as there was no singing of songs or slogan shouting. Instead, the children would loudly make the sound of a rooster, kukuru-ku (cock-a-doodle-do), and hold up placards with messages on maintaining hygiene, hand washing, and promoting the use of their toilets/latrines to stop open defaecation. They would go to a central and busy location and hold up the placards so that more community members would be exposed to the messages.

Materials to Support Children’s Activities
Various materials and aids were developed for children to use during the rallies and classes:

- For the Bulawwa Tolis, bright yellow aprons, with matching blue and yellow cap, and colourful badges were developed to be worn by all the children taking part in the Bulawwa Toli.

- Banners with slogans were also prepared for children to carry along with them during the rally.

- Colouring books were developed for use by the children during the Masti ki Kaksha.

- Placards discouraging open defaecation and promoting cleanliness were also developed for use by children during the Kukuru-ku or rooster rallies.

Successes and Achievements
Child Participation

- Involving children to support the programme helped in creating awareness of polio vaccination and immunisation and instilled a spirit of volunteerism among school-going children. The children were enthusiastic, as their role gave them a sense of pride and importance. The involvement of children in rallies and Bulawwa Tolis was first started with government and private schools and soon involved the Madrassas as well. More than 1,000 schools were involved. Between 2007 and 2012, over 5,000 children participated in 29,683 rallies in 44 rounds of polio vaccinations (CGPP, 2012). Bulawwa Tolis were widely organised in all the areas. Since the children were from the same community, they had a big influence in establishing immunisation as a social norm.

Building Trust
The Bulawwa Tolis seemed to have provided a trusted and convenient way for parents to get their children immunised. There was little resistance from parents to sending their children with the Bulawwa Tolies to the booths for immunisation. Parents trusted these children because they were from their own community, and often they knew the child and her/his family. In fact, parents who were reluctant to trust health workers appeared to be far more willing to listen to children. Also, parents felt it was convenient to send their children with them, as they did not have to go to the booths themselves.

Booth coverage
Because of the Bulawwa Tolies, taking children to the booth for polio immunisation became a normative behaviour.
“On the Polio Sunday, ... most of the children who come to the booth are through the Bulawwa Tolies.” (CMC from Kashidham Block)

During field visits by the CGPP team, many CMCs endorsed the role of the Bulawwa Tolies in increasing booth coverage in their areas.

“The Bulawwa Tolies have played a big role in increasing booth coverage in our area. At the start of the programme, our booth coverage was about 50-55, but since Bulawwa Tolies’ involvement, the coverage has gone up to 80-88.” (CMC from Sardhana Block)

- This is corroborated by quantitative findings from 2016, which show that in areas covered by CMCs, 83 percent of children under 5 years received OPV at booths compared to only 44 percent in areas not covered by CMCs (CGPP, 2016). By extension, these statistics can also be applies to the impact of the children-run activities. Figure 11 shows how the programme had an impact on booth coverage from 2008 - 2016 (CGPP, 2016)

**Health and Hygiene Behaviour**

- More than 100,000 families were reached with health messages by 1,500 bands of children.

- In schools, the Masti ke Door ensured that all children would wash their hands before their midday meal. Because of this, the school authorities started keeping soap for children and ensuring that water was available for washing hands. Following the Masti ki Kaksha, most participating schools initiated ‘good personal hygiene’ practices and encouraged children to clean and comb their hair, clean their nails, and wear clean uniforms to school.

---

*Figure 11*

**Trends of Booth Coverage during SIA campaigns in districts covered by CGPP India, 2008-2016**

![Chart showing booth coverage trends](image)
Qualitative evidence shows that the knowledge children gained from the programme was passed onto the family and had an impact on health-related behaviour:

“Involving children as Masti ke Doot had a lot of effect not only for the Pulse Polio Programme but also in improving the health of the family and community. These children would tell their parents about the importance of hand washing and keeping their surroundings clean.” (CMC, Meerut)

“I listen to my children when they say we must cover our food. I know it’s a good behaviour and so I follow it.” (A mother of a child participant of Masti ki Kaksha)

“My children tell me that we must wash our hands with soap after defecation. I happily obey their instructions.” (A father of a child participant of the Kukuru-ku rally)

Reflected
Reflecting on the intervention with children, Rina Dey, CGPP BCC Advisor, felt that when working with children it is essential to keep the activities simple and fun-oriented. This may require that coordinators and workers unlearn how they interact with children and become creative and flexible to engage and maintain the attention of children.

“It should be fun-oriented – learning through play is very important as it makes it easy for children to grasp new information, believe in it and adopt the behaviours.”

Rina Dey also talked about the challenges they faced in their work with schools and how to overcome these, which may be useful to other agencies that want to involve school authorities and children for health promotion and behaviour change activities. She said, “As we did not involve teachers and school authorities in developing the microplans, or offer training for teachers to conduct the classroom activities, we were unable to give them responsibility to conduct the sessions instead of the CMCs. Therefore, the transition or transfer of knowledge and skills from the CMC to the teachers was limited. In future programmes, such a partnership should be done from the start - wherein the school and teachers should be given equal responsibility to feel like partners and own the change.”
“On booth day, *Bulawwa Tolies* play a big role in creating a festive atmosphere. At the start of the Pulse polio programme, very few children would come to the booth for polio drops.

Then it was thought that why not involve children to call parents to bring their children to the booths. Children were seen as non-threatening. Thus, this is how people started sending their children to the booth.”

*CGPP, Baghpat*
World Immunization Day
विश्व टीकाकरण दिवस
10 नवम्बर 2015
R.I. CAMP
Bamanpura

SAFETY FOR LIFE  IMMUNIZE
One of the key reasons polio eradication efforts in India were undermined was because of difficulties in consistently vaccinating children living in migratory families (Grassly, 2013). Since they were always on the move, they were often missed from routine and supplementary immunisation rounds, resulting in inadequate protection (Bandyopadhyay et al., 2013). In appreciation of the size of these mobile populations, in 2007, a comprehensive migrant vaccination strategy was introduced to target children of migrant labourers who travelled seasonally throughout India from U.P. and neighbouring Bihar (Orr, 2007). In 2008-09, the migrant populations were included under the expanded Underserved Strategy that provided common definitions and contextualised strategies for tracking, identification, coverage, and monitoring different underserved group (Deloitte, 2014).
Analysis of WPV1 cases from 2007-2009 showed that migrant populations played an important role in sustaining polio transmission across the country. Not only were more polio cases recorded among children from these migrant communities, they were also less well vaccinated compared to the general population. Therefore, occurrence of polio in these mobile communities posed a risk for continued circulation of WPV in the country. Thus, IEAG recommended the need to identify mobile communities and transit areas for inclusion in the operational plan and for SMNet to respond to emerging risk factors associated with migrant populations.

In 2007, a comprehensive migrant vaccination strategy was introduced to target children of migrant labourers who travelled seasonally throughout India from U.P. and neighbouring Bihar (Orr, 2007). Innovative strategies such as “transit vaccination”, in which OPV was administered to mobile and transitory populations, were also introduced.

**Designing the Intervention**

Target populations were divided into two categories - static or mobile populations. Mobile populations were categorised as High-Risk Groups (HRGs) owing to their high-mobility, low socio-economic status, poor nutrition status, poor hygiene and sanitation levels, and limited access to public amenities. They were identified and categorised as - nomads, construction workers, brick kiln workers, and slum dwellers. BMCs and CMCs were made responsible for the identification and mapping of these mobile populations, and for implementing the mobilisation activities that were tailor-made for each group.
Implementing the Intervention
Identifying Informers to Access HRGs
In the initial stages of the migrant strategy, tracking and mapping of migrant communities was difficult, as there was little knowledge of the different kinds of groups and their socio-demographic characteristics. The BMCs, with assistance from the CMCs, were responsible for mapping, enumeration, and data validation. The first step, therefore, was for the BMCs and CMCs to identify key informers, who interacted with migrant families. These informers were a valuable source of information on the location and movement of migrant families in the area (Coates et al., 2013). The informers included landlords, shopkeepers, barbers, security guards, property dealers, and social health workers such as ASHAs and AWWs. The main role of an informant was to identify and help connect BMCs and CMCs to the mobile populations. In addition, they were enlisted to provide information on newly emerging HRG locations and the movement of these communities. Regular meetings were held with informants to familiarise them with their role in the polio eradication effort, as well as to involve them in helping the vaccination teams during immunisation rounds.

Mapping the Sites
At the outset, efforts were focussed on mapping migratory populations in the area according to the type of site - nomadic, brick kilns, construction sites, and slums (See Figures 12 and 15). As these populations were constantly on the move, the maps were updated regularly and especially before every vaccination round (See Figures 2 and 3). Various markers and identifiers were used for the sites, such as a metal plate for numbering brick kilns. In addition to locating and mapping these populations, the BMCs and CMCs also tried to collect information about the numbers, socio-economic status, language/dialect, and employers of the mobile populations. This provided key information for developing detailed micro plans and for engaging mobile vaccination teams to reach these sites.

Partnering with Employers
In order to gain entry into the communities and build partnerships for carrying out programme activities, it was essential to connect with the employers at the construction or brick kiln sites. However, at the start, employers were wary of the social mobilisers and their interest in their workforce. They felt like they were being scrutinised around their adherence to labour laws. Some employers also felt that their workers may be ‘poached’ for work on other sites. At times, the BMCs were turned away by the security teams at
these sites. To address these concerns, the BMCs were entrusted to initiate dialogue with owners and associations of brick kiln workers, builders, developers, and employers to allay their fears and engage them as facilitators and influencers. In addition, meetings were held with employers and managers to introduce the CMCs and build a rapport by gaining their trust.

It was a gradual process, and required time to build these partnerships. Once these were established, some employers even provided additional support to the programme by offering space for setting up vaccination booths, aiding with logistics, and motivating their workers to take part in the booth day activities and to get their children immunised.

- For BMCs, building rapport with the employers of migrant workers was key to reaching these migrant communities. As stated by a BMC: “…tapping this population was very important for the success of our programme, and we did it.”

**Building Rapport with Mobile Communities**

With the help of the informants and employers, the CMCs made regular visits to the mobile sites in order to build a rapport with the community and understand their needs. They first familiarised themselves with the dialect/language spoken by the community in order to gain their trust.

They then held several meetings with various community members to understand their reasons for non-participation in polio vaccination drives. In some sites, the CMCs had to visit early in the morning or late in the evening to ensure maximum participation, as these were the time slots when they would most likely be available at their homes.

These interactions helped the programme planners realise that migrant communities were not resistant to vaccination, but that the low participation was more due to a lack of access to information and services. In communities that were not in the CMCs' assigned geographical area, the BMCs were responsible for reaching out to the communities.
Outreach and BCC Activities
To address the low levels of awareness about health needs and services, an emphasis was placed on effective communication and outreach activities among HRG communities. In addition to regular meetings and engagement with contractors and employers, meetings with community men and women were also carried out. For example, the CMCs organised mothers’ and fathers’ group meetings as well as IPC sessions to inform and raise awareness of various health- and immunisation-related issues.

These meetings and interactions were undertaken at a location and time convenient to the community. In areas where the CMCs could not reach, it was the BMCs who conducted the BCC activities. To ensure that basic health and sanitation services were made available to these communities, the CMC and BMC would inform the DMC, who would then advocate for these services with district health departments/officials.

The CMCs prepared lists of eligible children so that they could be registered for the immunisation rounds in order to ensure that not a single child was left out. When new families moved into the area after the vaccination rounds, their information was documented and forwarded by the CMCs to the immunisation teams, who would visit the community to vaccinate the children.

Immunisation Teams
The tracking information prepared by BMCs and CMCs was used to provide vaccination to children of migrant communities by either house-to-house immunisation teams or mobile teams specifically constituted for this purpose.

Since children usually accompanied their parents to their work sites, immunisation teams were also given information about the time when children were most likely to be available (at the worksite), either early morning or late evening. The mobile teams were specially constituted to reach remote, difficult-to-reach areas like brick kilns, nomadic populations, and construction sites.

Special immunisation teams were formed under the transit vaccination strategy to reach and vaccinate children of migrant populations at transit points such as railway stations, bus stations, check posts, border areas, marketplaces, religious gatherings, etc. CMCs would also enter buses and
trains at inter-city bus and train stations to give educational talks to migrant families and register their children for immunisation (Murphy, 2012).

**Materials Developed**

Specific communication messages and tools were developed for migrant communities. At first, they were provided with basic hygiene and sanitation messages, and were given soap strips and information on diarrhoea management. Then they received information on the importance and need for polio vaccination and RI. A slogan “Wherever you are, wherever you go, immunise your child against polio with two drops, every time” was developed, focussing on mobile and migrant families. To assist with this key message, families were provided with immunisation cards and card holders to help them track their children’s vaccinations, and to help link them to health services in the new areas they travelled to.

**Achievements**

- The tracking and mapping of mobile sites helped include mobile populations in the micro plans. More than 250,000 settlements with migrants were identified and covered by the CMGs.

- As per the NFSP monitoring data, all the efforts of mapping and reaching out to migrant families resulted in a decrease in the number of unimmunised children in mobile communities (IEAG, 2009).

- There was an increased awareness among migrant populations about health services and how to access them when on the move. Eight million children in transit were immunised in India during each round, of which 100,000 were in running trains.

- Involving key stakeholders and gatekeepers of migrant populations, such as employers, contractors, etc., helped to ensure that all children were immunised. As stated by a brick kiln owner:

> “When I got associated with the NGOs work and understood the need to immunise every child, I ensured it in my brick kiln.”

- For BMCs, building rapport with the employers of migrant workers was key to reaching these migrant communities. As stated by a BMC: “…tapping this population was very important for the success of our programme, and we did it.”

- As per a BMC who was key in building rapport with the employers of migrant communities, “tapping this population was very important for the success of our programme, and we did it.”

**Reflections**

Migrant families were the most challenging to reach and include in the programme. However, with the coordinated efforts of all the partners, accessing and immunising the children of mobile families was achieved.

Jitendra Awale, Deputy Director of CGPP India, is of the opinion that for any programme to succeed, it is very important to have a strong review and feedback mechanism for making mid-course corrections, if needed. He also added that one of the key aspects of working with migrant communities was the establishment of rapport with gatekeepers or informants in order to access these hard-to-reach populations.

In addition, he suggested that with changing technology, the paper tracking system that was designed for the Pulse Polio programme should be modified to use a mobile-phone-based tracking system. He stated that “Getting real-time data on movement of various migrant populations will help reach them faster and better. Thus, it is important to keep pace with changing and new technology. For this, programmes should plan and invest in these technologies from the inception stage.”
For any programme to succeed, it is very important to have a strong review and feedback mechanism for making mid-course corrections, if needed.

One of the key aspects of working with migrant communities is the establishment of rapport with gatekeepers or informants in order to access these hard-to-reach populations.
References


----. 2013. From 200,000 to Zero - The Journey to Polio Free India.


----. 2013b. Determinants of Performance of Supplemental Immunization Activities for Polio Eradication in Uttar Pradesh, India: Social Mobilisation Activities of the SMNet and Core Group Polio Project (CGPP). BMC Infectious Diseases.13:17

