

Social Mobilization

Lessons from the CORE Group Polio Project in Angola, Ethiopia, and India

By Elaine Murphy, PhD

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Abstract

The CORE Group Polio Project (CGPP) and its partners in India, Angola, and Ethiopia have led successful social mobilization efforts to reach difficult-to-access populations critical for polio eradication. These include extremely poor rural and urban communities, ethnic and religious minorities who resist immunizing their children, and others such as newborns, pastoralists, migrants, and those in transit across national borders. Working through grassroots nongovernmental organizations (NGOs), CGPP social mobilization activities have contributed to the current polio-free status in all three countries and have improved the coverage of children’s routine immunizations as well. Marking a shift from the earlier dominance of epidemiological perspectives, today behavior-change communication — advocacy, interpersonal communication, and social mobilization — is recognized internationally as the way forward in this final phase of polio eradication.¹ This shift is reflected in WHO’s May 2012 Global Polio Emergency Plan: 1) Establish/scale up social mobilization networks at community level in infected areas; 2) Undertake systematic monitoring to identify and understand the social reasons for chronically missed children; 3) Build interpersonal skills to enhance vaccination performance, including addressing reticence and refusal; 4) Apply best practices for reaching high-risk and chronically missed children (e.g., migrant and underserved); 5) Re-energize public support, motivate vaccinators, enhance ownership of key stakeholders (media, physicians), and increase local leader accountability; and 6) Apply to routine immunization lessons on identifying and reaching missed children, especially among underserved, mobile, and minority populations.

This report places CGPP within the context of the Global Polio Eradication Initiative (GPEI) that began in 1988, defines and describes three varieties of social mobilization, and presents as case examples CGPP’s successful social mobilization work in India, Angola, and Ethiopia. It is intended for those interested in best practices to move polio eradication from its current 99.9 percent success rate to 100 percent, and all who want to “reach the hardly reached” with routine immunization, new vaccines and other life-saving maternal and child health services.

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CORE Group emerged organically, in 1997, when a group of health professionals from non-governmental development organizations realized the value of sharing knowledge, leveraging partnerships, and creating best practices for child survival and related issues. Fifteen years later, we have evolved into an independent non-profit organization with 60+ Member NGOs, Associate Organizations and Individual Associates. This group works in 180 countries, collectively reaching over 720 million people every year — one tenth of the world's population.

Much of our dynamism is generated through our lively *Community Health Network*. CORE Group builds on the energy and knowledge of the *Network* to take on additional efforts: we run a Practitioner Academy for Community Health, design and administer community health grant programs, advocate for community health approaches, and develop technical guidance and tools — like this report. Learn more, and access our free resources and webinars at www.coregroup.org.

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Acronyms and Abbreviations

ASHA	Accredited Social Health Activist
BCG	Bacille Calmette Guerin
BMC	Block Mobilization Coordinator
CCRDA	Consortium of Christian Relief and Development Association
CDC	US Centers for Disease Control and Prevention
CGPP	CORE Group Polio Project; CORE Group Polio Partners
CMC	Community Mobilization Coordinators
CVSFP	Community Volunteer Surveillance Focal Point
DTP	Diphtheria, Tetanus, and Pertussis
GOA	Government of Angola
GOI	Government of India
FMOH	Federal Ministry of Health
GPEI	Global Polio Eradication Initiative
HEW	Health Extension Worker
ICC	Interagency Coordinating Committee
MOH	Ministry of Health
NGO	Nongovernmental Organization
OPV	Oral Polio Vaccine
PVO	Private Voluntary Organization
RI	Routine Immunization
SIA	Supplemental Immunization Activity
SM	Social Mobilization
SM Net	Social Mobilization Network
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization

Table of Contents

I. Introduction: The Global Polio Eradication Initiative	1
A. We are Nearing the Finish Line	1
B. What Will it Take to Cross the Finish Line?.....	3
II. What is Social Mobilization?	4
A. Pragmatic SM	4
B. Activist SM	5
C. Hybrid SM	5
III. The CORE Group Polio Project (CGPP): SM Plus	7
A. Social Mobilization In India	7
B. Social Mobilization in Angola	14
C. Social Mobilization in Ethiopia	18
IV. Lessons learned: Insights for future planning	24
V. Recommendations	27
Recommended print and online resources	28
Endnotes	29



I. Introduction: The Global Polio Eradication Initiative

A. We are Nearing the Finish Line

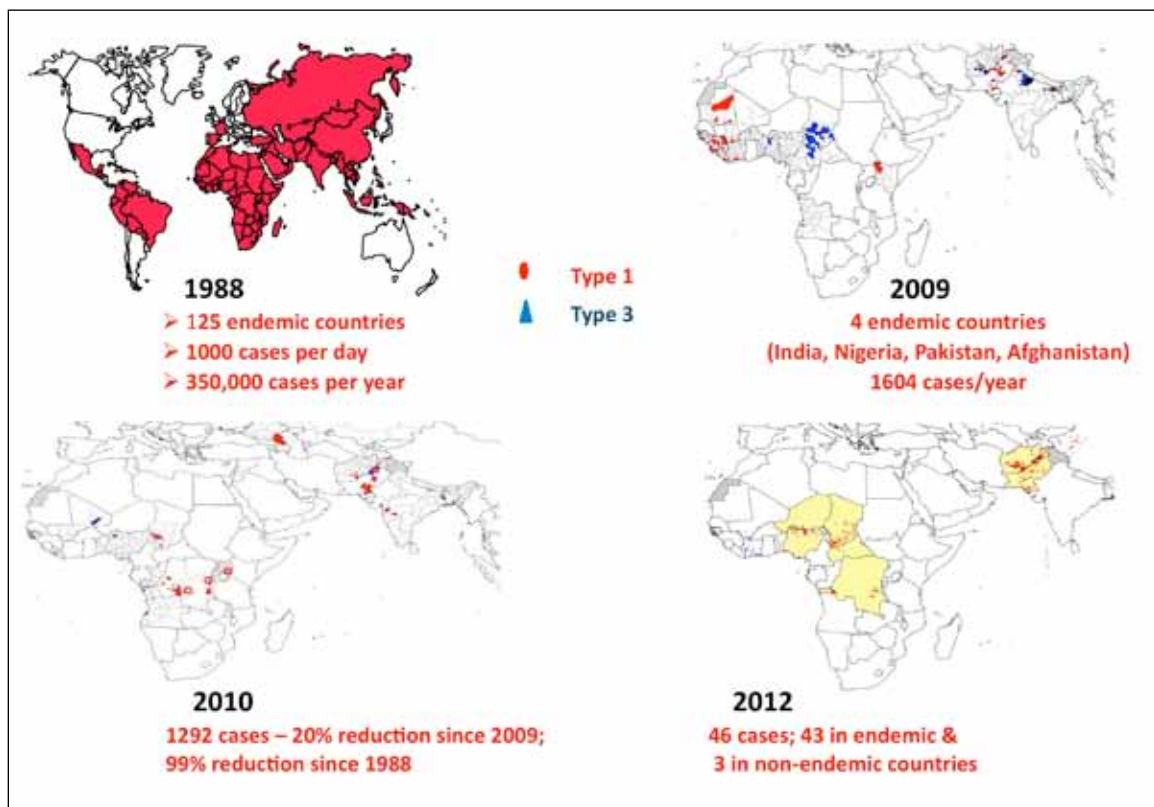
We have almost won the race against polio. The situation today is dramatically different from 1988 when the Global Polio Eradication Initiative (GPEI) began. At that time there were 125 countries where polio was endemic and polio killed or paralyzed over 350,000 each year. Now it is endemic in only three countries: Afghanistan, Nigeria, and Pakistan. Clearly we are nearing the finish line: massive investments to eradicate polio throughout the world have been almost 100 percent successful. But “almost” is not good enough for a virus that can be imported into previously polio-free countries, flare up again, and spread rapidly. For this reason, the director-general of the World Health Organization (WHO) recently said that the battle against polio is at a “tipping point between success and failure” and in May of 2012 the 194 member states of the WHO declared polio eradication a programmatic emergency. If polio exists in even one country, the rest of the world is at risk. This became glaringly obvious in northern Nigeria:

In 2004, the global polio eradication initiative, after spending more than US\$3 billion and involving some 20 million volunteers over a period of 16 years, was placed at risk of failure by the actions of one local administration. In the Kano state of Nigeria, local leaders claimed that the polio vaccine was tainted with the AIDS virus and sterility drugs and declined to participate in a national immunization day program. The European Union then declined to pay for the national program in Nigeria believing the money would be wasted. **One consequence was the subsequent spread of polio to nine formerly polio-free countries.** [Emphasis added.] Concerted efforts by WHO later persuaded local leaders in Nigeria to rejoin global efforts but special vaccination programs had to be launched over a population area of more than 300 million persons. This situation dramatically illustrated the vulnerabilities inherent in a weakest-link public good.

— *Disease Control Priorities in Developing Countries*, World Bank, 2006²

Thus, the major players in global health have come together to eradicate polio once and for all — WHO and its country members, UNICEF, the US Centers for Disease Control and Prevention (CDC), Rotary International, USAID, the World Bank, the Bill & Melinda Gates Foundation, other donors, and many NGOs, medical institutions, and the private sector. The CORE Group, a coalition of 60 U.S.-based private, voluntary organizations (PVOs) and other nongovernmental groups whose common goal is to improve the health of mothers and children, is playing a significant role in these efforts through its CORE Group Polio Project (CGPP). Working through grassroots NGOs in developing countries, CGPP and its collaborating partners have made significant contributions through strategic social mobilization in high-risk communities, most notably helping to achieve the current polio-free status of India, Angola, and Ethiopia. Applying lessons learned from these case examples could make a critical difference in other countries. Such lessons would also greatly inform other programs that seek to engage the whole community in order to make a transformative change.

Progress in Polio Eradication: 1988–2012



Source: WHO 17 04 2012

B. What Will it Take to Cross the Finish Line?

Although one celebrates the remarkable achievement of reducing worldwide prevalence of polio cases by over 99 percent in less than 25 years, there is no guarantee of reaching the finish line. The situation may be akin to an ocean liner that has efficiently crossed the sea but cannot navigate up the river to reach its final destination. The rest of the journey may well be the hardest. Why? Although routine immunizations against childhood diseases (including polio), supplemented by well-organized National (and sub-national) Immunization Days, are responsible for the success to date, there are still many children who are not fully immunized. Therefore reservoirs of the poliovirus remain. Who are these children? Where do they live? What will it take to complete the job?

The poliovirus persists among populations who are largely unreached by health services, including polio and other vaccinations. These may be groups who are geographically hard to reach such as migrants, pastoralists, and people living in remote locations. Or they may be socially marginalized and “hardly reached,” i.e., underserved by health systems and other government programs: very poor communities and members of religious and ethnic minorities. Many of these groups have little or no trust in government and may be actively or passively resistant to immunizations of any kind. Reaching these poor and socially marginalized children is critical not only for polio eradication but for wider child survival efforts. This point was emphasized at a June 2012 summit in Washington DC, the “Global Call to End Preventable Child Deaths by 2035,” where health leaders from around the world pledged to take stepped-up and more strategic action against preventable childhood diseases.³ Among the strategic actions recommended is social mobilization.

After many years of experience in polio eradication, a consensus has emerged that reaching high-risk and unconvinced populations calls for intense and varied social mobilization efforts and that the role of NGOs, largely ignored in earlier days of GPEI, is critically important. Underserved communities are more likely to respond positively to grassroots NGOs because they have a history of serving community needs, their outreach workers come from the communities they serve, and they engage highly respected community leaders as integral parts of social mobilization efforts.

The accomplishment of India, Angola, and Ethiopia in being free of polio cases for more than a year (since 2008 in Ethiopia) is largely attributed to successful social mobilization efforts of NGOs in reaching underserved populations. Local, research-driven strategies such as incorporating imams as spokespersons for vaccination, and relying on lay workers to track child immunization and perform defaulter and newborn follow up were key.

CGPP — working through its in-country PVOs and grassroots NGOs in coordination with the government and other organizations — has made a major contribution to the success of all three countries.⁴ At the heart of the project is its variety of creative and tailored social mobilization activities.



II. What is Social Mobilization?

Social Mobilization (SM), as defined by UNICEF, is a broad-scale movement to engage people's participation in achieving a specific development or health goal through self-reliant efforts — those that depend on their own resources and strengths. It involves all relevant segments of society: policymakers and other decision-makers, opinion leaders, the media, bureaucrats and technical experts, professional associations, religious groups, the private sector, NGOs, community members, and individuals. It is a planned decentralized process that seeks to facilitate change through a range of players engaged in interrelated and complementary efforts. It takes into account the felt needs of the people, embraces the critical principle of community involvement, and seeks to empower individuals and groups for action. Mobilizing the necessary resources, disseminating information tailored to varying audiences, generating intersectoral support, and fostering cross-professional alliances are part of the process.⁵

While UNICEF offers a clear if optimal description of SM, a groundbreaking paper by Obregon and Waisbord notes that in practice there are many interpretations of what SM is and examples of what is labeled SM in many projects differ dramatically. This lack of clarity in defining SM contributes to ambiguity, inconsistencies, and difficulties in identifying essential features or models of SM.⁶ Their analysis of the literature, case studies, interviews and on-the-ground observations led them to identify three kinds of social mobilization used in polio eradication efforts: pragmatic SM, activist SM, and a hybrid SM that combines both pragmatic and activist elements. Understanding these categories can be helpful in designing and evaluating health programs that include SM.⁷

A. Pragmatic SM

Pragmatic approaches, as the name implies, are practical ways in which health programs can utilize community groups and leaders to pass along important information to intended beneficiaries and assist the program in performing other important tasks needed to achieve program goals. Pragmatic SM seeks to involve community actors as instruments to help achieve predetermined goals such as immunizing all children against polio; their support and activities will maximize the reach of eradication efforts. In polio eradication work, this may entail meetings with political, community, and religious

leaders to obtain their cooperation and prepare them to communicate polio messages to their constituencies; training outreach workers to go door-to-door to persuade caregivers to bring their children to the vaccination booths during campaigns; or involving the community in surveillance and reporting of polio cases.

These and related activities, when part of well-designed and implemented projects, have been very successful in increasing the number of children immunized and thereby reducing the number of polio cases. Pragmatist SM works particularly well in situations where there is a lack of information about why and where to immunize children or encouragement by home visitors and media messages will motivate caregivers fairly readily. However, these approaches are seldom enough when there are populations resistant to polio immunization. Nor would pragmatist approaches be likely to sustain the motivation of key community actors to continue undertaking polio or other child survival activities after a project ends.

B. Activist SM

Community ownership characterizes activist SM. In its pure form activist SM refers to the wresting of decision-making power from global or national direction to local communities who identify their own goals and strategies. An underlying challenge of this approach is that it may be threatening to governments to encourage marginalized populations to become advocates for their rights. NGOs facilitating true activist SM might expect resistance from the government. Nevertheless, activist SM has the potential to produce a much more lasting change than pragmatic SM alone. Examples of successful activist SM occur throughout the world but on a small scale: communities have taken action to demand and contribute to improved water and sanitation in their local environment, arrange their own transportation system for health emergencies and pool their money as a form of local health insurance.⁸ As applied to polio eradication, activist SM would mean that communities take charge of and adapt the national immunization program to meet their own needs, or in some cases such as in northern Nigeria, organize widespread opposition to polio immunization. Many pragmatist SM efforts evolved to add activist SM features because pragmatist approaches have limitations: even though cordial and cooperative liaisons are formed, it is essentially a top-down process and thus does not usually benefit from the insights, suggestions and strategies that would emerge if community actors became true partners rather than information conduits.

C. Hybrid SM

As desirable as the empowerment of communities to solve their own problems may seem, purely activist SM is not feasible in a global program to eradicate polio. It is unrealistic to expect communities in every



“One cannot expect positive results from an educational or political action program which fails to respect the particular view of the world held by the people. Such a program constitutes cultural invasion, good intentions notwithstanding.”

— Paulo Freire,
Pedagogy of the Oppressed,
1968⁹

part of the world to identify polio eradication as a high priority and then marshal the commitment, resources, and strategies to immunize all their children. What has emerged over time is a blend of pragmatist and activist elements — a hybrid form of SM — that is characteristic of the most successful polio eradication efforts. Where once community leaders were simply asked to pass along messages to their constituencies, now their ideas and strategies to reach the hardly reached are solicited and put in motion. Community leaders and members have become engaged partners in planning, implementing, and evaluating activities; goals and methods are negotiated rather than merely accepted and carried out. Polio planners have also responded to the extent possible to community demands that services go beyond provision of oral polio vaccine (OPV) and in some cases more holistic health programs were the outcome.

Work with the media also was transformed over time as polio planners realized that the media are community actors too and must be engaged actively; they have their own viewpoints and often reflect community sentiment. Initial efforts had considered media outlets merely as information channels and this sometimes had unexpected negative consequences, e.g., “bad press” for polio campaigns in northern Nigeria. Programs also came to realize that interpersonal communication is more effective than mass media in bringing about positive behavior change among hardly reached and resistant households that have not responded positively to more general, mass media messages. Programs evolved so that the role of community social mobilizers, family visits, and engagement of religious and other influential leaders as partners became the central and most successful SM strategy NGOs used to increase immunization of children.¹⁰

Finally, programs realized that the presence and voices of women were crucial if polio was to be eradicated. Where vaccination teams previously had been all male, women SMs now reach out to women caregivers. Women are admitted to households where men cannot enter and are more likely to be perceived as sympathetic and trustworthy than men. In addition, women now play leadership, management, and supervisory roles in the polio program. At the community level, programs engage with both women and men leaders as genuine partners. Seeing women actively involved in the fight against polio, including serving as program leaders, may also inspire women in male-dominated societies; research has found that disempowered women are less likely to get their children immunized.¹¹

Hybrid approaches combine the best of both pragmatic SM (organizing and coordinating activities) and activist SM (tapping the power and insights of the community). Combining them has resulted in greater success in reaching and immunizing children in high-risk populations. As one example, activist SM can give NGOs new insight into the community, especially on the reasons behind resistance and barriers to polio immunization on which they can build pragmatic responses.



III. The CORE Group Polio Project (CGPP): SM Plus

In every country where it works, CGPP’s field work exemplifies a successful hybrid of pragmatic and activist SM. SM is the centerpiece, but is not the only important feature of CGPP; one might call its approach “SM plus.” CGPP also contributes funding, technical guidance, various forms of support to government health systems, research and evaluation, and joint planning and coordination of activities with national and international collaborating groups — all aimed at strengthening host country efforts to eradicate polio and improve routine immunization. The project brings together several CORE Group PVO member organizations to implement the **CORE Group Secretariat Model**, a time-tested mechanism for increasing collaboration, coordination and equitable sharing of resources. A **U.S.-based Secretariat** serves as a global partnership liaison and provides overall technical assistance and financial management to the country teams.

Central to the model and to each CGPP country site is an **in-country Secretariat**, staffed by a small number of neutral technical advisors not employed by any of the CORE Group partner PVOs. The in-country Secretariat facilitates communication, coordination, and transparent decision-making among all PVO partners. It also unifies the community-level expertise of the PVOs and their local NGO affiliates with the international expertise and strategies of the Global Polio Eradication Initiative partners such as WHO, UNICEF, CDC, Rotary, and national governments. CGPP does not work independently from the host country’s polio eradication plans and policies: it is part of the country plan. CGPP leaders participate officially on formal, government-sponsored bodies to review and revise high-level strategy, give feedback from the field, and conduct collaborative planning in response to government needs.

A. Social Mobilization In India

1. Background

India had long been considered one of the toughest places in the world to eradicate endemic polio. As recently as 2009, India reported 741 polio cases, more than any other country in the world. But in

Who are the hardy reached?

Social mobilizers and vaccinators must make extraordinary efforts to reach:

Children in geographically remote areas

Newborns and infants

Children who belong to ethnic, religious, and other minorities

Street children and children in work places

Migrant children, children in transit, and children in nomadic groups

Children living in urban slums, children of squatter and internally displaced families

Children living in high-rise buildings

Children of elites and children of people employed by elites

— Ellyn Ogden, USAID. Polio Eradication: Child to Child¹²

http://transition.usaid.gov/our_work/global_health/mch/news/photogallery/polio/polio03.html

January of 2011 India reported its last case and one year later WHO declared India polio-free. It is now in the three-year certification phase of polio eradication, as are Angola and Ethiopia. Certification of polio eradication is conducted on a regional basis. Each region can consider certification only when all countries in the area demonstrate the absence of wild poliovirus transmission for at least three consecutive years in the presence of certification standard surveillance.

This remarkable achievement is the result of years of hard work and dedication by the Government of India (GOI) and the many groups that joined the fight against polio in India, including CGPP and its extensive social mobilization program. Ellyn Ogden, USAID Worldwide Polio Eradication Coordinator, has called it “a triumph of coordination.”¹³ India’s primary strategy to end transmission of wild poliovirus has been to increase the percent of children who are fully immunized with OPV through both supplemental immunization activities (SIAs — immunization campaigns) and routine immunization (the usual childhood series of vaccinations, including polio) in high-risk areas. This therefore became the focus of CGPP work.

2. CGPP in India

CGPP’s India Secretariat is located in New Delhi and consists of a team of four independent consultant advisors. It operates through three CORE Group PVO members — Project Concern International, Adventist Development and Relief Agency India, and Catholic Relief Services — and 11 in-country NGO partners. Since 1999, CORE Group polio partners have worked tirelessly to achieve the GOI goal of immunizing every child and have contributed significantly to these efforts in the state of Uttar

Pradesh (UP), one of the last strongholds of the poliovirus in India. It works in 56 blocks (jurisdictions consisting of 100–150 villages, towns, and some urban areas) within ten high-risk districts in UP, reaching annually more than 1.7 million children under 15 years old.

Before CGPP India reached out to the hardly reached, it began with detailed formative research. This started a continuous research process, the results of which are used to implement real-time adaptation to tailor programming to community need. Research has included household surveys; discussions and interviews with community members; feedback from knowledgeable informants such as local NGOs, health officials, and community leaders; findings from government reports, academic research studies, and information from the polio Interagency Coordinating Committee (ICC) and other collaborative bodies of which CGPP is a member. CGPP acted on an essential principle: understand the people you serve and the context of their lives. CGPP undertook systematic enumeration and tracking of children under five years old in high-risk areas (utilizing Ministry of Health [MOH] lists and forms), discovered the varied reasons why children were not being vaccinated and then followed up with highly focused and coordinated social mobilization activities. Throughout this process the CGPP Secretariat liaised with district and local health officials and the government vaccination teams who immunize children at facilities and SIAs.

3. The social mobilization network (SM Net)

To reach high-risk populations, CGPP has joined with UNICEF and the National Polio Surveillance Project to deploy an extensive network of Community Mobilization Coordinators (CMCs), frontline workers who interact with their own community. CGPP CMCs and UNICEF CMCs together make up the Social Mobilization Network; they use similar approaches but in different geographic areas. Representatives from the three organizations jointly lead SM Net and serve as the formally recognized body responsible for determining the strategies to reach resistant and underserved populations in endemic areas of the country. Women make up the majority of CMCs, although there are some men in this cadre as well. They receive training, coaching, and supportive supervision from block mobilization coordinators (BMCs), who in turn are guided and supervised by District Mobilization Coordinators. CMCs work at the grassroots level visiting households and counseling families on a regular basis. In rural areas, each CMC maintains contact with 500 families; in urban slums the CMC works with 300 families. The SM Net coordinates its work with district and local governments, Rotary International, and other groups.

4. Social mobilization activities in India

The CMCs undertake a variety of strategically related social mobilization activities in their assigned areas and also participate in training sessions to improve their skills:

- **Tracking children.** CMCs track the immunization status of all children under 5 in high-risk areas using health system and SIA records. This results in micro-planning with district and local MOH staff, community leaders, and BMCs to identify the best ways to reach the unimmunized children.
- **Visiting homes.** Activities begin with home visits to educate caregivers of unimmunized children about OPV and engage them to fully immunize their children. CMCs first target families furthest from routine immunization points, resistant in the last SIA round, and where a newborn resides,

and then secondarily any home behind schedule on routine immunization, and finally households fully up-to-date on vaccination. Visits provide CMCs an opportunity to gain more information about barriers to immunization that they may not have previously understood. They can then use this information to tailor messages and interventions. Home visit is the first strategy because some caregivers might simply need information about when and where vaccination booths will be set up during SIAs or how to access routine immunization. Or they are not convinced of the value of polio immunization but might change their minds when CMCs provide information on the importance and safety of OPV. CMCs gently correct misinformation and reassure parents that vaccines do not affect fertility. They stress that newborns should be immunized against polio as soon as possible and that it is fine to immunize sick children. If repeated home visits do not work, CMCs try other strategies such as bringing to the home the caretaker's friends and relatives who have immunized their children. These "positive deviants" have proved to be very convincing. CMCs also involve influential community members.

- **Engaging influencers.** Involving high-level community leaders as champions for a cause has been an effective behavior change strategy throughout the world,¹⁴ CGPP made it central to SM activities.

In Muslim neighborhoods families have been particularly resistant to immunizing their children. They may believe that Islam is against immunizations or an imam may have spoken out against polio immunization. In such instances, high-level Islamic leaders who are involved as community partners have taken action. Although not directly confronting those giving negative messages, they make positive statements about polio immunization from the pulpit (*minbar*) or from mosque loudspeakers and also give information on when and where children can be vaccinated. In group meetings called *Ijtemas*, held separately for men and women, both male and female leaders use exhortations from the Koran and the Haddiths to stress the obligation of parents to protect the health of their children. CMCs are often invited to speak at these meetings and are trained to do so. Many Muslim leaders also visit the homes of resistant caregivers to counsel them to immunize their children. The authority of male religious leaders combined with women's trust in female CMCs is a powerful combination. Young women CMCs also have an opportunity to gain influence, respect, and visibility in their communities.

In non-Muslim areas, CMCs engage with Hindu and Christian religious leaders, who then speak in favor of immunization in their sermons and in other gatherings. CMCs also involve local political leaders such as members of the *panchayat* (town council) and other civil society leaders in the fight against polio and other vaccine-preventable diseases. These leaders then encourage their constituencies to immunize their children and also visit homes of caregivers when necessary.

CMCs and often their supervisors escort religious and other influential persons when they visit resistant homes. Visits from such influentials have been very successful. In addition, Muslim and Hindu religious leaders have become so convinced of the importance of immunization that mosques and temples often offer space to vaccinators to set up booths in their premises.

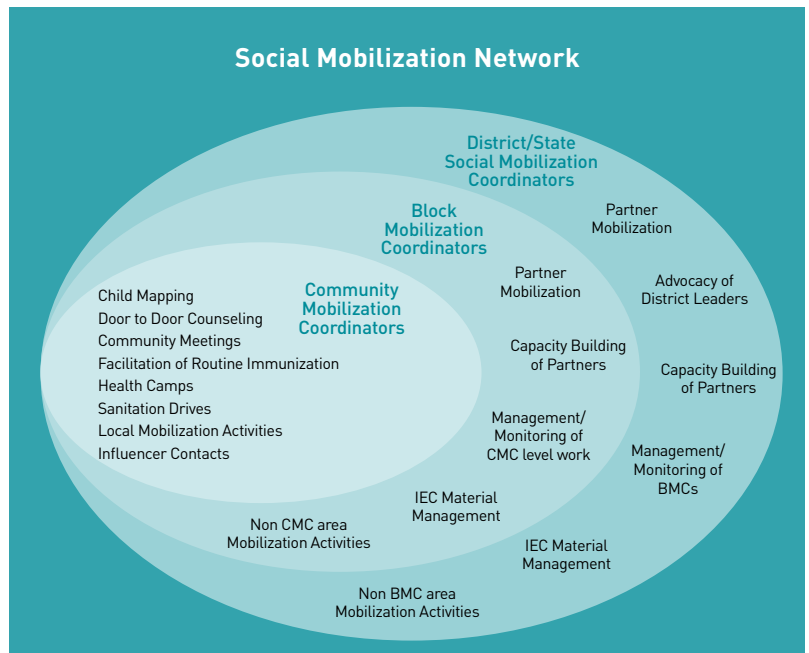
- **Involving community groups and individuals.** CMCs meet with women's groups and other community-based organizations to share information about SIAs and routine immunization and enlist their support in spreading the word. Female CMCs organize daytime gatherings of mothers to encourage them to immunize their children and male CMCs or male influencers organize gath-

erings of fathers when they return from their fields or shops. In addition to religious and other leaders, almost everyone in the community has played an active role in the campaign: *haj* returnees (devout Muslims who have made a pilgrimage to Mecca); traditional healers; ration dealers, who distribute food to the poor; barbers; tea shop owners; government workers; brick kiln owners; local businessmen; school teachers and students.

- **Working with schools and students.** Partnering with school teachers and students has extended the reach of CMCs' work. CMCs

give classroom talks to educate children about the importance of polio immunization and routine immunization against other childhood illnesses that have affected their community. They urge students to share this information with their parents and neighbors and encourage them to bring children under five to the vaccination booth during SIAs. CMCs sponsor school essay and art contests on polio themes. Schoolteachers help by organizing school rallies, including at Muslim religious schools. They also organize *bulawa tolis*, child brigades who bring caregivers and children to the vaccination booth during SIAs, all the while calling out to mothers, singing songs about immunization, wearing project caps, and waving flags. Involving children as mobilizers is a colorful and effective way to increase coverage, educate the next generation, and instill a spirit of community service that can be tapped for other child health problems.

- **Putting community creativity to work.** Many community members have artistic talent and CMCs contact them in advance of SIAs to organize street theater, dancing and singing events, and art shows that convey polio messages. CMCs themselves often put on "polio skits" and set up immunization information booths during festivals or fairs.
- **Broadening the scope.** Some caregivers and community leaders complain about polio-only campaigns because they have many other health and development needs that have been ignored. In response, CMCs' messages include the importance of routine immunizations so that children will also be protected against measles and other vaccine-preventable childhood illnesses; the importance of hand-washing and better sanitation; using oral rehydration therapy during children's diarrheal episodes; and making sure children get enough Vitamin A in their diet and from supplements available at health centers.
- **Reaching the hardest-to-reach.** In the case of India, newborns and mobile populations are the most difficult to find. However, CGPP developed strategies to ensure that they are included in the immunization program.



- **Tracking newborns.** Newborns are a special focus and the use of lay workers to identify and track them was an important asset. CMCs identify and meet with pregnant women and mothers of newborns with greater frequency than with mothers of older children to emphasize the importance of a birth dose of OPV and follow-up with all required OPV doses plus routine immunization. They ask about pregnancy status during home visits and neighboring women's pregnancy status. They contact traditional birth attendants who are knowledgeable about who is pregnant or a new mother. CMCs give talks to mothers-in-laws and grandmothers on the importance of the OPV birth dose because they have great influence over their married sons and daughters.
- **Reaching mobile populations: migrants, border crossers, pastoralists and seasonal workers.** CGPP makes extra efforts to find these populations on the move and ensure that their children are immunized.

“The most important thing is listening to our clients and caring about them. They are just like us — people who want the best for their children.”

— Dr. Roma Solomon,
Secretariat Director,
CGPP India

Pastoralists visit towns periodically to sell their goods and pick up supplies; CMCs work with knowledgeable informants who give regular updates on the families who have come in from outside or those that have returned. This permits the CMCs to reach them to register their children for immunization sessions and ensure that they have government immunization cards that they can carry with them wherever they go. All brick kilns, set up seasonally and manned by migrants, are registered and eligible children lists are prepared so that they can be linked to an SIA session and not a single one is left out. CMCs also reach migrant families at inter-city bus and train stations — and even enter the buses and trains to give educational talks and register children. Particular strengths of the GOI polio program were the systematic enumeration and tracking of children, comprehensive recordkeeping, and a pervasive surveillance system that relied on local staff, such as the CMC. These efforts contributed to program success, including with hard-to-reach populations.

5. Related Activities

- **Training and mentoring.** BMCs train CMCs in interpersonal communication (IPC) so that they express sincere friendliness and helpfulness to often skeptical or suspicious caregivers, while conveying accurate and reassuring information. Through talks, role plays, and guidelines, CMCs learn the importance of asking about the caregivers' health and well-being and taking the time to listen to them. They learn how to dispel rumors and misinformation respectfully. Through training, CMCs also learn how to approach and work with leaders, peers of resistant caretakers, mothers-in-law, and other influencers. They learn negotiation skills and how to conduct effective meetings. Refresher training, supportive supervision — including supervisors accompanying CMCs to homes and group talks — and self-criticism sessions with other CMCs reinforce IPC skills. CMCs also receive training in record-keeping and acute flaccid paralysis surveillance. Morale among CMCs, who are paid fulltime workers, is high and there is very little turnover. Because they work in their own village, where there are few public roles for women, the satisfaction of working visibly with community leaders to advance public health is highly motivating.

- **Working with the mass media.** An important communication challenge is notifying the community of the date and place of the SIAs — and reassuring families that OPV is important and safe. CGPP and other partners collaborate with radio and television officials to mount intensive media campaigns, including radio talk shows featuring community leaders to convey this general information.
- **Developing and pretesting materials** such as posters and pamphlets. CGPP develops, field-tests and distributes a variety of materials for use throughout the community — different materials for different groups. For example, it gives a handout with “frequently asked questions” to literate individuals, group members, and leaders. For home visits, CMCs use a ring binder with positive statements about OPV from religious and other community leaders to show and read to caregivers. CMCs generally have ten years of education and can read, but receive training on how to use practical demonstration techniques and interactive materials such as pictorial board games and story cards.
- **Integrating activities with the local health system.** CMCs and BMCs extend the reach of government health facilities by aligning their SM activities to promote polio immunization and routine immunization. This alignment includes timing, content, and materials. They coordinate their work with local auxiliary nurse-midwives and the new cadre of Accredited Social Health Activists (ASHAs) and add value to their training. For example, when auxiliary nurse-midwives train the ASHAs to give immunizations, CGPP staff lead the sessions on IPC. CGPP provides assistance for cold chain logistics for routine immunization and gives feedback on ways to improve the quality of SIAs. MOH and CGPP merge their lists of missed kids and share tracking forms. CMCs assist the vaccination team by monitoring coverage during SIAs and following up with routine immunization defaulters. They also refer caregivers to local health posts for other life-saving child health interventions and reinforce health workers’ messages about hand washing, sanitation, and oral rehydration therapy.
- **Capitalizing on trust during SIAs.** CGPP literally “opened doors” for the MOH vaccination teams. These teams had not been received well in door-to-door outreach and in some instances were chased away with sticks. People were wary of the government “pushing” polio immunization since they felt their other important needs were ignored. But the CMCs were from the community and were welcomed and trusted by caretakers. They recommended cooperation with the government vaccination teams and subsequently uptake of polio and routine immunization increased significantly.

A peer-reviewed research article¹⁵ and the USAID mid-term evaluation of the project¹⁶ both found that CGPP social mobilization in Uttar Pradesh had made a significant and positive difference. In the high-risk areas where CGPP social mobilizers worked — where immunization rates had been extremely low because of underserved and resistant populations — polio immunization coverage improved dramatically. It reached levels that were as high, and for the most part even higher, than the comparison low-risk areas. The project has received both national and international recognition. The GOI has invited CGPP to work in Bengal even though it is not one of its catchment areas. In addition, high-level delegations from Pakistan and Afghanistan have visited CGPP India to learn about the project’s strategies and to go on site visits. This is important because Pakistan and Afghanistan are two of the three remaining polio-endemic countries in the world, the third being Nigeria.

B. Social Mobilization in Angola

1. Background

Angola is one of many African nations with high fertility and infant mortality rates. Almost half its population of 20 million people — 48 percent — is under age 15.¹⁷ Although it is committed to eradicating polio in the country, immunizing all of Angola’s children has been a challenge for the MOH. In addition, a weak surveillance system has meant that polio cases often go undetected and/or unreported and consequently the government is not able respond in time to prevent spread of the poliovirus. For example, the year before CORE Group polio activities began in 2001, there was a major outbreak of over 1,000 cases, clustered in the capital city of Luanda. Given that less than one percent of people infected with the poliovirus show signs of acute flaccid paralysis, the most visible symptom of polio, this meant that the highly contagious poliovirus was widespread in this city. Among African countries, Angola is one of the most urbanized (59 percent urban). This concentration of people means that the poliovirus can spread very rapidly.

Following the serious outbreak in 2000, there were four polio-free years. Then in 2005 there was another outbreak, unfortunate not only for Angola but for six other countries that were re-infected due to border crossings.¹⁸ Since that time, Angola has made steady progress and there have been no cases since July 2011. Angola is now considered polio-free, but certification of polio eradication will take three to five years of careful surveillance for acute flaccid paralysis. The fact that as of June 2012 there were still 450,000 children who had not received even one polio immunization dose is worrisome should polio cases crop up during this process.¹⁹

2. CGPP in Angola²⁰

The CORE Group began its social mobilization program to reach difficult-to-access and underserved populations in 2000. From the beginning, the CORE Group Secretariat and PVOs worked in cooperation with the other major players working in Angola to eradicate polio through SIAs and improved access to OPV through routine immunization. Partners included the MOH, provincial and district health systems, and multilateral organizations such as WHO, UNICEF, and Rotary International. Social mobilization, centered on high-risk communities, was the main strategy of the first CORE Group project, and that focus continued when the follow-on CGPP began in 2007. Based on the recommendations of a USAID external review,²¹ CGPP built on the achievements of the earlier project and stepped up its efforts to improve the quality of SIAs, continue defaulter tracing to ensure a complete series of OPV in each child’s first year of life, explore reasons for higher-than-expected resistance, and increase awareness of acute flaccid paralysis among caregivers and community leaders.

The CGPP Secretariat is located in Luanda and is staffed by independent technical advisors. The Secretariat sets the strategic direction of the project and coordinates the work of six US-based PVO partners — Africare, CARE International (former partner), Catholic Relief Services, Salvation Army World Services Office, Save the Children (former partner), and World Vision. In addition, it represents the PVOs at the Inter-agency Coordinating Committee and other institutional planning bodies in

Angola, ensures that PVO activities support national and international polio eradication strategies, and directs monitoring and evaluation activities. The six PVOs work directly with several community-based NGOs and a large cadre of volunteers, the CGPP Community Workers. Together they have mounted a massive social mobilization effort, implementing activities in 39 high-risk districts in 12 provinces of Angola and reaching approximately 3.8 million children under 15 each year.

3. CGPP Community Workers

At the heart of CGPP's social mobilization strategy in Angola are the community volunteers, who are selected by the communities they serve. They interact on an ongoing basis with caregivers and community members and leaders. Focal points, also volunteers, support the CGPP Community Workers by reviewing records, observing their home visits and health education activities, mentoring them, communicating with key community leaders, and facilitating information exchange with the PVO staff. Staff of the CGPP PVOs provide supportive supervision to both the community workers and the focal points in their catchment area. They conduct trainings and records review and often accompany volunteers in their activities to give them feedback and respond to their questions and concerns. They also coach the focal points on the best ways to engage community leaders. In turn, each PVO coordinator supports and mentors the supervisors through training of trainers and accompanied supervisory visits. Finally, the Secretariat provides training, oversight, and on-site supervision to the PVO coordinators. In sum, the CGPP organizational structure is an inverted triangle with the frontline community volunteers at the top, supported by the PVOs and the Secretariat.



4. Social mobilization activities in Angola

CGPP Angola's social mobilization activities are varied and mutually reinforcing:

- **Engaging community groups and leaders.** In addition to building vital partnerships with government health entities (e.g., the Luanda MOH) and international polio actors such as WHO, UNICEF, and Rotary, CGPP engages local groups, community leaders, and other helpful individuals as partners by:

Soliciting the ideas and involvement of church leaders who subsequently have organized health education talks and other community activities. Church leaders have wide influence with families and have made a difference in securing caretakers' cooperation in immunizing children and learning how to recognize and report cases of acute flaccid paralysis.

Integrating other local influentials in a way targeted to each community's local context. For example, the program incorporates heads of community development committees as leaders in urban areas where those committees exist and are influential, and concentrates on including traditional leaders in rural areas, where their influence remains stronger. These leaders have deep knowledge of the

community. They speak with authority and their voices are important in conveying polio messages.

Partnering with schools and scouts groups to engage youth in promoting immunization messages. Young persons add enthusiasm to campaigns, especially when signs of “campaign fatigue” arise, and they alert their families and neighbors to the importance of immunization and surveillance. In addition, their involvement in SIAs instills a sense of civic participation that can be tapped for other child health campaigns.

Collaborating with media officials, UNICEF, and MOH to foster and provide information for radio spots on routine immunization, SIAs, and surveillance of acute flaccid paralysis.

Seizing opportunities for new partnerships. For example, because CGPP had gained the respect and trust of government leaders, military officials agreed to deploy soldiers for quality monitoring during SIAs (see SIA section).

- Home Visits.

To provide one-on-one counseling to families with children under five. The CGPP Community Workers urge caregivers to seek routine immunizations, including polio vaccination, at their local health facility and give them cards that entitle them to expedited services. Because volunteers provide information about immunizations for other childhood illnesses and interventions such as oral rehydration therapy and Vitamin A, messages about polio are better received. In the early days of the project, home visits and community talks focused more on surveillance of acute flaccid paralysis since strengthening the surveillance system was a government priority; later the government program and CGPP evolved so that immunizing every child became an equally important message.

To support complete immunization (polio and other antigens) through SIAs and routine immunization services. An increase in utilization of routine immunization is an important goal of the MOH, CGPP, and other polio actors in Angola; it is also a complementary tool for polio eradication. CGPP Community Workers provide one-on-one education and encouragement to vaccinate children during SIAs and at routine immunization services. By careful tracking via child registers, CGPP Community Workers identify the households where children are not fully immunized or not immunized at all. Home visits provide cues to action and prompt caregivers who might otherwise be uninformed or indifferent to immunizing their children.

To support surveillance and to raise awareness of acute flaccid paralysis symptoms, provide links to the health facility for reporting of cases and treatment of paralyzed children, and urge cooperation with the collection of blood and stool samples in case of suspected acute flaccid paralysis.

- Health education.

Talks, radio spots, puppet shows, street theater, and other outreach activities. Repetition of important health messages from various sources is a factor in changing behavior and an aid to remembering key points so CGPP Community Workers gave frequent talks on routine immunization at marketplaces and other gathering places. They harnessed the interest that street theater performers and puppet shows attract to emphasize routine immunization and also involved women’s groups and other associations in sharing information with their constituencies.

Talks to mothers' groups, church groups, traditional leaders, and civic groups. These activities to reach influential groups, plus media spots on where, when, and why to immunize children against polio; use of child mobilizers; and street theater all encourage a high turn-out for SIAs, as they do for routine immunization.

Other outreach activities such as supporting mothers in taking child to regular vaccination clinic. This practical assistance to mothers can make a real difference, especially if they have other small children to care for. This has an impact on polio coverage as well as that for other vaccines. Street theater is also used to alert the community in advance of and during SIAs.

Health education talks at public gatherings to create awareness of the symptoms of acute flaccid paralysis and encourage prompt reporting.

- **Partnering with the military for quality monitoring.** In the course of the project, civil strife ended and Angolan soldiers became available for nation-strengthening tasks, including polio eradication. They partner with CGPP to conduct the independent quality monitoring of SIAs — to assess how well the SIAs reach children in need of immunization. They use CGPP child registers to identify clusters of children who have been missed before and then find out if they have been immunized during the SIA. If not, they will help parents bring the children to the vaccinators or the vaccinators will visit the household. There were initial worries that use of soldiers might be seen as coercive but interviews with caregivers show that this is not the case and in fact families were pleased that the government was showing an interest in their welfare. The soldiers keep careful records and update CGPP child registers. This information is used to improve future SIAs.
- **Strengthening community surveillance skills.** As Angola maintains its current polio-free status, surveillance of acute flaccid paralysis becomes even more important. Activities include:

Enlisting aid in identifying and reporting cases of acute flaccid paralysis from local leaders, traditional healers, and informal leaders such as grandmothers. These visits reach beyond simply informing leaders of case definitions to constitute active, community-based case search. CGPP volunteers visit these formal and informal leaders regularly to ask whether they themselves have seen, treated, or assisted cases, not simply depending on a passive surveillance model assuming these leaders will report cases unprompted.

Performing active case search in hospitals using non-medical CGPP program staff.

5. Activities that support social mobilization

CGPP in Angola also exemplifies a “social mobilization plus” project. Various other activities support or complement its social mobilization efforts:

Micro-planning for SIAs. Understanding the physical and social reality in the catchment areas is critical to the success of SIAs and entails planning at every level:

- *Planning at the national level:* the CGPP Angola Secretariat plans and coordinates activities with the MOH, WHO, UNICEF, Rotary, and other stakeholders.

- **Planning at the local level:** PVO staff coordinates with the MOH to work with provincial, municipal, and health post facilities. For example, CGPP IPC activities are synchronized with MOH mass media.
- **Community mapping** is a product of micro-planning at the local level with MOH, community leaders, and volunteers. CGPP Community Workers and the military use these detailed maps before and during SIAs.



Supporting local MOH facilities for routine immunization, SIAs, and acute flaccid paralysis surveillance:

- **Training in surveillance best practices** including improving logistics in stool sample collection and handling.
- **Serving as vaccinators, monitors, and supervisors during SIAs.** Because the MOH does not have a cadre of community health vaccinators, this is a major contribution of CGPP volunteers and PVOs.
- **Developing and sharing child registers.** CGPP worked with partners to pilot-test, modify, and launch a national, MOH-approved child registration system for monitoring immunization coverage and tracing missed children. The registers are also used by soldiers for quality monitoring of SIAs and to record cases of acute flaccid paralysis. The child register forms are a major contribution to standardized data collection and analysis and have led to improved micro-planning in Angola.

An external evaluation²² found that CGPP social mobilization activities have made significant contributions to the Government of Angola's (GOA) goals of immunizing all children against polio, strengthening routine immunization, and improving the surveillance system. The MOH and other collaborating groups have publicly recognized the ability of CGPP PVOs and NGOs to reach difficult-to-access and resistant populations and have great respect for the Secretariat director and staff.²³ The GOA also appreciates CGPP activities to strengthen the local health facilities and to partner with the government health system at every level to better carry out routine immunization, SIAs, and surveillance activities.

C. Social Mobilization in Ethiopia

1. Background

Although the GPEI was launched in 1988, the Ethiopian Federal Ministry of Health (FMOH) did not join it until 1996. It then adopted the universal GPEI strategies of increasing routine immunization coverage, conducting supplemental immunization activities (SIAs), improving surveillance of acute flaccid paralysis, and reaching children in particularly high-risk areas or populations. The country was

polio-free — no polio cases were reported — between January 2001 and December 2004. All those working to eradicate polio in Ethiopia were keenly disappointed when there were four separate importations of wild poliovirus from Somalia and Sudan between December 2004 and October 2006. There have been no polio cases reported since 2008 but the government, CGPP, and other partners have not become complacent. They know that immunizing all children and maintaining excellent surveillance are the best protections against imported poliovirus.

When CGPP began activities in Ethiopia in 2001, the war with Eritrea had just ended and, according to the 2000 Ethiopia Demographic and Health Survey (DHS), rates of routine child immunization (BCG, DTP3, polio 3+, and measles) were low — only 14 percent were fully immunized. Although successful SIAs led to higher rates for polio immunization, only 35 percent of children had completed three or more doses.²⁴ By the time of the 2011 DHS, rates had steadily improved but not as quickly as the FMOH, CGPP, and other partners had hoped: 24 percent of children were fully immunized against vaccine-preventable diseases and 44 percent had received three or more polio doses. Clearly there is more work to do; polio immunization rates must more than double before Ethiopian children are safe from imported wild poliovirus. The urban populations are well on their way: 79 percent of children are fully immunized in Addis Ababa and 59 percent in Dire Dawa and Tigray, but only 9 percent in rural, predominantly pastoralist Afar.²⁵ Since only 17 percent of Ethiopia's 87 million people live in urban areas,²⁶ eradication efforts must extend to remote agrarian areas and also reach mobile populations such as pastoralists and those who live in border areas.

2. CGPP Ethiopia

CGPP has responded to these challenging circumstances by focusing on reaching underserved rural and mobile populations. Wherever it works, it strives to achieve the national goal of increasing coverage of both polio immunization at SIAs and routine immunization, improving surveillance for acute flaccid paralysis and strengthening local health services.

In Ethiopia, as in all CGPP countries, the Secretariat provides strategic direction and technical support to the program and the PVO partners who implement it and represents the partner PVOs, the collaborating NGOs and the community voice in national and international forums. The Consortium of Christian Relief and Development Association (CCRDA) hosts the Ethiopia Secretariat office. The 11 CGPP partners²⁷ include seven PVOs with on-the-ground experience in Ethiopia — American Medical Research Foundation, CARE, ChildFund International (formerly Christian Children's Fund) International Rescue Committee, PLAN, Save the Children, and World Vision — and four local NGOs: Alemtena Catholic Church, Harerghe Catholic Secretariat, Ethiopian Evangelical Church Mekane Yesus, and the Pastoralist Concern Association of Ethiopia.

In addition, CGPP Ethiopia also sits on the national ICC and engages in joint planning and coordination with other key actors in Ethiopia: FMOH, USAID, WHO, UNICEF, CCRDA, and Rotary International. For example, in July 2011 a CGPP Partners Annual Planning Forum took place at the CCRDA training center in Addis Ababa. A total of 91 participants from *woreda* (district) health offices, regional health bureau representatives, partner field and head office staff, and other organizations working in polio eradica-

tion attended. Participants gave updates of current immunization, new vaccine introduction, SIAs and surveillance, presented on project progress and best practices. CGPP also led the initiative to establish regional ICCs in three of the highest risk regions out of the seven in which the project works.

3. Community volunteers

In Ethiopia, the volunteer outreach workers are called Community Volunteer Surveillance Focal Persons (CVSFPs); this name reflects the prominence of surveillance activities in the country, not only for polio but also for measles and neonatal tetanus, which afflict many children. The communities select their own CVSFPs in cooperation with the participating CGPP PVO. They receive necessary training, mentoring, supervision and support from the project. While they are not paid, they receive incentives such as clothing items and umbrellas with the project logo and bags in which to carry supplies and educational materials. Because they come from the communities they serve and the community is involved in their selection, they are well received and trusted. The number of community volunteers has steadily increased as CGPP expands to new geographic areas and there are now close to 4,000 CVSFPs engaged in social mobilization and related activities. The caretakers of the children in the communities they reach are very poor and have little or no education; the volunteers link them to essential information and services through social mobilization activities.

4. Social mobilization activities

In 55 *woredas* of seven large regions in the country, CGPP is implementing social mobilization activities in remote villages of approximately 1500 households and reaching out to mobile pastoralists. These activities annually reach approximately 4.8 million people, including 2 million children under age 15. The Ethiopian health system is underfunded and understaffed; many of the areas where CGPP works have only small health posts, managed by two government health extension workers (HEWs), and some remote and sparsely settled villages have no health services at all. A 2008 household survey²⁸ found that among caretakers whose children had not been immunized, the main reasons were that health workers did not come to their village, they lacked awareness of vaccinations or there was no health facility in the locality. CGPP has stepped in to bolster the local health facilities' reach and effectiveness through the volunteers' work and other direct assistance. Social mobilization is the key feature:

- **House-to-house focused counseling on routine immunization and SIAs specifically targeting newborns and defaulters.** CVSFPs visit families to encourage them to immunize their children against polio, measles and tetanus during SIAs. In between SIAs, the volunteers urge caretakers to seek routine immunization at their local health post. If the community lacks a health post, the volunteers and CGPP PVOs arrange for vaccinator teams to visit the community. In addition to providing messages on the importance and safety of polio and other immunizations, the volunteers shape their messages to respond to research findings on the populations they serve. For example, the 2008 survey found that the vast majority of respondents thought that the polio vaccine should be given when a child is four weeks old or older. More than 98 percent also thought that children can receive polio vaccinations too often. The volunteers include information that gently corrects these misperceptions. They visit pregnant women to urge them to have their newborns vaccinated as soon as possible and return to give the birth dose themselves if caregivers do not bring the newborn to

receive the dose. Volunteers also encourage hand washing, building and use of latrines, full breast-feeding for at least six months, and use of oral rehydration therapy for children's diarrheal episodes.

- **Child tracking for acute flaccid paralysis, as well as the other vaccine preventable diseases in Ethiopia's Integrated Disease Surveillance system (measles, yellow fever, and maternal-neonatal tetanus) surveillance.** Surveillance is the key strategy for polio eradication, measles control and neonatal tetanus elimination programs, followed by increased immunization coverage. The facility-based surveillance system cannot detect all cases in the community because families may not be sufficiently informed about the symptoms and/or they may not report them due to misinformation or cultural beliefs about the causes of paralysis. Community volunteers can detect cases early and report cases to the health facility as they are part of the community and know the families. Community leaders also conduct active case search among their constituencies and inform the volunteers of cases they have learned about.
- **Influencer involvement.** The volunteers along with their PVO back-stoppers identify leaders in the community and approach them to solicit their aid in influencing families to immunize their children and participate in surveillance. These include Christian religious leaders in most communities and Muslim leaders in the predominantly Muslim areas such as the Somali region. The religious leaders are true partners and suggest and implement ideas such as including immunization and surveillance messages in sermons during services and at other meetings of the faithful. Civil society organizations, such as the Pastoralist Concern Association of Ethiopia, also participate and communicate the messages through their activities. The volunteers and CGPP PVOs meet with these leaders on a regular basis to share information and refine their approaches.
- **Group education sessions on SIAs and routine immunization.** The CVSFPs also hold regular educational sessions in each village. These are organized for the community-at-large and also for various groups (e.g., women's groups). They stress the importance of immunizing children against polio and other vaccine-preventable diseases and the number of immunizations children should receive. They also stress the importance of polio vaccination for newborns. If a SIA is about to take place, the volunteers inform the community about when and where and encourage their participation. In between SIAs, the community talks encourage families to seek routine immunization for their young children.
- **Involving teachers and students.** The government is raising polio awareness and support with children through the educational systems. As there is a primary school in almost every village, volunteers involve the teachers and give talks to the students, encouraging the children to tell their families and neighbors about immunization and surveillance, a strategy that reinforces messages received through home visits and other channels. The volunteers engage some of the children as mobilizers during SIAs. Research had found that when mothers are absent, older children become the caretakers of younger siblings and so peer education became a mobilization strategy.

“Routine immunization, polio campaigns and surveillance of polio, measles and tetanus are the three pillars of our work.”

— Dr. Filimona Bisrat,
Director, CGPP Ethiopia

- **Reaching out to pastoralists.** Mobile populations such as pastoralists are by definition difficult to access. They drive their herds over long distances, often in forbidding environments, in search of water and grazing lands. The involvement of Pastoralist Concern Association Ethiopia as a CGPP partner means that experts in reaching pastoralists and promoting their well-being are able to use their know-how to find, counsel and provide child vaccination services to this elusive group. The project identifies key informants from pastoralist communities or those who interact with them in villages. The informants help link pastoralists with CGPP and government health workers via either village-based or mobile counseling and vaccination teams to vaccinate their children.
- **Serving cross-border populations.** Ethiopia has porous borders where ethnic groups move back and forth and communities span borderlines. For example, the people who live in the Somali region of Ethiopia and in the borderlands of Somalia constitute one community. It would be futile to educate caregivers, vaccinate children and conduct surveillance activities on only one side of the border. Therefore, volunteers conduct their activities with the entire community including those who actually live in the adjoining country. They are able to do this because of CGPP participation in high-level regional forums such as the Horn of Africa Technical Advisory Group. The group meets regularly to encourage solutions to problems that do not stop at borders.

5. Related Activities to strengthen the health system

CGPP Ethiopia is also a “social mobilization plus” endeavor. While social mobilization is the cornerstone, other contributions are necessary to achieve project goals. In fact, CGPP Ethiopia’s motto well might be: it takes what it takes — and this includes motorbike maintenance for government outreach workers. Strengthening the local health systems is one of CGPPs goals and the following activities reflect the project’s commitment to support and collaboration:

- **Regional advocacy workshops.** CGPP organizes workshops for district and regional health officials to advocate for more government commitment to polio and routine immunization and surveillance of acute flaccid paralysis, measles and tetanus. Although there has been a response in terms of some increases in funding, personnel, and supplies, much more is needed. CGPP will continue these advocacy efforts.
- **Technical assistance for micro-planning.** CGPP shares its research findings on communities’ vaccination knowledge, attitudes, and coverage with the health system so that local health facilities can adjust their vaccination and surveillance strategies in accordance with the realities on the ground. It also shares findings from operations research on reaching newborns, cross-border populations, surveillance quality, and immunization service delivery. Using research findings, CGPP engages in evidence-based, detailed micro-planning with the district and local health personnel for SIAs, routine immunization, and surveillance.
- **Campaign activity support and monitoring.** There is strong collaboration between the volunteers, participating PVOs, and the health system in planning and implementing SIAs. CGPP volunteers and many PVO partner staff assist the health system in monitoring the quality of SIAs by tracking defaulters and giving feedback to government health workers’ on their activities during the campaign.

Beyond Social Mobilization: INGO Support for Immunization Services

Although this paper focuses on CGPP's social mobilization efforts in support of polio eradication, all country efforts supported the government's immunization program in areas such as cold chain management, health worker training, quality control, logistics, and supportive supervision.

Each country team coordinated at all levels of government health services — national, regional, district, and community. As the India CGPP director said, "We would show up at government's door and say 'what do you need from us this week? We will do whatever it takes.' "

Although specific inputs differed by country need, CGPP loaned the health system vehicles during SIAs and outreach to remote communities, provided kerosene for refrigerators where vaccine doses are stored and gasoline for government-owned motorbikes used in outreach, maintained motorbikes, and provided needed spare parts.

INGO contributions such as these help ensure that the health system's facility-based and outreach efforts can continue without interruption.

- **CVSFPs link with government HEWs** to support all primary health care activities, not only polio and routine immunization. Because of high infant and child mortality, CGPP PVOs and volunteers in each community meet with local health workers to develop key messages to include in home visits.
- **Educational materials on polio immunization, routine immunization, and surveillance.** CGPP develops educational materials based on community research, translates them into local languages and field-tests them with the community. Field-testing is especially important in low-literate communities to ensure understanding and acceptability of illustrations and terms. After the materials are finalized, they are printed and shared with the local health systems. Both CVSFPs and the government health extension workers use these materials.

Outcomes of these mutually reinforcing activities include significantly increased routine vaccination and OPV coverage and increased involvement of communities in routine immunization, SIAs, and surveillance activities. SIA coverage reached more than 95 percent in almost all implementation areas.²⁹ There is also higher reporting of suspected acute flaccid paralysis cases. After more than a decade of work in Ethiopia, CGPP is recognized as a major and valued partner by government and UN agencies. There are more requests to expand into other geographic areas than CGPP can manage. Future increases in funding and staff will permit such expansion.



IV. Lessons learned: Insights for future planning

Whether working in predominantly rural or urban areas or a mixture of both, CGPP's social mobilization work reflects these principles and lessons. They can be applied to polio eradication efforts elsewhere and to maternal/child health programs everywhere.

1. **Use research to tailor messages to the context of people's lives.** Information useful for program planning can be gathered from knowledgeable informants, meetings with community and religious leaders, reports and studies on high-risk populations, child registers, and other sources of data. Ask the people themselves: formative research through focus group discussions, structured interviews, and household surveys is one of the most effective ways to understand local beliefs and barriers to change. Micro-planning — or planning at the local level — for difficult-to-access or resistant populations is based on understanding the beliefs; concerns; and physical, social, and economic obstacles that stand in the way of immunizing children. Implementing dynamic, tailor-made strategies for different high-risk groups is the key to success. CGPP had different basic SM strategies in Angola (rural/urban), Ethiopia (Christian/Muslim; pastoralist/agrarian) and India (rural/urban, male/female, mother/mother-in-law). CGPP was successful at least in part because it customized its SM approaches not just to these national contexts, but even from one neighborhood to the next, as needed. The process to gather information and apply it directly to programming must be ongoing and occur in real time.
2. **Make the link between national priorities and local action.** NGOs can translate strong national leadership and systems, such as recordkeeping and surveillance, into direct action at the community level. They can bring to bear their knowledge of and trustworthiness in the community to overcome barriers to acceptance in marginalized, hard-to-reach, and suspicious communities that represent the last push for polio eradication.
3. **Reach the people repeatedly with key messages: through home visits, involvement of community leaders, public education and outreach to mobile populations are central to polio-related SM and must be coordinated with other agencies.** People are more likely to take action if they hear the

same behavior-change messages from a variety of trusted sources over time.³⁰ Involving the media, peers, and positive deviants also helps reinforce behavior-change messages. Communication approaches must vary for different groups and be fine-tuned through monitoring and evaluation.

4. **Be persistent.** One visit to a resistant household is seldom enough; similarly, securing the cooperation of community leaders may take more than one meeting. If one approach fails, look for other opportunities. Never give up: governments, CGPP, UNICEF, and other partners worked tirelessly to achieve the current polio-free status of Angola, Ethiopia, and India.
5. **Implement activities targeted to a specific disease in a way that supports and strengthens related health services.** Health facilities in poor communities are understaffed and underfunded, making it difficult to provide good-quality routine immunization and other child and maternal health services. Mothers referred to poor-quality health facilities for routine immunization who must wait for hours and face stock-outs understandably form negative opinions and these opinions spread through social networks. Furthermore, children vaccinated only through SIAs are less likely to receive enough doses to ensure immunity. A strengthened routine immunization system is essential to gain acceptance among communities and to achieve full immunity to the wild poliovirus. Supporting the routine system for delivering immunizations is not an add-on component that would be a nice extra benefit, but an indispensable element of successful eradication.

In some countries, campaigns that focused only on polio have met resistance because the community has felt that its other important health needs are being ignored or that the intense focus on polio over other immunizable diseases is in itself suspicious. Addressing polio through health camps and campaigns addressing other concerns made polio immunization more palatable. In addition, some health professionals worry that single-focus campaigns siphon off resources from routine immunization provided by government health services. Moreover, where routine immunization functions well and most children are fully immunized against polio through routine immunization, the need for labor-intensive SIAs goes down dramatically. Those working in eradication and routine immunization programs continue to learn from each other's lessons; for instance, using intense SM approaches to reach low-populated areas, nomadic populations, etc. with routine immunization. CGPP social mobilization work would be especially relevant for increasing DTP₃ coverage in such populations.

6. **Devote time to the selection, training, and support of community-based outreach workers.** Community involvement in the selection of frontline workers from the locale increases the likelihood of their acceptability in door-to-door and group education as well as receptivity to their messages. Training community workers in interpersonal communication is particularly important since these workers must engage directly with caregivers and community leaders and be able to provide accurate information, answer questions, and dispel rumors in a respectful manner. Ongoing support and encouragement from supervisors increases motivation.
7. **Advance the participation of women** as social mobilizers, vaccinators, surveillance officers, and leaders in polio eradication efforts. Women influentials who speak out about vaccinating their own children serve as role models for children's caregivers — typically women — to emulate. Involving women as community workers is important because mothers and other female caregivers often

interact with women more comfortably than with men; women may also gain admittance to the homes of vulnerable families where men would be refused entry. In addition, the involvement of women at all levels helps advance women's status rather than reinforcing gender-inequitable norms.

8. **Involve children in campaigns to help counter “campaign fatigue”** and alert and motivate caregivers to immunize their children during SIAs. It also orients children to community service, instills in them preventive health behaviors, and equips them with life-saving knowledge they can share with their families and others.
9. **Recognize that partnership is powerful.** The CGPP Secretariat structure consisting of PVOs partnerships increases efficiency through clarification of roles and joint planning, collaboration, and coordination of activities. It decreases competition among collaborating groups because it is staffed by professionals not associated with any one of the PVOs and decision-making is transparent and based on program needs. The Secretariat model also simplifies liaison of government and other agencies with the CGPP PVOs and NGOs implementing on-the-ground activities by providing a central contact point; this contributes to the likelihood that all parties involved are “on the same page.” In addition, partnerships with the host-country government and other national and international actors create synergies and multiply project effectiveness. However, collaboration is not easy: it takes time to meet with, coordinate activities and build trust among all participants — and this process began with the project itself. It also requires that all parties retain flexibility to accommodate the needs and priorities of other partners.
10. **Select highly respected and well-connected individuals to direct the country project; this enhances the likelihood of having “a place at the table”** so that NGOs and the community voice will be represented in government, multilateral, and other forums where decisions and plans made. In addition, program leaders should be role models for everyone involved in the project, including frontline workers: intelligent, committed, active, well-organized, fair, willing to listen and negotiate, and possessed of leadership skills that motivate both staff and volunteers.
11. **Involve NGOs as central players.** The on-the-ground knowledge and practical experience of NGOs makes a critical difference in reaching the hardly reached and has been at the heart of CGPP success. It should be acknowledged that benefits of NGO involvement can also entail challenges inherent in joint planning, coordination, differing implementation approaches, etc.



V. Recommendations

Donors and organizations wishing to contribute to the final efforts to eradicate polio would do well to learn from CGPP's experience, especially its successful social mobilization strategies to reach the hardly reached, and should note both strengths and areas for improvement detailed in the project's mid-term and final evaluations.³¹ CGPP is an excellent example of how to strike the balance among activist, pragmatic, and hybrid SM to address recalcitrant obstacles to program success on a wide scale.

Results achieved from the massive investments in polio eradication can be applied to promote other child and maternal health interventions. As more and more countries become polio-free and await certification of eradication, donors should increasingly support utilization of social mobilization networks, data-driven planning, partner coordination and other key features of projects like CGPP to accelerate progress toward the maternal and child health Millennium Development Goals. Key CGPP lessons that directly apply to improving maternal and child health include partnering women community members and religious leaders to jointly address religious communities; improving use of recommended services through simultaneous attention to social norms, service quality, and logistics; and focusing on sustainable improvements in routine, holistic services at the same time initiative-specific efforts are underway.

Finally, because mothers with secondary education are two-to-three times more likely to have fully immunized children, and the children of educated mothers, even if poor, score far higher on every health indicator, holistic programs to improve health should also promote girls' education — for the girls themselves and their future children.

Recommended print and online resources

The Communication Initiative Network website: <http://www.comminet.com/global/spaces-frontpage>.

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