Polio Communications

QUARTERLY UPDATE • OCTOBER 2012

Missed

Reaching every missed child

- The proportion of vaccinated children continues to rise, but progress is not uniform. In the majority of current sanctuaries, more children have been vaccinated during May–October 2012 than the six preceding months. Improvement in coverage is evident everywhere except the Nigerian state of Zamfara and two northwestern areas of Pakistan: the Quetta Block of the Balochistan province and the neighbouring Federally Administered Tribal Areas (FATA). There, the proportion of children who live their first years of life without any immunization against the poliovirus have increased over the same time period.

- With the first phase of staff deployment nearly completed, social mobilizers are building trust on the front lines of polio-endemic Afghanistan, Nigeria and Pakistan. The proportion of high-risk communities with dedicated polio-eradication social mobilizers has doubled in the last quarter. More than 5,000 mobilizers currently work in 78% of the high-risk areas of the three countries. Each month they directly engage with over 800,000 households.

UNICEF/2012/M. SHAFIQ

sharing responsibility

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

THE PROPHET MOHAMMAD (S.A.W) SPEAKING ABOUT RESPONSIBILITY FOR CHILDREN'S HEALTH IN THE HADITH, BUKHARI KITABUL AHKAM, HADITH 6605

- Overall refusals of oral polio vaccine (OPV) continue to decline, accounting for an average of less than 1% of all under-5 children in the three endemic countries. However, share of refusals is significantly higher in several challenging areas of northern Nigeria, Pakistan's Quetta Block and the Katanga province of the Democratic Republic of the Congo (DR Congo), where as many as 3% of all under-5 children are missed due to caregiver refusal.

- Although the magnitude of refusals can seem insignificant, statistically small clusters of non-compliant households continue to spark outbreaks among under-vaccinated children. In the Kano and Sokoto states of Nigeria and in Pakistan's Quetta Block, more than 60% of this year's polio cases have been among families who refused OPV to their children.[1] These high-risk areas and families require intensified social-mobilization efforts and increased resources.

- While the programme has scaled up to reach more families and children on the doorstep, more needs to be done to reach them in farming areas, in schools and on the move. More than 40% of missed children in the priority countries of Afghanistan, Pakistan, Chad, DR Congo and Nigeria are missed because they are not at home when vaccination teams visit. Addressing this challenge requires creative new strategies that combine the operational and social expertise honed during recent years.

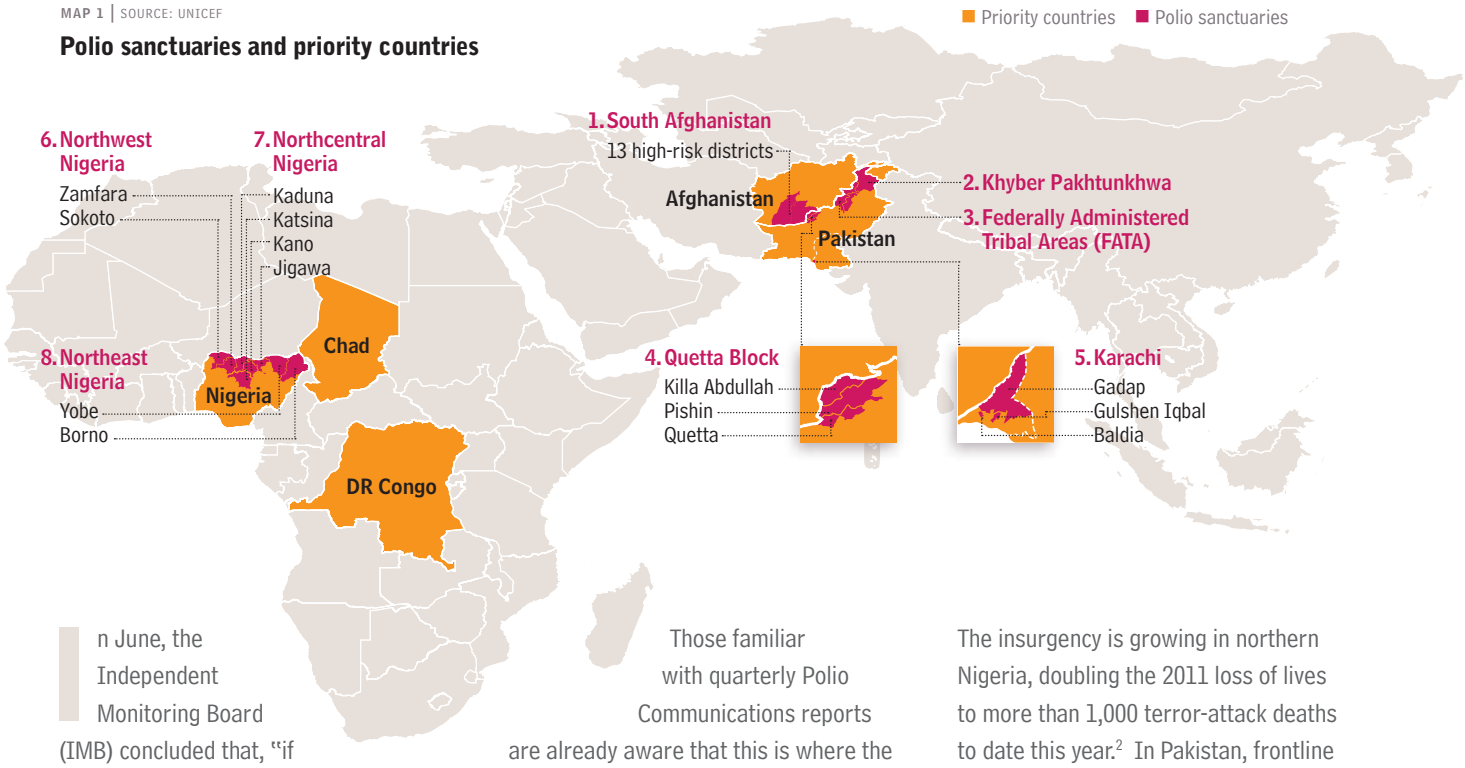
- In-depth social-data analysis is helping identify children most likely to be missed in future vaccination rounds. Particularly vulnerable, for example, are children growing up with caregivers who cannot read or write; or in conservative societies where elders are the primary decision makers. Communities with lifestyles or livelihoods that make their children difficult to locate, such as Nigerian nomads and farmers, offer another example. Caregivers dissatisfied with vaccination team makeup or performance are more likely to refuse vaccination. Consequently, shifting the programme's focus—from districts, sanctuaries and generally geographic criteria to specific communities, groups, households and children united by common social characteristics—is a priority.

- Many children that fall between the 'social' and 'operational' realms of responsibility continue to be missed. To find and vaccinate them, partners in the Global Polio Eradication Initiative (GPEI) have recognized the need to work closer together and have established shared data processes, joint planning tools and unified teams on the ground. It is now time to move these resources into an aggressive, collective effort to reach every missed child.

1 Data as of 12 October 2012.

MAP 1 | SOURCE: UNICEF

Polio sanctuaries and priority countries



In June, the Independent Monitoring Board (IMB) concluded that, "if the eradication effort cannot track down and vaccinate 'Every Missed Child', this will be its downfall." The board also characterised the polio-eradication programme as one that "thinks and acts too much in isolation. Children missed by polio teams may be reached by other services. Stronger, more effective alliances can bring eradication closer."

In making such observations, the IMB is calling for a paradigm shift in on-the-ground programme operations, including monitoring progress and measuring success. Such a change in focus would involve placing the missed child front and centre of the programme and attaining the full engagement of the leaders, influencers and parents of the affected communities in this very last push for polio eradication.

Those familiar with quarterly Polio Communications reports are already aware that this is where the communications programme has focused its efforts. The past 18 months have seen the emergence of a powerful platform to collect and analyze social data, and the birth and subsequent growth of a network of skilled community mobilizers who contribute contextual evidence about the feelings, opinions and other variables responsible for many of the same children being repeatedly missed (see 'Missed: the most at-risk children', page 20).

Despite the vastly improved understanding, some critical obstacles remain beyond the programme's control. Conflict is chief among them, with key areas continuing to struggle with fragile or deteriorating security, threatening programme success, staff morale and ability to build trust with local communities. Conflicts persist in southern Afghanistan and eastern DR Congo.

The insurgency is growing in northern Nigeria, doubling the 2011 loss of lives to more than 1,000 terror-attack deaths to date this year.[2] In Pakistan, frontline workers members were physically attacked multiple times during the last quarter, including two fatal shootings of vaccinators in Gadap Town of the Sindh capital city of Karachi, and the Quetta district of Balochistan. Such incidents serve as a tragic reminder of the courage, commitment and sacrifice of all who work in the polio programme, particularly on the front lines.

Maintaining an appropriate—accurate and positive—public image of the polio eradication effort is another considerable challenge. Some of the highest-risk programme areas are home to continued negative reports about the polio programme. In others, caregivers place little faith in the media and trust only interpersonal communications from local religious or community leaders and influencers.

2 *The Economist,* 2012, "Nigeria's insurgency: Hold your nose and talk", 29 September, p. 14.

On an international scale, the 18-month-old story of the fake Pakistan vaccination campaign remains prominent in the news, casting a shadow of mistrust on the eradication programme.

To combat such perceptions, efforts continue to be made to foster local buy-in and ownership by engaging influential Muslim scholars, Imams, popular celebrities and communities themselves. The need to ensure that polio eradication is not seen as a programme driven by outside interests must often be balanced with the humanitarian needs in a state of emergency, and the urgency and external pressure to achieve results.

The gold standard remains to motivate parents to actively seek OPV, and there are signs of progress in some programme areas. For example, the first nine months of 2012 have seen an increase in Pakistani parents who said they would go their nearest health centre to vaccinate their children. Since January, more parents now say they would complain to the polio hotline or health officials if teams don't arrive to vaccinate their children. However, without broader development support or efforts to partner with programmes and organizations able to provide it, creating a parental "pull" for OPV may be an unrealistic target for the most marginalized, volatile and insecure environments. Without a major shift at the macro development level, current investments and approaches may mean having to settle for OPV compliance, rather than actual demand.

That alone is no small feat amongst communities that are offered vaccination on a near-monthly basis but receive little else. OPV demand and acceptance are often adversely affected by lack of caregiver exposure to people affected by polio: many communities have not seen a case in years. Maintaining an accurate public perception of risk of disease, and trust in both the vaccine and its provider are the critical areas of future advocacy work.

Dedicated social mobilization networks are the key component of the operational strategy in highest-risk areas. Building on existing trust, the programme typically recruits mobilizers from the local communities they serve. The programme now has more social mobilizers on the frontlines than ever before, reaching out to some 800,000 of the highest risk households.

Social mobilization is no longer just about coverage. At this critical stage, reaching and immunizing an unprotected child must be prioritized. Programme data is critical to ensuring that the highest-risk areas receive appropriate levels of dedicated human resources support. Since a uniform investment is not possible everywhere, reaching large or widespread populations also requires programme staff to encourage, facilitate and otherwise support house-to-house communications to magnify and spread the goodwill generated by personal interaction on the doorstep.

New mass media campaigns that build on the power of interpersonal communications are underway in Afghanistan and Pakistan, with the ultimate goal of igniting a broad social movement against polio. Population awareness has already begun to rise in both countries as a result. As the media campaign continues to roll out in a series of planned phases, it must move beyond raising awareness to reinforce on-the-ground efforts of promoting local ownership and engagement.

UNICEF/2012/I. HASSAN

BOX 1

Global Communications Indicators

Following an expert consultation, the GPEI Communication Indicators were established at the end of 2010 to help key stakeholders assess and monitor progress towards milestones outlined in the 2010-2012 Strategic Plan. They provide insights into how well the high risk countries are performing in the areas of communications and social mobilization by measuring performance against a core set of indicators and targets. A programme's ability to collect and report on standard communications data is key to help guide or refine operational strategies, and to ensure that minimum standards are met.

Although we are using well-defined indicator outcomes and targets, we also include a subjective component to determine the overall judgment of risk. In spite of meeting a milestone, additional work may still be required in a country-specific context; classification of risk has therefore been determined using both a quantitative as well as a qualitative lens.

Category	Indicator	Target and Risk Assessment		Sources of information
Impact	Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Low	≤ 5% (strong performance)	CDC Risk Assessment
		Moderate	6-9% (intermediate performance)	
		High	≥ 10% (weak performance)	
	Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	Low	≥ 90%	CDC Risk Assessment
		Moderate	80-89%	
		High	< 80%	
Outcome	Trends in missed children due to refusal* to accept OPV nationally and in HR areas	Low	Downward trends in refusal to vaccinate nationally and in HR areas for all SIAs held in the past 3-6 months; OR if percentage accounts for < 8% of missed children *Refusal to vaccinate is defined as an overt refusal to accept OPV.	Independent Monitoring Data
		Moderate	Stable trends in refusal to vaccinate nationally or in HR areas for all SIAs held in the past 3- 6 months; OR if percentage accounts for 8-10% of missed children	
		High	Increasing trends in refusal to vaccinate nationally or in HR areas for all SIAs held in the past 3-6 months; OR if percentage is > 10% of missed children	
	Trends in missed children due to all social barriers* to accept OPV nationally and in HR areas	Low	Downward trends in all social barriers to accept OPV; OR if percentage of all social barriers accounts for < 8% of missed children. * Social barriers are defined as the cultural, religious, political and economic reasons that may contribute to an overt or covert resistance to vaccinate. This indicator will be aggregated from IM categories such as 'refusal', 'child sick', 'child not available', or 'other', as appropriate to the specific context and analysis for each country.	Independent Monitoring Data
		Moderate	Stable trends in all social barriers to accept OPV for all SIAs held in the past 3-6 months; OR if percentage accounts for 8-10% of missed children	
		High	Increasing trends in all social barriers to accept OPV for all SIAs held in the past 3-6 months; OR if percentage is ≥ 10% of missed children	
	Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	Low	≥ 90% of caregivers nationally and > 80% of caregivers in HRAs are aware of the polio campaign prior to arrival of vaccinators	Independent Monitoring Data; LQAS
		Moderate	76–89% of caregivers nationally and >70% of caregivers in HRAs are aware of the campaign prior to arrival of vaccinators	
		High	≤ 75% caregivers nationally and > 70% of caregivers in HRAs are aware of the campaign prior to arrival of vaccinators	
	Source of information from those caregivers who report having heard any campaign message* (Targets should focus on IPC, and higher trends in areas with communications staff than those without)	Low	The proportion of parents in HRAs citing IPC as a source of information is higher in areas with communications staff than areas without; trends are increasing	Independent Monitoring Data
		Moderate	The proportion of parents in HRAs citing IPC as a source of information is the same in areas with communications staff as those without; trends are stable	
		High	The proportion of parents in HRAs citing IPC as a source of information is less in areas with communications staff than those without; trends are decreasing or no data is collected	
Process	Social data is systematically used for communications planning	Low	≥ 90% of plans nationally and in HR areas reflect social data based on self-reporting and spot-checking. Social data is utilized consistently in planning based on regular coordination meetings and data reflected in minutes	UNICEF Monitoring
		Moderate	76-89% of plans nationally and in HR areas that reflect social data based on self-reporting and spot-checking. Social data is utilized inconsistently in planning based on regular coordination meetings and data reflected in minutes.	
		High	≤ 75% of plans nationally and in HR areas that reflect social data based on self-reporting and spot-checking. Social data is not utilized consistently in planning based on regular coordination meetings and data reflected in minutes.	
	Percentage of planned activities that took place in High-Risk Districts or LGAs	Low	≥ 95% of activities identified in district-level communications plans have been completed and verified through independent sources	New monitoring forms/ system to be developed for some countries. Reporting in 2012.
		Moderate	86-94% of activities identified in district-level communications plans have been completed and verified through independent sources	
		High	≤ 85% of activities identified in district-level communication plans have been completed and verified through independent sources	
Inputs	Percentage of identified polio communications personnel in place in a country programme	Low	≥ 90% occupancy of designated GPEI communications posts, nationally and in the field, at the point of each reporting period	UNICEF Monitoring
	Percentage of identified polio communications field personnel in place	Moderate	71%-89% occupancy of designated GPEI communications posts, nationally and in the field, at the point of each reporting period	
		High	≤ 70% occupancy of designated GPEI communications posts, nationally and in the field, at the point of each reporting period	
	Percentage of designated high risk areas with polio communications field personnel	Low	≥ 60% of identified high risk areas at sub-district level (UC, block, community, etc) have at least one communications officer working on behalf of the GPEI	UNICEF Monitoring. 2012 Reporting
		Moderate	41-59% of identified high risk areas at sub-district level (UC, block, community, etc) have at least one communications officer working on behalf of the GPEI	
		High	≤ 40% of identified high risk areas at sub-district level (UC, block, community, etc) have at least one communications officer working on behalf of the GPEI	
	Percentage of HR areas that receive timely communications/social mobilization funding	Low	≥ 95% of HR areas receive 100% of approved funding prior to the SIA for the past three SIAs	UNICEF Monitoring
		Moderate	86-94% of HR areas receive 100% of approved funding prior to the SIA for the past three SIAs	
		High	≤ 85% of HR areas receive 100% of approved funding prior to the SIA for the past three SIAs	

Abbreviations: AFP – acute flaccid paralysis; CDC – Centers for Disease Control and Prevention; GPEI - Global Polio Eradication Initiative; HR/HRAs – high-risk/high-risk areas; IM – Independent Monitoring; IPC – interpersonal communications; LGAs – local government areas; LQAS – Lot Quality Assurance Sampling; SIAs – supplementary immunizations activities; UC – Union Council; UNICEF – United Nations Children's Fund

conflict

Some critical obstacles remain beyond the programme's control. Conflict is chief among them, with key areas continuing to struggle with fragile or deteriorating security, threatening programme success, staff morale and ability to build trust with local communities.

FIGURE 1 | SOURCES: INDEPENDENT MONITORING DATA, UNICEF MONITORING

Priority country risk assessment by communications indicator, March–July 2012

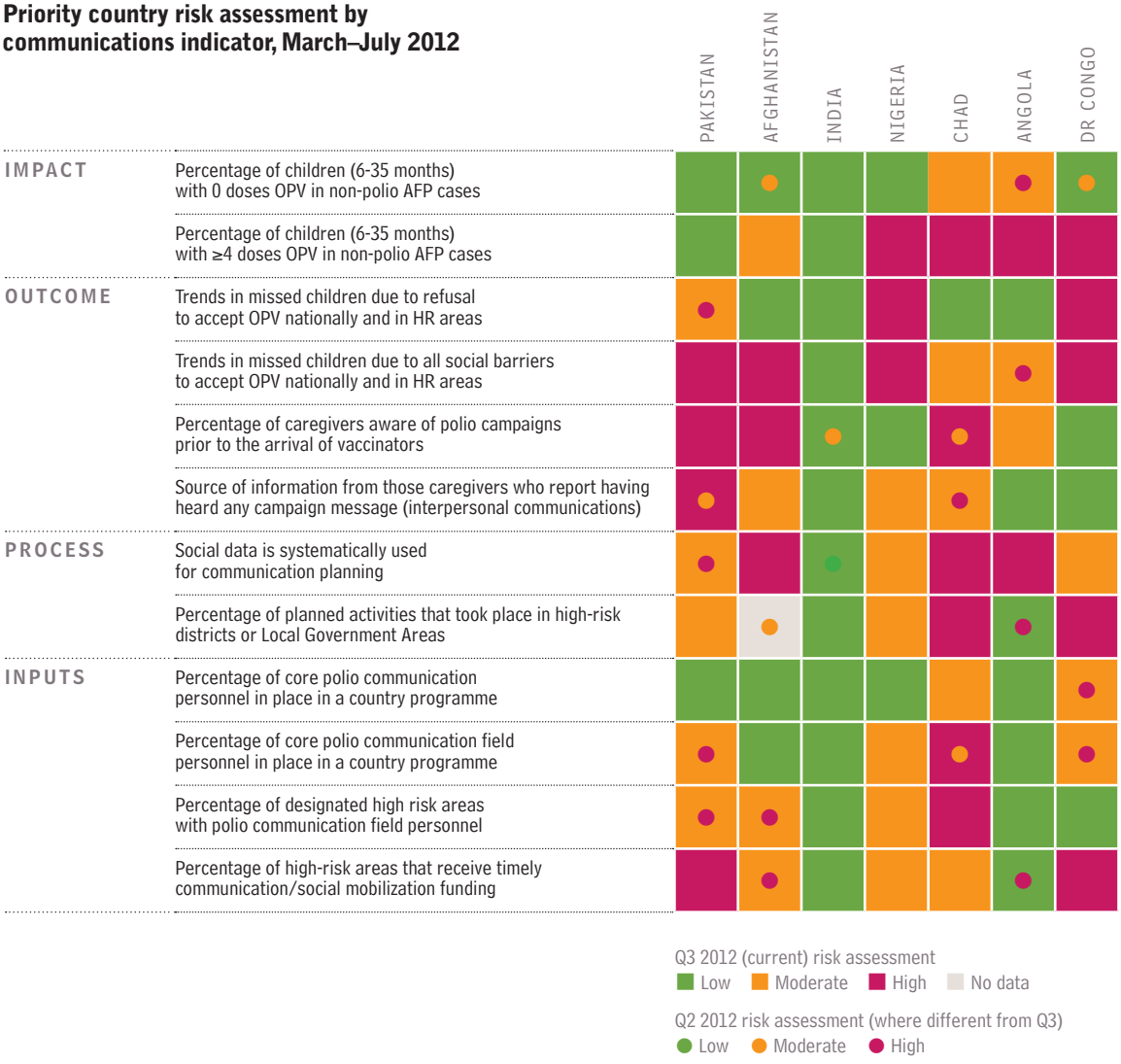
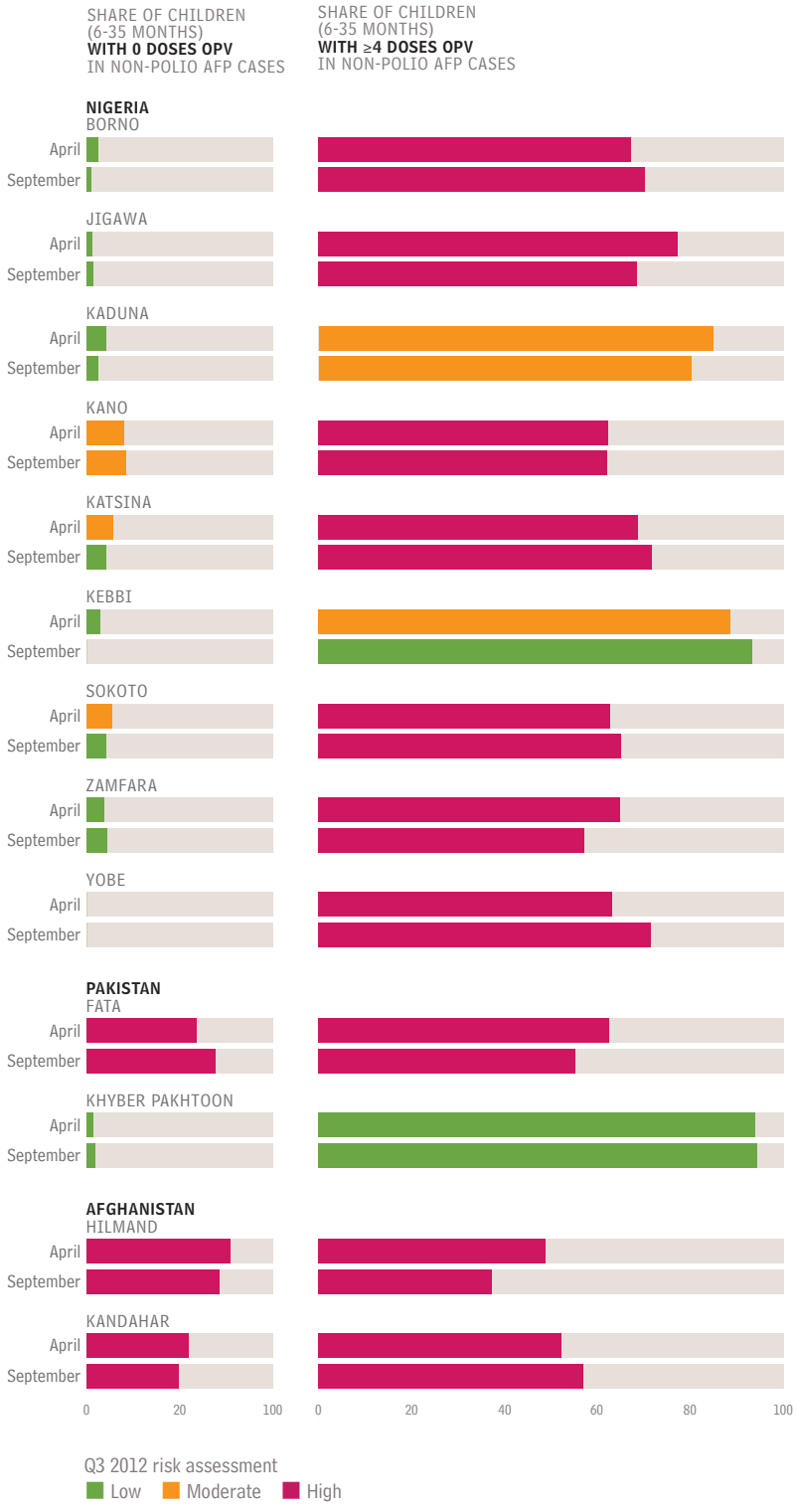


FIGURE 2 | SOURCE: WHO-HQ AS REPORTED IN THE GPEI STATUS REPORT, 3RD QUARTER

Non-polio acute flaccid paralysis (AFP) cases in select sanctuary areas, April–September 2012



Missed children

Despite considerable challenges, the programme has never been on stronger footing. Even with the recent surge of cases in Nigeria, the global case count is at its lowest since the 1988 GPEI launch, and more at-risk children are being reached in the remaining sanctuaries.

This quarter, the northern **Nigeria** states of Borno, Katsina, Kebbi and Sokoto have all shown slight progress in non-polio acute flaccid paralysis (AFP) coverage. In Katsina, for example, the share of children who received more than four OPV doses has increased from an average of 69% for the year ending in April 2012 to 72% for the year ending in September 2012; Kebbi rose from 88% to 93% during the same time period. All four states are demonstrating a corresponding decline in children receiving no doses of OPV. However, the pace of transmission in many of these areas demonstrates that such progress is not yet rapid or dramatic enough.

In Zamfara, **Nigeria**, where six cases have occurred in the first nine months of 2012, the proportion of children without any doses of OPV has increased from 3.8% to 4.4% over the last quarter. Children with four or more doses show an even greater magnitude of negative change, declining from 65% to 57%.

WHO/2011/T. MORAN

In the 13 high-risk districts of **Afghanistan**, Independent Monitoring data shows the percentage of missed children on a consistent monthly decline in accessible areas, from 13.97% in March to 9.74% in June. At the same time, the programme has consistently missed more than 12% of children in the accessible areas of Dehrawood, Nad ali, Panjwai and Shahid Hassas districts. While there has been an increase in children being reached with at least one dose of OPV in Helmand, fewer are receiving multiple doses: 37% of children are receiving 4 or more doses during the year ending September 2012 compared to 49% during the year ending April 2012. Kandahar is the only province showing a slight improvement in reaching children with more doses, with an increase from 52% to 57% for the same time period.

In Pakistan, Independent Monitoring data shows coverage to be stable since April, with approximately 2% of children missed nationally. Key reservoirs in the provinces of Balochistan and FATA remain the most challenging areas to vaccinate children.

The percentage of missed children in Balochistan more than doubled in the last two rounds, from 3.7% to 7.5% in June and July 2012, respectively.

In FATA, recent challenges with access have exacerbated existing coverage gaps.

coverage gaps

In the province's district of Killa Abdullah, the programme has continued to miss over 20% of target children since January, and in Pishin, monitoring data has been unavailable since March due to the challenge of recruiting qualified local monitors. In FATA, recent challenges with access have exacerbated existing coverage gaps: the proportion of children 6-35 months who have not received any doses of OPV has increased from 23% during the year ending April 2012 to 28% during the year ending September 2012.

While there have been no cases in **DR Congo** since January, the province of Katanga still demonstrates immunity gaps, as evidenced by the circulating vaccine-derived poliovirus (cVDPV) outbreak this year. Independent Monitoring data shows sporadic progress from one vaccination round to another, but the trend in coverage has been consistently positive, rising from 83% of children covered in January 2012 to 92% in May. Lot Quality Assurance Sampling (LQAS) data suggests that Independent Monitoring may have overestimated coverage, but non-polio AFP data corroborates progress: the proportion of children without any doses of OPV has declined from 16.3% during the year ending April 2012 to 11% during the year ending September 2012.

Inaccessibility

Continued progress will rely on adequate security and continued access to high-risk areas.

Eastern **DR Congo** has seen an increase in conflict over the last quarter, particularly in Katanga and Maniema, which are affected by multiple rebel movements that impact the frequency and quality of communications and vaccination campaigns. GPEI partners are evaluating the feasibility of the Short Interval Additional Dose (SIAD) approach to preserve the gains already made.

In **Afghanistan**, security incidents rose by 27% in the second half of 2012, and the number of inaccessible children has doubled from 62,631 to 127, 262 between April to June 2012. While there has been an overall decrease in security incidents from 2011, most of the violence takes place in the endemic southern and re-infected eastern regions, which account for as much as 54% of all security incidents nationwide.

In **Pakistan**, more than 256,000 children have been inaccessible since July 2012, due to the polio bans in FATA and Gadap Town of Karachi.

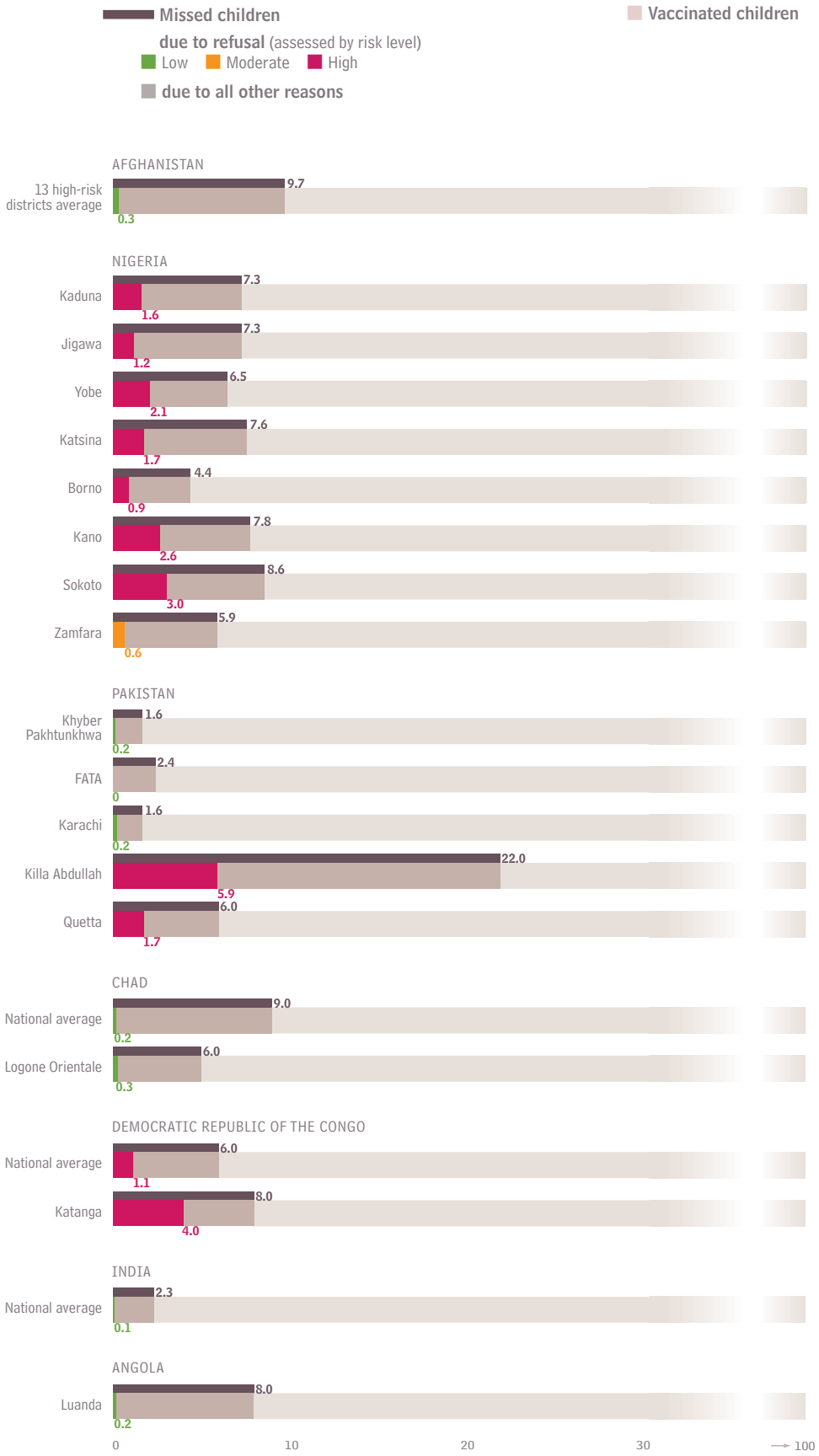
Nigeria is looking at ways to collect data on children missed due to inaccessibility following the Expert Review Committee's (ERC) recent recommendation.

The security risks that threaten operations in many countries around the world emphasize the need to strengthen coordination with other partners working in high-threat environments. Such organizations' existing networks and programmes can provide entry points for OPV distribution through health, development and other services that may be in greater demand by communities. Offering a broader service package will also facilitate greater trust and access into these areas.

UNICEF has led the establishment of a global inter-Agency Think Tank to review lessons learned in successfully operating in high-threat environments. Polio eradication is among the United Nations' Secretary-General's priorities, and several UN agencies have committed their support. The next critical step is to operationalize these proposed collaborations at the country level. At the same time, countries are conceptualizing and implementing new approaches to address accessibility concerns, including broadening the collaboration with and the involvement of all agencies in the UN Country Team.

FIGURE 3 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal in global sanctuaries and priority countries as share of all under-5 children targeted (%), July 2012



Social reasons for missing children

OVERT REFUSALS

Though it is not the main reason for missing children in any country, overt refusal continues to be a significant problem in some countries more than in others. Globally, refusals account for less than 2% of all under-5 children.

Refusals are lowest in **Afghanistan's** 13 high-risk districts, **India**, **Chad**, and **Angola**. In each, refusals stand at less than 5% of all missed children and less than 0.3% of all target under-5 children.

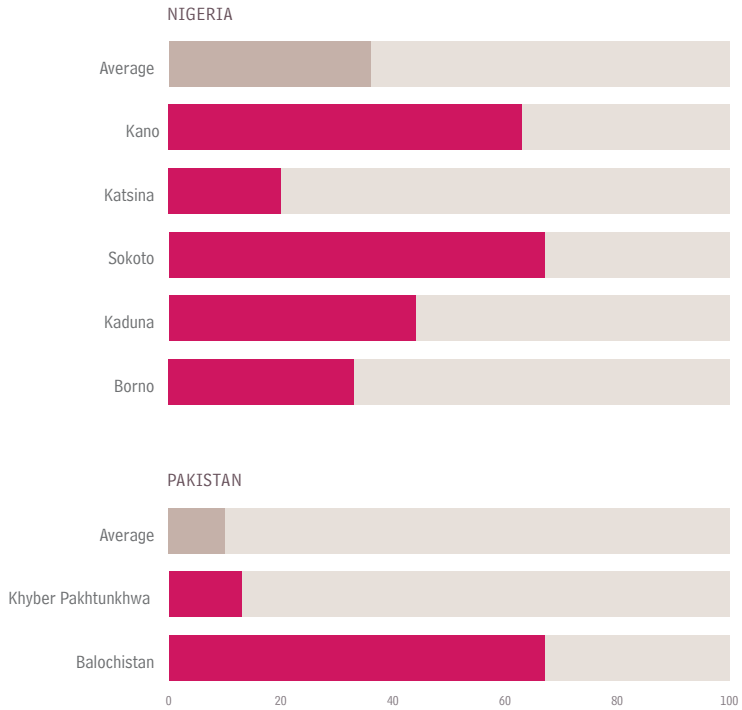
Refusals are highest in **Nigeria** and **DR Congo**, accounting for 24% and 19% of missed children in high-risk areas, respectively. In eight high-risk northern Nigerian states, this translates to approximately 1.7% of all under-5 children missed due to refusal.

Nowhere does non-compliance contribute more directly to the spread of the polio-virus than in northern **Nigeria**. Among this year's 58 polio cases that have been analyzed for social variables so far, more than a third of affected children are from families who refused vaccination (see figure 4).

UNICEF/2012

FIGURE 4 | SOURCE: DETAILED WPV CASE INVESTIGATION FORMS, OCTOBER 2012

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



Note: Data represents analysis of 58 cases in Nigeria and 40 in Pakistan as of 15 October 2012. Data not available for Afghanistan.

This represents the highest level of refusal on the global scale, and the magnitude of refusals may turn out to be even more significant once all of this year's cases are analyzed.

The states of Sokoto and Kano carry the highest burden of refusals and the largest number of polio infections resulting from such refusals, with more than 65% of cases attributed to families that refuse to vaccinate their children. Kaduna follows in third place, with 44% of polio cases occurring in refusal households. Given that close to half of all polio cases this year are emerging from these three states,[3] refusal cases should be investigated in detail and a report submitted to the partnership. Specialized plans should be developed to address what is clearly a chronic problem that may spread akin to the virus itself.

Data shows that 1 in 4 parents in the north refuse based on the belief that OPV is not necessary. The underlying causes for this low perception of risk range from parents feeling their children have received sufficient doses to those who don't see polio as a plausible threat to their own children or don't believe the virus has severe consequences. Other significant refusal reasons cited by parents include lack of caregiver consent (15% of all refusals) and concern about OPV safety (12%)—symptoms of pervasive lack of trust.

The Volunteer Community Mobilizers (VCM) network, now deployed in seven northern states, is already helping address these issues in some areas. Data from Kano settlements with VCM presence shows fewer children missed due to non-compliance between May and July 2012 (see figure 5). Independent Monitoring data from Kano also shows improvement in overall reductions of non-compliance, declining from 2.9% in March to 2.64% in July (see figure 6).

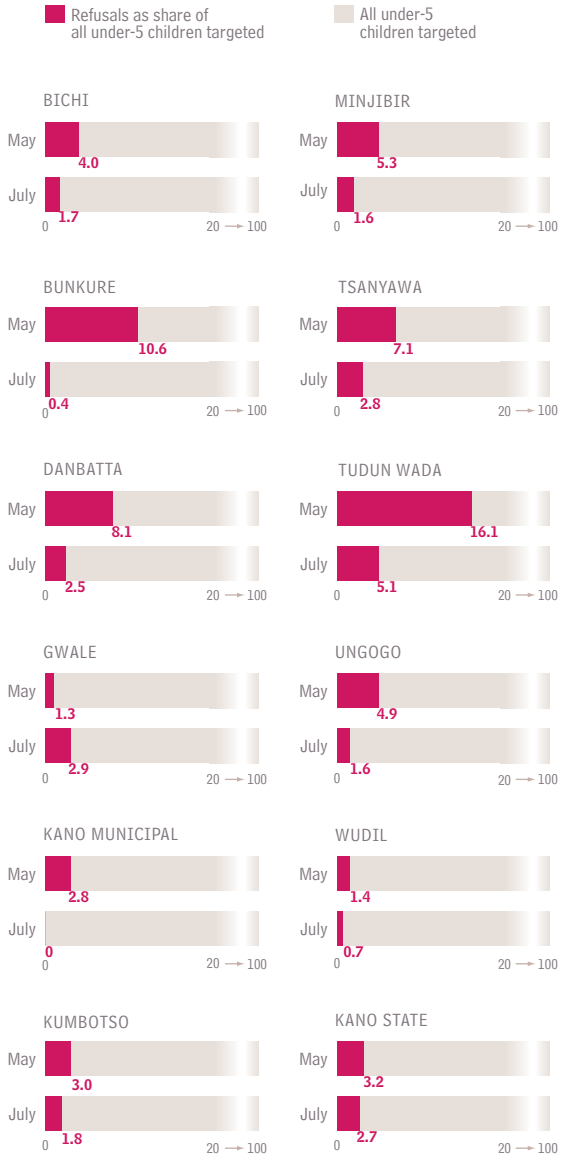
3 Data as of 8 October 2012.

refusals

The states of Sokoto and Kano carry the highest burden of refusals and the largest number of resulting polio infections, with more than 65% of cases attributed to families that refuse to vaccinate their children.

FIGURE 5 | SOURCE: VOLUNTEER COMMUNITY MOBILIZER DATA, UNICEF

Missed children due to refusal in Volunteer Community Mobilizer settlements in Kano, Nigeria (%), May–July 2012



The Katanga province of **DR Congo** has the highest global refusal rate, with 50% of missed children—equal to 4% of all under-5 children in the province—attributed to lack of caregiver consent in the July vaccination round (see figure 7). At the same time, Katanga is also the area demonstrating the most dramatic improvement: during the last six months, the total proportion of under-five children missed due to refusals has decreased from 10.54% in January to 4% in July 2012. Still, religiously motivated refusals, fatigue from multiple rounds of OPV doses, and rumours that the vaccine is unsafe continue to limit progress in resistant strongholds of northern Katanga and Maniema.

Successful engagement with resistant families can be partially attributed to participatory approaches, supported by partners like the United States Center for Disease Control and Prevention (CDC), which has provided communities with training to help identify and resolve issues leading to refusal. This strategy aims to foster local ownership and yield a more sustainable and positive attitude toward all social services, particularly vaccination.

FIGURE 6 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal in northern Nigera (%), March–July 2012

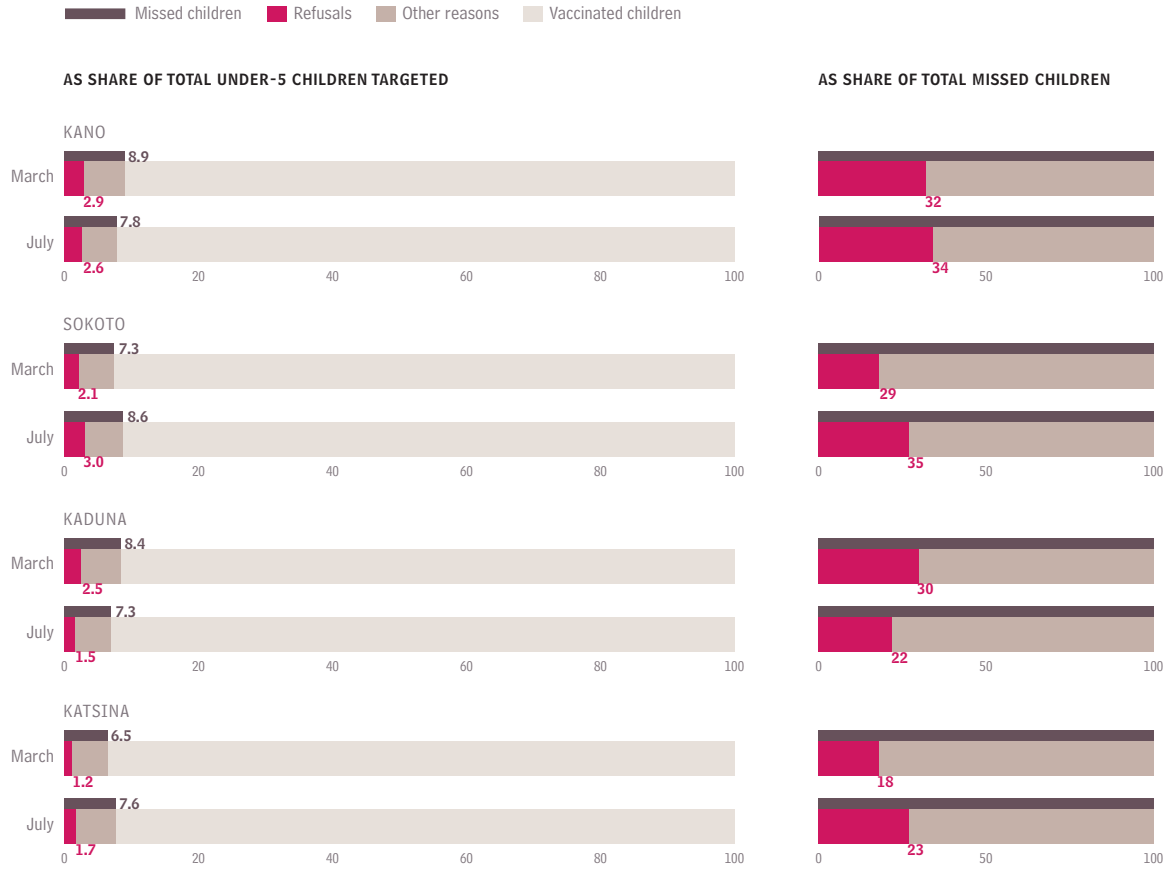


FIGURE 7 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal in Katanga, DR Congo, January–June 2012 (%)

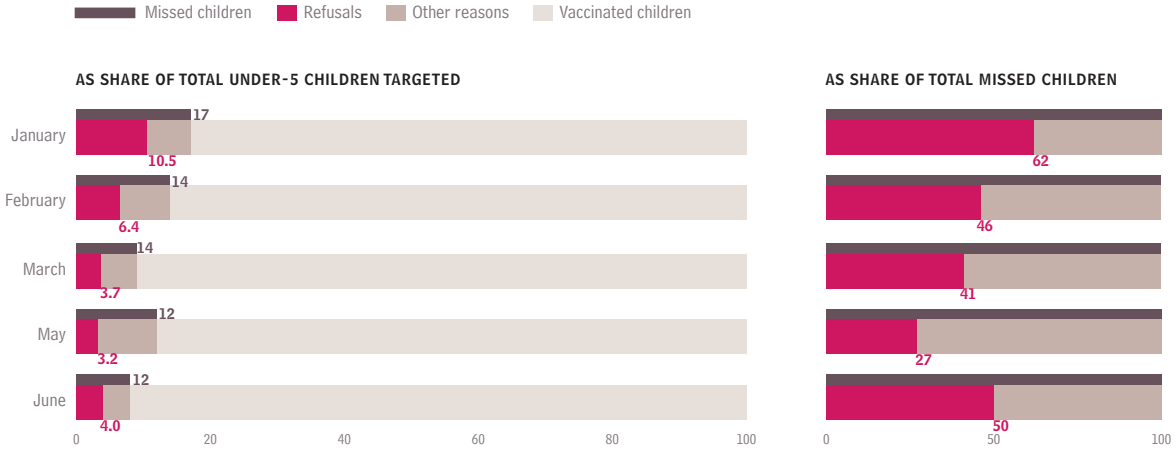
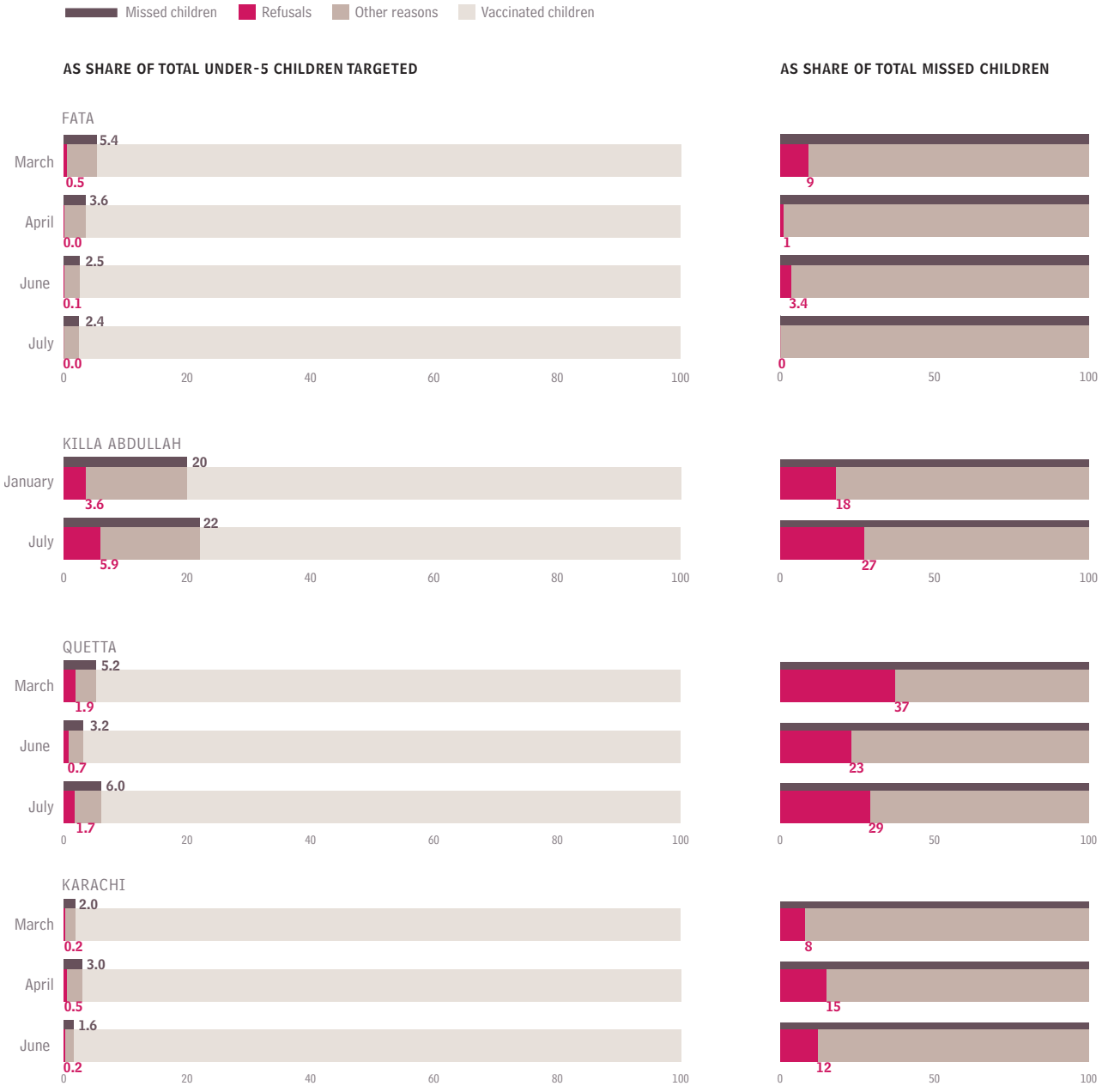


FIGURE 8 | SOURCE: INDEPENDENT MONITORING DATA

Missed children due to refusal as share of total under-5 children targeted in Pakistan sanctuaries (%), March–July 2012



UNICEF/2012/V. PETIT

This local capacity-building approach has worked particularly well in the Tanganyika district in northern Katanga. Here, local community members from some of the major religious groups who refuse the vaccine are asked to participate in the programme by facilitating debates about vaccination. In place of more aggressive, coercive vaccination techniques used in the past, this dialogue has led to excellent results. The project is now expanding this work to another 240 facilitators in six more health zones in the area.

The 18,688 government community health relais now fall under UNICEF's technical and financial management for the 5 days per month spent on polio campaigns. To improve the quality of interpersonal engagement with parents, district communication staff has recently been trained in 212 of the highest-priority health zones. In these same areas, staff has also been provided with over 9,000 bicycles to ensure valuable time before the campaign is spent speaking to families rather than traversing long distances on foot.

In **Pakistan**, refusals as a reason for missed children have declined from 11% to 8% of missed children nationally, from March to July. With most of the country vaccinated, this national refusal rate accounts for less than 0.5% of all under-5 children. The volume of polio cases due to refusal has also declined significantly in the last year, from 26% in 2011 to 10% in the first nine months of 2012 (see figure 4). The four 2012 cases linked to refusal are in Khyber Pakhtunkhwa (KP) and Balochistan.

While refusals are not a widespread phenomenon, a continuous stream of rumours, politically inspired protests and negative media coverage have a significant effect. Each such event alone produces a notable corresponding increase in the number of refusals, and when all three collide, the negative programme impact can linger for months. This volatile context serves as a constant reminder of extremely fragile vaccine and programme confidence, and of how quickly en masse refusals can ignite from one day to the next. It is critical to monitor and address social risk factors across the country to ensure a solid foundation for vaccine demand, even in areas beyond the polio sanctuaries (see 'Missed: the most at-risk children', page 20).

FATA, Karachi and the Quetta Block remain the strongholds of mistrust. In addition, lack of access in some areas of FATA and Karachi means that the real magnitude of the challenge in the most difficult areas is not fully understood.

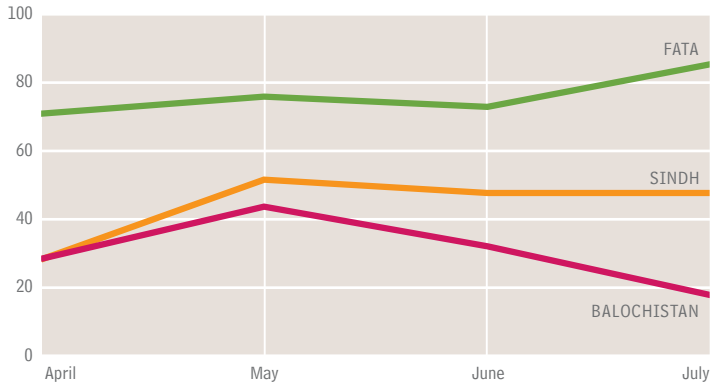
Deeper analysis of 2012 Knowledge, Attitudes and Practices (KAP) survey data[4] has shown that FATA parents are 40% more likely to refuse OPV than in any other part of the country, mostly due to beliefs that it leads to sterility and is composed of ingredients that are not *halal*.

Despite such sentiments, refusals have been on a consistent decline, falling from 9% of missed children in March to 3% in May and 0% in July (see figure 8). This data does not reflect the opposition to the programme and the strong tendency to reject the vaccine in the districts of North and South Waziristan, where Taliban-inflicted polio-bans have prohibited all access since July. Against this background, the stark decline of refusals in Pakistan's other high-risk areas is all the more impressive, particularly because it demonstrates the power and effectiveness of social mobilization that engages all segments of society, focuses on addressing specific misconceptions and utilizes multiple communications channels.

4 'Polio Knowledge, Attitudes, and Practices Baseline Study', UNICEF-SoSec, Pakistan January 2012.

FIGURE 9 | SOURCE: POLIO CONTROL ROOM DATA/PRIME

Refusals converted by COMNet staff in high-risk areas of Pakistan, April–July 2012



Progress in FATA is largely due to the concentrated and rigorous outreach to religious and traditional leaders, alongside persistent mobilization by Communications Network (COMNet) staff and localized media support. In FATA, the COMNet rate of refusal conversion is the highest in the country (see figure 9): 3 of 4 parents who initially refused vaccinate their children after interaction with a COMNet mobilizer. In-person interaction between programme staff and parents or communities has been further bolstered by a tailored mass media campaign designed to address FATA's unique challenges and cultural context.

There are clear tribal links between FATA and Karachi, and migration of FATA community leaders to Gadap Town has significantly contributed to the erosion of programme trust in this Karachi township during the last quarter. Without taking migration into account, KAP data suggests that Gadap parents are not pre-disposed to refusing OPV more than caregivers in other parts of Pakistan. The recent violence directed at programme staff likely do not reflect an intrinsic community opposition to the eradication effort. Continued mobilization of key influencers in FATA will be critical to opening doors in Gadap.

SOCIAL AND CULTURAL REASONS

In southern **Afghanistan**, vaccination teams standing outside doorways, surrounded by children holding up younger children for vaccination are a common sight. Women rarely answer the door to men, so it is typically the older children who bring younger siblings out to the vaccinators. If a child is less than 40 days old, it is considered bad luck to bring him or her out of the house, and if children are sick or sleeping, it is unlikely that their older brothers or sisters, themselves children of only 7 or 8 years old, will understand the importance of bringing younger siblings out for vaccination.

Some districts appear to have overcome this barrier. One example is Shahid hassas, where newborn, sick or sleeping children accounted for 21% of all missed children in January but steadily declined to the current 9%. Understanding, documenting and replicating the strategies that worked in Shahid hassas in the country's other high-risk districts should be prioritized in light of the high-district average of more than 19% of missed children attributed to this reason.

CHILDREN NOT AT HOME

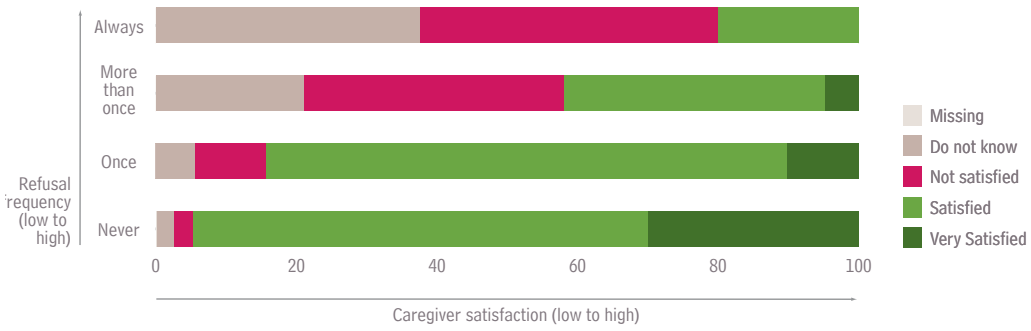
The most common reason for missing children in all priority countries is simply that they are outside the house when vaccination teams visit. **Nigeria** is the only country that consistently collects detailed information on this indicator for micro-planning purposes, revealing that 1 in 5 children are not available because they are at the family farm. Despite close to 50% of Nigeria's polio cases originating in these farming communities, the programme has yet to formulate a clear operational and communications strategy to address this critical issue. Social events and children in playgrounds close to the house make up another 50% of Nigeria's absent children. Whilst special teams exist to catch children in play areas and social events, these strategies must be reviewed, aggressively intensified, and adjusted as data reveals additional information. Data collection systems to capture more detailed information about where to reach children when they are not at home during vaccinator visits must also be standardized across the programme.

on the move

The most common reason for missing children in all priority countries is simply that they are outside the house when vaccination teams visit.

FIGURE 10 | SOURCE: UNICEF KAP STUDY, 2012

Correlation of caregiver satisfaction with team performance and refusal frequency in Pakistan (%)



TEAM PERFORMANCE

Data from **Pakistan** underscores the inextricable link between team performance and vaccine acceptance. In all high-risk areas of the country, parents satisfied with team's makeup (the age, gender and appearance of staff) and performance, including professional credibility and how much time they spend in the household, are less likely to refuse OPV. Among those who say they "always" refuse OPV, only 20% were satisfied with team performance, compared to more than 95% satisfaction among those who say they "never" refuse (see figure 10).

Interpersonal skills are of particular importance for all frontline workers, because interaction with mobilizers and vaccinators is often the only interaction between parents and the programme. As such, training to improve the interpersonal skills of vaccinators has commenced and will require a sustained effort.

Missed

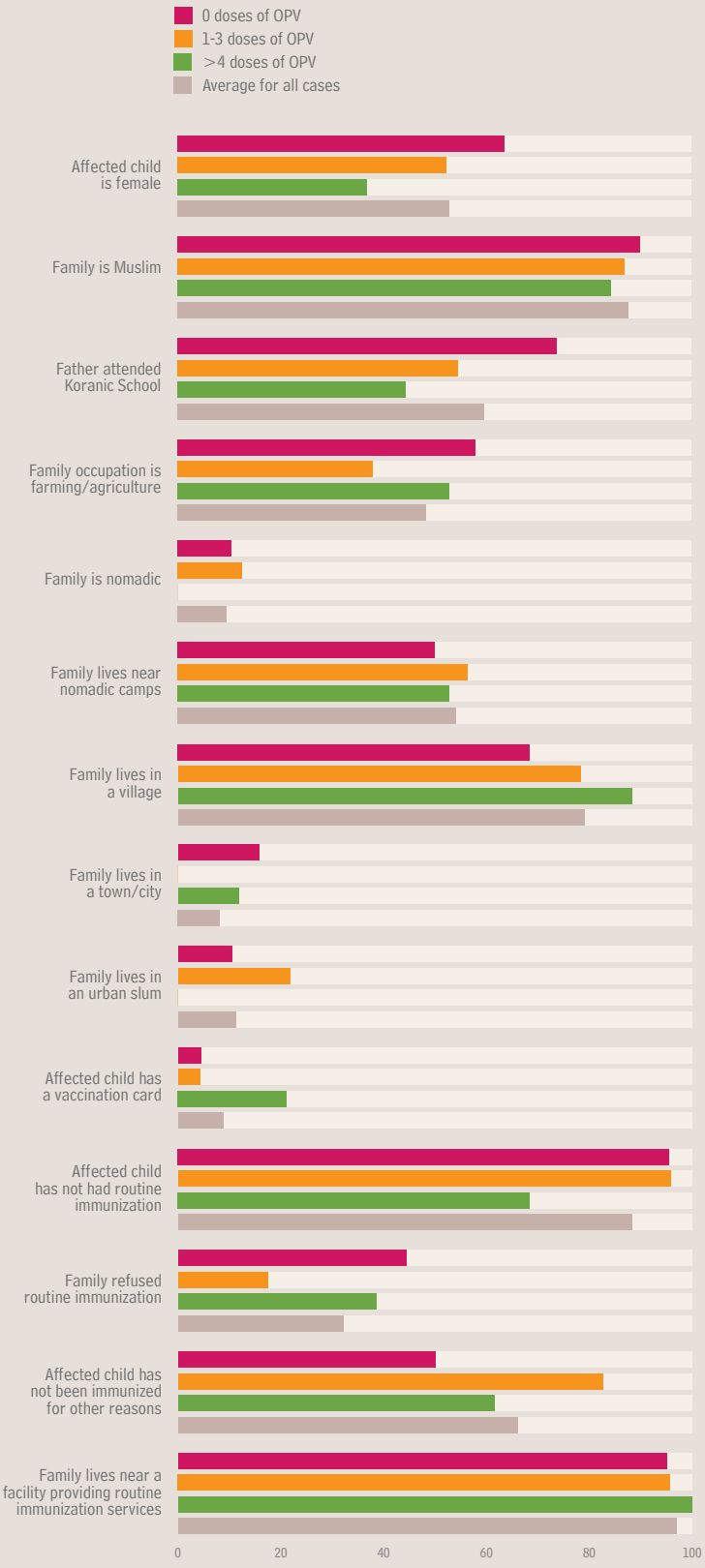
The most at-risk children

Identifying and focusing intensive efforts on the highest-risk geographic areas has been the key to success of the polio eradication effort thus far. At this very last stage, however, a purely geographic focus is no longer enough. The programme must drill down even further—to specific communities, households and even individual children who are most at risk—in order to identify and respond to the specific socio-cultural circumstances and beliefs that continue to act as polio's last line of defence.

WHO/2011/T. MORAN

FIGURE 11 | SOURCE: DETAILED WPV CASE INVESTIGATION FORMS, 2012

Profile of Nigeria's wild poliovirus cases, October 2012



Note: Analysis is based on 65 Detailed WPV Case Investigation Forms for 2012 cases. As of 17 October, forms for additional 32 cases were not available for review.

In reducing polio incidence by 99%, the eradication programme has demonstrated an unprecedented commitment to reaching and immunizing children in the most challenging and hard-to-reach areas of the world. Yet millions of children remain unvaccinated, living beyond the reach of even the most basic health services. To improve the planning, social mobilization and service delivery to reach these children, a systematic and evidence-based process of risk assessment is underway to further understand exactly which children are most likely to be missed in Nigeria and Pakistan, and why.

The analysis presented in this section draws on both new and existing information available from different areas of the global polio-eradication programme. Nigeria's analysis relies on analysis of case investigation surveys, while Pakistan's assessment is primarily derived from a Knowledge, Attitudes and Practices Survey conducted in January, 2012. Pulling this information together from various sources has provided critical new insight, and illustrates the power of sharing data more systematically within the GPEI partnership. Although the preliminary profiles of at-risk groups presented in this section are not exhaustive, they will continue to deepen and are already specific enough to help refocus current on-the-ground efforts and inform strategic planning going forward.

All Nigerian children living in communities with 2012 polio cases are at an extreme risk, given the combination of incidence and lack of vaccination: 27% of such children have not been immunized by either polio campaigns or the government's routine services.

routine
munization

Northern Nigeria

WHO

Children of farmers, traders and nomads

Nigeria's farming families are a particularly high-risk group. This year, nearly half (48%) of the country's polio-affected children [5] and 58% of zero-dose children came from farming families (see figures 11 and 12)—not entirely unexpected in a region where nearly three quarters of adults are directly or indirectly involved in agriculture.[6] However, given that almost 70% of missed children are absent when vaccination teams visit, it is imperative to refine operational and communications strategies to reach farming families with information and vaccine either at different times or beyond the homes and closer to the field.

A further 12% and 10% of 2012 cases came from trading and nomadic families, respectively.

Frequent changes of location, whether livelihood or lifestyle-dependent, are a factor that needs further scrutiny and targeted action. A recent assessment by CDC-supported National Stop Transmission of Polio (N-STOP) enumerated nomadic communities in 41 northern Local Government Areas (LGAs) and reviewed micro plans to determine whether or not these populations were likely to be covered by vaccination teams. Among the 10,329 identified nomadic settlements, 1,578 were never visited, translating to more than 15,000 unvaccinated (zero-dose) children.[7]

Children never reached with routine services

Almost all (95%) of Nigeria's polio-affected children who have never been vaccinated with OPV during supplementary immunization activities (SIAs) have also not received routine immunization. Only 4.5% of these never-reached children had a vaccination card, compared to 20% of children with four or more OPV doses (see figure 11).

All Nigerian children living in communities with 2012 polio cases [8] are at an extreme risk given the combination of incidence and lack of vaccination, as 27% of all such children have not been immunized by either polio campaigns or the government's routine services. Nigeria's Federal and LGA-level authorities face the same access challenges as the polio-eradication programme: since 2008, routine immunization coverage has remained persistently low—less than 50%—in current polio-sanctuary states of Borno, Kano, Katsina, Kebbi and Yobe.[9]

The partnership must intensify efforts to devise strategies that complement and improve the performance of all vaccination efforts.

5 Data from Detailed WPV Case Investigation Forms on 65 cases among a total of 97 cases as of 18 October 2012.

6 International Commission on irrigation and Drainage see http://www.icid.org/v_Nigeria.pdf.

7 'Nomadic Settlements Enumeration, Landscape Analysis and IPDs Micro-Planning Exercise In Northern Nigeria', Report of the National Stop Transmission of Polio, August 2012, Nigeria.

8 Data from 33 community surveys with a sample size of 1,704 children.

9 International Vaccine Access Center, Johns Hopkins Bloomberg School of Public Health, *Landscape Analysis of Routine Immunization in Nigeria: Identifying Barriers and Prioritizing Interventions,* August 2012, Baltimore [MD].

FIGURE 12 | SOURCE: DETAILED WPV CASE INVESTIGATION FORMS, 2012

Occupational distribution of polio-affected families in northern Nigeria, 2012

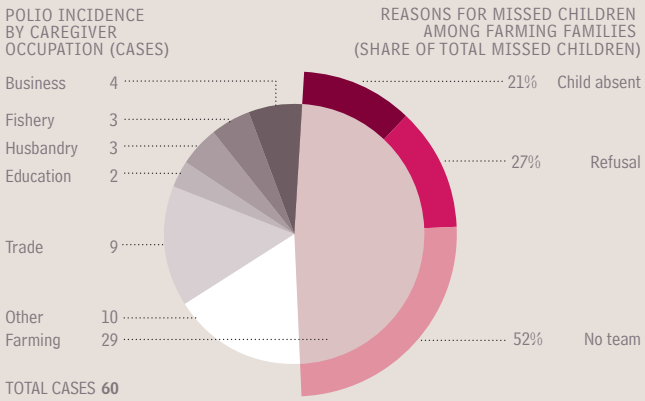
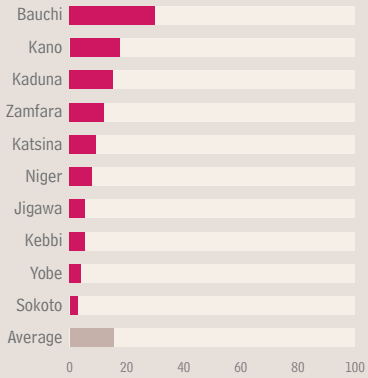


FIGURE 13 | SOURCE: N-STOP 2012

Nomadic settelments never visited by vaccination teams as share of all identified settlements in northern Nigeria (%)



Note: A total of 1,578 nomadic settlements were identified by N-STOP.

Children of parents lacking a formal education

Absence of a formal education is another clear risk factor. Among all of Nigeria's polio-affected zero-dose children, 74% of fathers have received only a Koranic education (see figure 11). In contrast, among polio-affected children with more than 4 doses of OPV, fathers with Koranic-only education accounted for a much lower 44%, and 20% went to primary school—double the proportion of primary education in zero-dose families.

Social research from other countries has previously demonstrated that primary education is a critical driver for vaccination, ranking as more important than either secondary or post-secondary education. Nigeria is among the countries that have yet to come close to the goal of attaining universal primary education, but there is a stark difference between the incredibly low education levels in polio sanctuaries and the national average of some 80%.[10]

10 Nationmaster website; see: http://www.nationmaster.com/graph/edu_edu_pri_com_rat-education-primary-completion-rate

Lack of knowledge on the importance of OPV is a substantial challenge for vaccination advocacy. The communications programme must ensure that its strategy—from mobilizer recruitment to advocacy material development—addresses the low education and literacy levels of high-risk caregivers.

WHERE

- **Bauchi State:** Almost a third (30%) of identified nomadic settlements were never visited by vaccination teams (see figure 13).
- **Kano** and **Sokoto States:** More than 60% of families with polio-affected children had previously refused OPV (see figure 4).
- **Yangero (Gaya LGA, Kano), Sabuwar Kaura (Mani LGA, Katsina)** and **Dalauda (Tundun LGA, Kaduna) settlements:** More than 89% of children surveyed never had a single dose of OPV (see table 1). In two of the three settlements, all children were missed due to the absence of vaccination teams.
- **Zuwa Dawuri (Maiduguri LGA, Borno)** and **Sheme (Sumaila LGA, Kano) settlements:** More than 60% of parents refused vaccination, contributing to a third of the settlements' children not having received a single dose of OPV (see table 1).

UNICEF/2012

WHY

More than half (52%) of the farming families affected by polio said they did not vaccinate their children because **teams did not arrive** (see figure 12). In the 8 sanctuary states, the proportion of missed children who are not vaccinated due to teams not arriving is approximately 7%.

Another third of polio-affected farming families **refused OPV** during an SIA. Although an extremely small sample size from which to make conclusions,[11] among the farmers who refused, almost half said they refused because their **child was already protected**; 21% said they refused due to **religious reasons**.[12]

Among the zero-dose polio cases, 44% refused routine immunization services. Anecdotal evidence suggests that many of these families do not know why routine immunization is important.

More than a third (38%) of the 10,329 nomadic settlements identified by N-STOP were neither included in a microplan nor identified to the programme by a tribal leader.

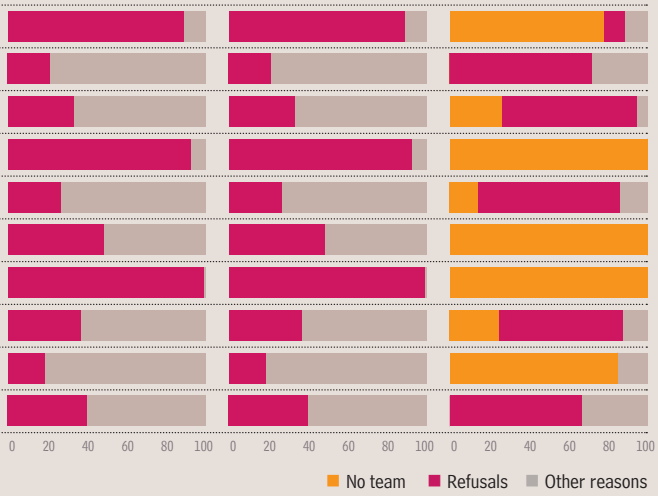
11 Data from 19 families surveyed.

12 WHO Outbreak Investigation Report, Nigeria 2012.

TABLE 1 | DETAILED WPV CASE INVESTIGATION FORMS AND COMMUNITY SURVEYS, 2012

Profiles of select polio-affected communities in Nigeria, 2012

STATE	LGA	SETTLEMENT	WPV CASE PROFILES			COMMUNITY PROFILES		
			0 doses OPV	1-3 doses OPV	≥4 doses OPV	Children with 0 doses OPV through SIA (%)	Children with 0 doses OPV through routine immunization (%)	Reasons for missed children through SIA (share of total, %)
Kano	Gaya	Yangero	1					
	Tudun Wada	B/Kasuwa			2			
	Sumaila	Sheme	1		2			
	Tudun Wada	Dalauda	1					
Kaduna	Ikara	Bareda			1			
	Birnin Gwari	Ung. Maiyashi Saidu	1	1				
Katsina	Mani	Sabuwar Kaura	1					
	Sandamu	Karkarku		1				
	Batsari	Gasakoli	1		2			
Borno	Maiduguri	Zuwa Dawuri		1				



Note: Data represents a selection of 33 cases with both case and community profiles available. An average of 36 children were sampled in each settlement.

Among more than 1,100 nomadic caregivers surveyed, practically all (99%) said they would be willing to vaccinate their children with routine immunizations.[13] However, 64% do not know where to go for immunizations, and only 17% can reach their nearest health facility within 30 minutes on foot.

TABLE 2 | UNICEF KAP STUDY, 2012

Drivers of caregiver decision to vaccinate in Pakistan, 2012

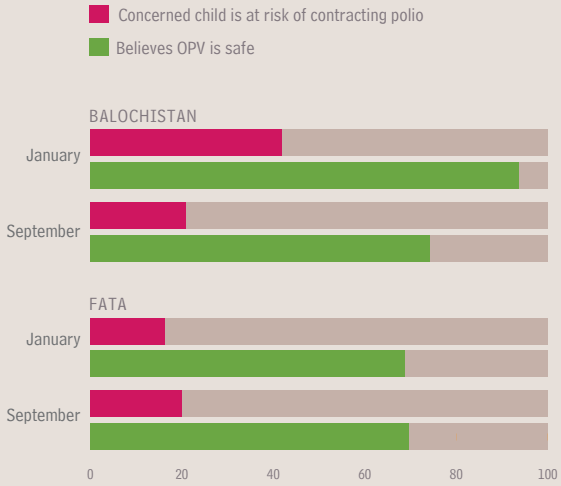
VARIABLES	PARENTS WHO REGULARLY VACCINATE
Concerned child at risk of polio	**0.034*****
Observations	4,623
Pseudo R2	0.00272
OPV is safe	**0.155*****
Observations	5,559
Pseudo R2	0.0216
Decision maker: Mother	**0.043*****
Observations	5,555
Pseudo R2	0.00482
Decision maker: Father	**-0.030*****
Observations	5,555
Pseudo R2	0.00212
Satisfied with vaccination teams	**0.257*****
Observations	5,564
Pseudo R2	0.0289
Knowledge of campaign dates	**0.090*****
Observations	5,557
Pseudo R2	0.0145

Notes: *, **, ***: significance at 90%, 95%, and 99% respectively.
Parents who regularly vaccinate is the dependent variable used for regression analysis.

13 N-STOP 2012.

FIGURE 14 | SOURCE: UNICEF KAP STUDY, 2012

Caregiver perception of risk and OPV safety in Pakistan, January–September 2012



UNICEF/2011/A.ZADAI

Pakistan

Highest-risk Pakistani families, largely Pashto speakers, remain those who live in security-compromised areas or are migrating to escape violence or to seek economic opportunity. However, risk factors that compound these families' vulnerability to polio are not limited to their geopolitical context. Analysis of 2012 KAP data from all of the country's high-risk areas highlights the socio-cultural determinants of whether high-risk families accept or refuse vaccination and shows how the two groups differ in knowledge, attitudes and beliefs (see table 2).

THE NON-VACCINATING FAMILY: A RISK PROFILE

Families that persistently refuse vaccination in Pakistan are united by low risk perception, patriarchal or traditional decision-making structures within the family and the larger community, concerns of OPV safety, dissatisfaction with team performance and low campaign awareness.

While the major challenges to vaccination in Pakistan remain operational, managerial and political, multiple factors often converge at the doorstep, making engagement more complex. A frontline worker with the wrong profile, message or dialect could spark a reaction that may not necessarily be directly related to the vaccine or the programme. In this context, the interaction between caregiver and frontline worker must quickly evoke credibility and trust; dialogue must clearly articulate the risks and severity of polio, and the vital need for OPV. Outreach must go beyond primary caregivers to proactively engage elders.

Low risk perception

Many of the highest-risk families simply do not feel their children are at risk of contracting polio.

Most recent data shows that parents in Balochistan are now less concerned about their children contracting the poliovirus than they were in January 2012, when 42% of parents reported such concern.

BOX 2

Standardizing the case investigation process

Undertaking a social risk assessment has revealed several challenges with current data collection systems and processes in place to investigate polio cases.

Many case investigation forms do not have social variables completed for all polio cases. In addition, community surveys are not undertaken for all polio cases identified, despite global guidelines that recommend one for each case.

The community surveys also collect almost no social or demographic data, so it is difficult to assemble a comprehensive profile of those most at risk of contracting polio and impossible to compare polio-affected children to others in their communities to determine if deeper layers of social exclusion exist for particular population groups.

Agreement has been reached on the essential data required for all partners to evaluate risk and effectively allocate programme resources. Protocols must quickly be established on the sharing of this critical information between partners, which has yet to become standard practice.

UNICEF/2012/S. ALI

BOX 3

The refusal family: a risk profile

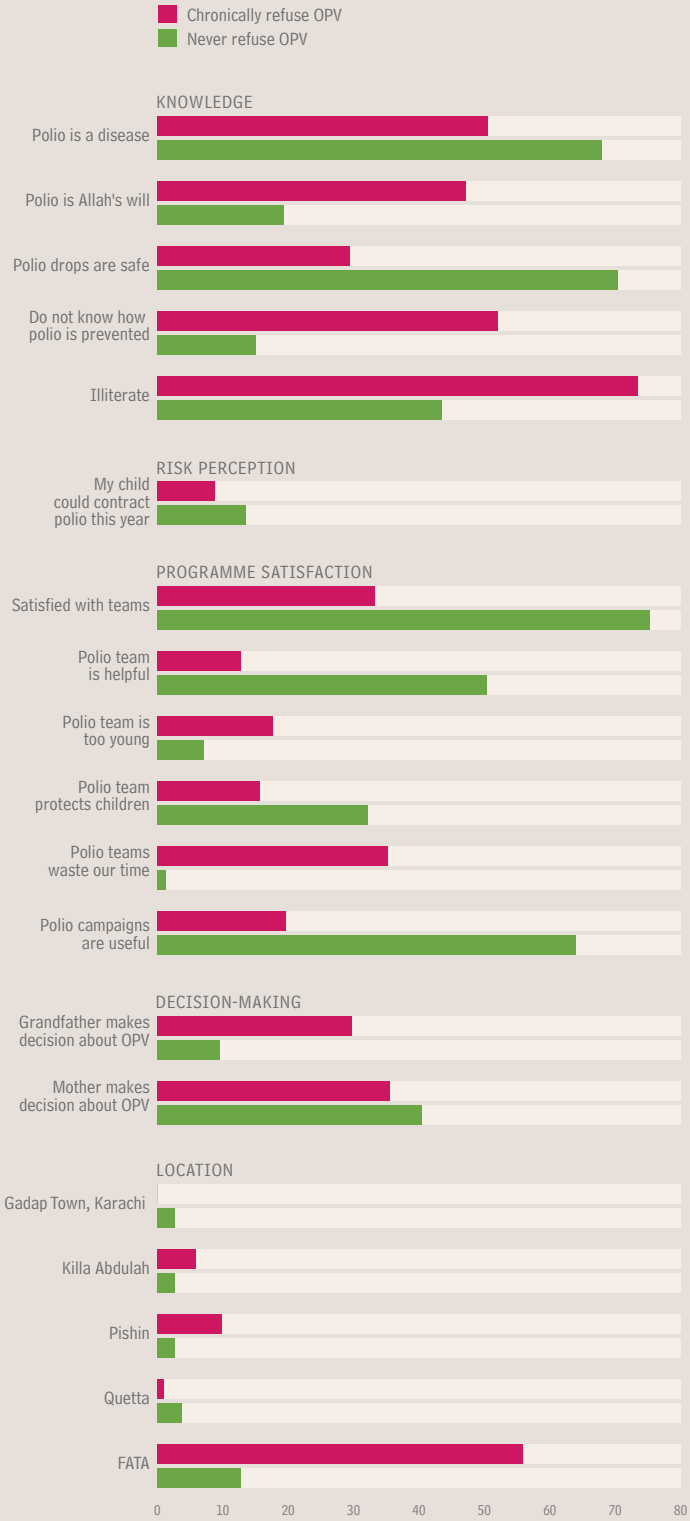
According to the 2012 KAP study, only 1.7% of caregivers chronically refuse OPV in Pakistan's high-risk areas. However, even this relatively small proportion of households could cause clusters of unprotected children that could lead to an outbreak. It is, therefore, important to understand what distinguishes this group of caregivers from others in order to develop targeted strategies to engage them in dialogue.

Though their reasons are not always identical, chronic refusers are not drastically different from caregivers who do not regularly vaccinate their children (see table 2). Contrasted with families who never refuse, characteristics of families and caregivers that refuse chronically include:

1. Lower or lacking knowledge and understanding of the nature, risk and consequences of polio and the importance and preventative nature of OPV;
2. Low confidence and mistrust of the polio-eradication programme, its staff, and the origin, effectiveness, purpose and safety of OPV;
3. Lower level of satisfaction with team performance;
4. Higher likelihood of a male or elderly primary decision maker; and
5. Higher likelihood of living in FATA, Pishin or Killa Abdullah, in order of risk.

FIGURE 15 | SOURCE: UNICEF-SOSEC 2012

Profile of Pakistani families who chronically refuse OPV, 2012



Their share has now halved, dropping to 21% in October (see figure 14). In FATA, risk perception has increased slightly during the same time period, from 16% to 20%, but despite such progress, the overall ranking of risk perception remains very low throughout Pakistan's highest-risk areas.

Pakistan is identical to other polio sanctuaries in that parents concerned their children are at risk are more likely to vaccinate them, while parents who do not experience the threat of a disease are less likely to take preventative measures (see table 2). The fact that half of chronically refusing caregivers—and 15% of families that always vaccinate their children—cannot articulate that polio is a disease suggests that educational communications efforts about polio are a high priority in Pakistan (see figure 15).

Patriarchal or traditional elder-led decision-making

Men or elders make many family decisions in high-risk communities of Pakistan, and although the health of children is generally left to the mother, men often participate in or even drive the decision on whether or not to accept OPV.

While there is a considerable body of evidence on the critical role mothers play in the health of their children, table 2 quantifies this effect: a Pakistan household where the mother is the decision maker is more likely to vaccinate a child with OPV. In households where the father is the decision maker, there is a potentially negative effect on vaccination. However, gender alone is not a dispositive indicator; programme data demonstrates that grandparents are more likely to impede than champion vaccination (see figure 15).

Lack of campaign awareness

As is the case of neighbouring Afghanistan (see page 32), child vaccination rates among Pakistani parents who know a campaign is taking place are 9% higher than among parents unaware of campaign dates (see table 2).

Concerns of OPV safety

Pakistani parents who believe OPV is safe are 15% more likely to vaccinate their children. In Balochisan, the proportion of parents who believe OPV is safe has dropped drastically since January: 94% compared to 74% in September. In FATA, historically the province with the lowest confidence in OPV safety, concerns remain at the same levels as in January. Still, maintaining the status quo can be viewed as progress—or at least not a setback—given the bans that exacerbated an already difficult operational environment and could have spread beyond the two districts of Waziristan.

Dissatisfaction with team performance

Perhaps the largest driver of vaccination in Pakistan is satisfaction with team performance. Families with a positive impression of vaccinators—as credible, knowledgeable and socially appropriate in both dress and age—are 26% more likely to vaccinate their children.

While the vast majority of the population (96%) in Pakistan are satisfied with vaccinators' performance, those that state the least satisfaction reside in the most challenging areas where it is difficult to recruit qualified frontline workers, and where a lot of programme distrust is rooted. For example, in North and South Waziristan, 44% and 19% of caregivers respectively stated they were not satisfied with teams in the January KAP. Among high risk groups, 14% of Pashto speakers stated dissatisfaction with teams compared to only 4% of the general population.

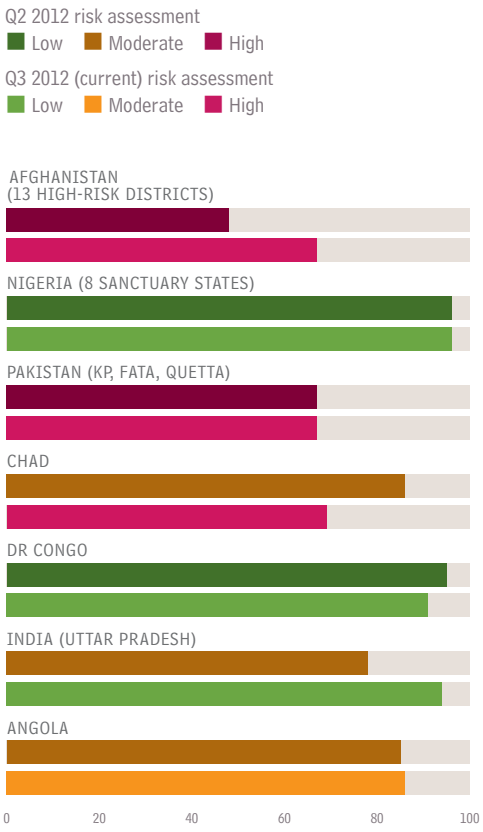
This highlights the critical need to review team profiles against minimum criteria of age, gender, linguistic fluency and interpersonal skills that are critical to projecting competence and establishing trust with caregivers.

If global eradication is to be achieved, deeper knowledge of the local communities where the poliovirus continues to circulate will be critical. While the programme has mainly focused on deploying staff for maximum coverage in the highest-risk areas, it is now time to recalibrate teams, messages and the focus of communications strategies to respond to the most at-risk families with the programme's most targeted efforts.

UNICEF/2012

FIGURE 16 | SOURCE: INDEPENDENT MONITORING DATA

Caregivers aware of polio campaigns as share of all caregivers in sanctuaries and priority countries (%), March–July 2012



Note: Chad's data reflects March–June 2012.

Campaign awareness

Only **DR Congo** and **Nigeria** consistently meet the target for the campaign awareness indicator. **India** has taken swift action against the growing complacency in Uttar Pradesh, bringing public awareness back up to 94% in September —an improvement by more than 15% since previous quarter.

Although progress is also evident in **Pakistan** and **Afghanistan**, both countries continue to struggle to achieve higher awareness of campaign dates in high-risk areas.

In Afghanistan's 13 high-risk districts, the share of parents who were aware of the polio campaigns before vaccinators arrived has grown from 49% in January 2012 to 67% in July. Awareness is even higher in communities that have a dedicated social mobilizer, and these rates have continued to improve, rising from 66% to 74% during the last quarter. The surge in awareness is most likely due to a revised media plan that tripled the frequency of radio broadcasts, particularly by channels geared to women in southern areas.

With a view to the future, Afghanistan is currently undergoing further pre-testing of the campaign's design to ensure campaign goals translate into clear calls to action that resonate with each distinct segment of the target audience. As illiteracy is commonplace among Helmand and Kandahar women, less than 2% of whom are able to read and write,[14] materials must be pictorial, clear and respectful of the cultural norms of this deeply conservative society.

In **Pakistan**, campaign awareness increases have been considerably less dramatic, despite a more sophisticated and highly visible mass media campaign launched in March 2012. Caregiver awareness has risen from a national average of 63% in January to 72% in April, but has since stagnated at 73%. In the sanctuaries of the Quetta Block, FATA and KP, available data shows no change in awareness since the April 2012 figure of 67%. The reasons for this stagnation must be investigated and addressed.

14 Provincial Development Plan, Kandahar Provincial Profile, Ministry of Rural Rehabilitation and Development (MRRD), 2007. See http://www.foodsecurityatlas.org/afg/country/provincial-Profile/Hilmand

BOX 4

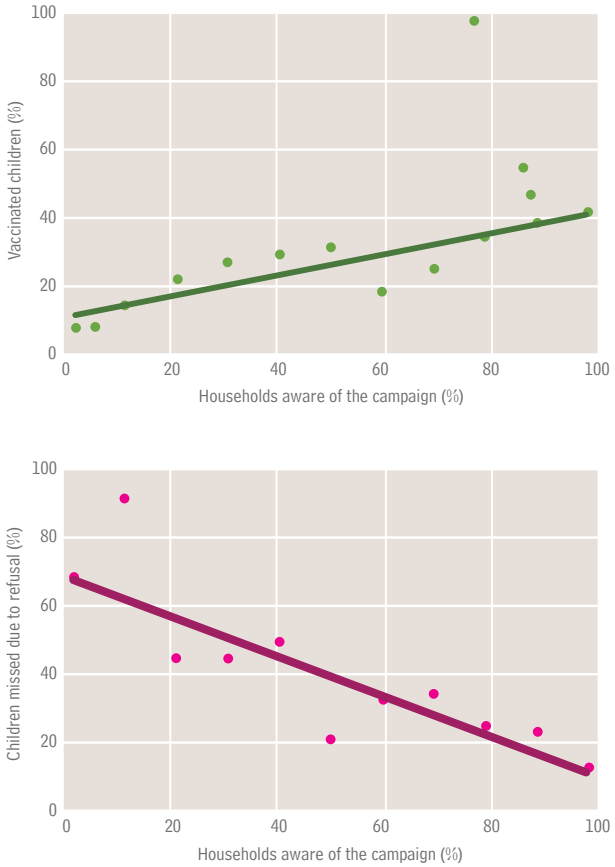
Afghanistan: higher awareness, expanded coverage

In the context of relatively low refusals and high child absence, even a marginal increase in campaign awareness levels could help reach additional children. Recent analysis of Afghanistan's Independent Monitoring data shows a positive correlation between campaign awareness and vaccination rates: areas with higher awareness tend to have higher vaccination and lower refusal rates (see figure 17).

While campaign awareness alone is not a sufficient driver for vaccine acceptance, it is a significant contributor. If vaccinators reach every household, for every 1% increase in parents' awareness the percentage of vaccinated children in Afghanistan can go up by 0.12%.

FIGURE 17 | SOURCE: INDEPENDENT MONITORING DATA

Correlation of campaign awareness and vaccination rates in southern Afghanistan, July 2012



Pakistan's mass media campaign promoting polio vaccination competes in a crowded space of 252 daily newspapers and more than 100 radio and TV channels. In areas of fragile security and active resistance to polio vaccination, a direct reference to the programme can negatively affect caregivers' willingness to vaccinate, particularly in front of their peers. Still, mass media efforts must be more deliberate about moving into the highest-risk areas, where the programme continues to miss children of illiterate populations that rely on and trust local or informal communications.

While media campaigns in both Afghanistan and Pakistan aim to demonstrate an individual's power to spark collective action for increased vaccination, the programme has also experienced individuals sparking collective action for precisely the opposite effect. For this reason, the new campaigns advocate a shared responsibility for eradication. Increasingly, vaccination is being positioned as a universal public good, deeply entrenched in the pillars of Islam and specifically its teachings that promote parental and community responsibility for children's health.

In the future, media and other communications campaigns will need to further expand on the concept of collective social responsibility for vaccination. The GPEI partnership must also commit to measuring the effects of communication campaigns. All indications point to the fact that campaign awareness—a proxy for measuring how many people have been reached with more specific behavioural messages—is a critical driver for vaccination, yet data on this indicator is collected in Pakistan only once per quarter. Further, the quality of awareness data is questionable in all countries. Although at the global level, GPEI partners agreed to include this indicator into LQAS methodology, it has yet to be implemented in the field—and the programme is running out of time to translate data into action.

UN PHOTO/2012/S. RAMSON

BOX 5

World leaders make a pact to end polio at the 67th Session of the United Nations General Assembly

On 27 September 2012, the largest contingent of global leaders came together in a display of unprecedented commitment to end polio. Led by Secretary-General Ban Ki-moon, a United Nations General Assembly side session for polio hosted the presidents of the three polio-endemic countries, ministers and Heads of State from key donor countries—including Australia, Canada, Japan, the United Kingdom and the United States of America—the president of the Islamic Development Bank, Bill Gates and the leaders of all GPEI agencies.

The session, entitled 'Our Commitment to the Next Generation: The Legacy of a Polio-free World', was recognized as the most important international meeting on polio eradication in the past 20 years. It demonstrated the exceptional energy, solidarity and commitment to ending polio in these final days of the battle.

The high-level event was followed by the Global Citizen Festival on 29 September 29. The concert brought together more than 60,000 people in New York's Central Park to inspire a global movement of support for eradicating polio and ending extreme poverty.

The GPEI partnership will build on this momentum in the coming months.

UNICEF/2012

BOX 6

Redefining change agents: polio communications campaigns promote new roles for parents and leaders

Afghanistan: The "Polio is my responsibility" media campaign aims to distribute the responsibility of polio prevention among the entire range of stakeholders, turning mothers, fathers, religious leaders, teachers and political leaders into agents of change. When the campaign fully launches in November 2012, people from each group will be featured fulfilling their responsibility to vaccinate children in their family, school and religious or political community in different regions and areas of the country.

Pakistan: "How far would you go" aims to position real people at the heart of the eradication effort, showcasing heroes who go to great lengths to promote or deliver vaccination. A new advertisement was developed after the tragic attacks on programme staff in Karachi. The ad featured Abrar Khan, a polio-affected Pakhtun from Karachi's Baldia Town. Khan now works as a COMNet social mobilizer in his community and epitomizes overcoming challenges to ensure every child is vaccinated. His personal call to action has been widely publicized, and he has been well-received across the country as a champion of eradication.

In Pakistan, the proportion of parents who will now more actively seek vaccination for their children in the absence of a visiting team has increased over the last 9 months. When asked what they would do if their children did not receive OPV during a scheduled campaign, the proportion of parents who said they would "do nothing" has gone from 27% in January to 22% in September, according to the latest KAP survey conducted across high-risk areas. The share of caregivers who said they would take their child to a health centre went up from 59% to 62% during the same time period. This rise in parental responsibility for vaccination is further supported by the slight increase in the number of those who said they would complain about the absence of teams to the polio hotline or the health facility.

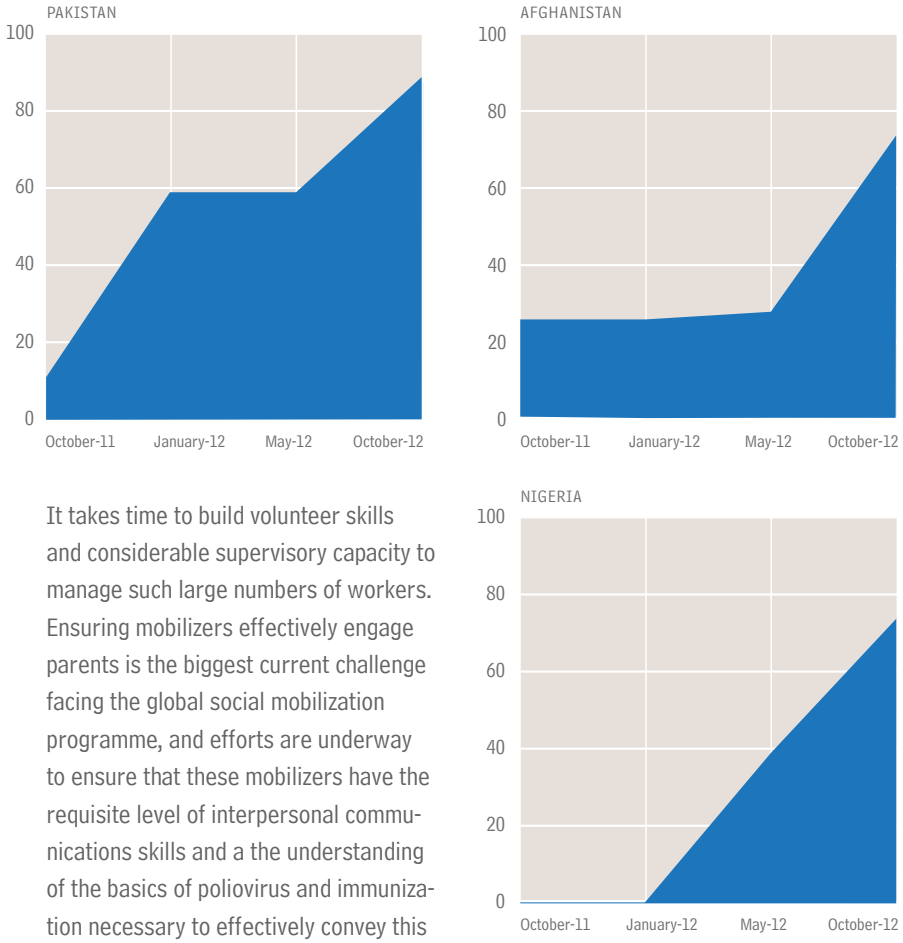
Personnel

With all staffing targets met at the national and community levels, more communications staff are on the ground mobilizing communities than ever before. Over the last quarter, the proportion of high-risk areas covered by social mobilization networks in the endemic countries has nearly doubled, rising from 41% to 78% (see ftable 4). Such expansion leads to needing stronger supervision and quality assurance, which means staffing requirements are likely to increase in 2013.

In the highest-risk areas of Nigeria, DR Congo, Pakistan, Afghanistan and India, nearly 32,000 dedicated polio-eradication workers mobilize demand for OPV. Before each vaccination campaign, these workers personally reach more than 13 million families to discuss the importance of vaccination. In the three polio-endemic countries, more than 5,000 mobilizers reach almost 800,000 families per month.

FIGURE 18 | SOURCE: UNICEF MONITORING

Scale-up of social mobilization networks as share of target high-risk areas covered, October 2011 – October 2012



Nigeria has just completed the second phase of recruitment for the Volunteer Community Mobilizer network, with 82% of the 2,500 mobilization staff members currently deployed in 7 states and 104 Local Government Areas (LGAs). Deployment is lagging only in Yobe, where the delay is due to security challenges. Now that most staff have been deployed, administrative, management and monitoring systems must follow with expedience to ensure the network functions effectively.

Pakistan's COMNet staff exceeds 1,000 people who operate nationwide, but there are large variations in the numbers of houses covered by individual mobilizers in different areas, highlighting the need to establish minimum coverage targets for each.

Afghanistan's Polio/Immunization Communication Network (P/ICN) mobilizers are hired anew on a monthly basis and must be given refresher training before each campaign. The recent expansion—from 23% of the high-risk areas covered in April to the current 73%—requires careful monitoring to ensure the speed of scaling up has not compromised quality of programme delivery.

It takes time to build volunteer skills and considerable supervisory capacity to manage such large numbers of workers. Ensuring mobilizers effectively engage parents is the biggest current challenge facing the global social mobilization programme, and efforts are underway to ensure that these mobilizers have the requisite level of interpersonal communications skills and a the understanding of the basics of poliovirus and immunization necessary to effectively convey this information to caregivers.

Across all countries, a more systematic approach is needed to ensure the quality and reach of these fledgling networks. Although the contexts in which these networks operate vary across and within countries (see box xx), standard procedures—with clearly laid out deployment criteria, minimum household coverage targets, training standards and key performance indicators linked to a broader accountability framework—must be established and implemented for all areas.

SOCIAL MOBILIZATION NETWORKS

To address diverse needs and contexts, the programme employs variations of three main models of social mobilization networks across the five priority countries. In each country, a model is selected based on its potential to maximize the available human and financial resources, while achieving the greatest impact in the required geographical areas.

Government outreach model

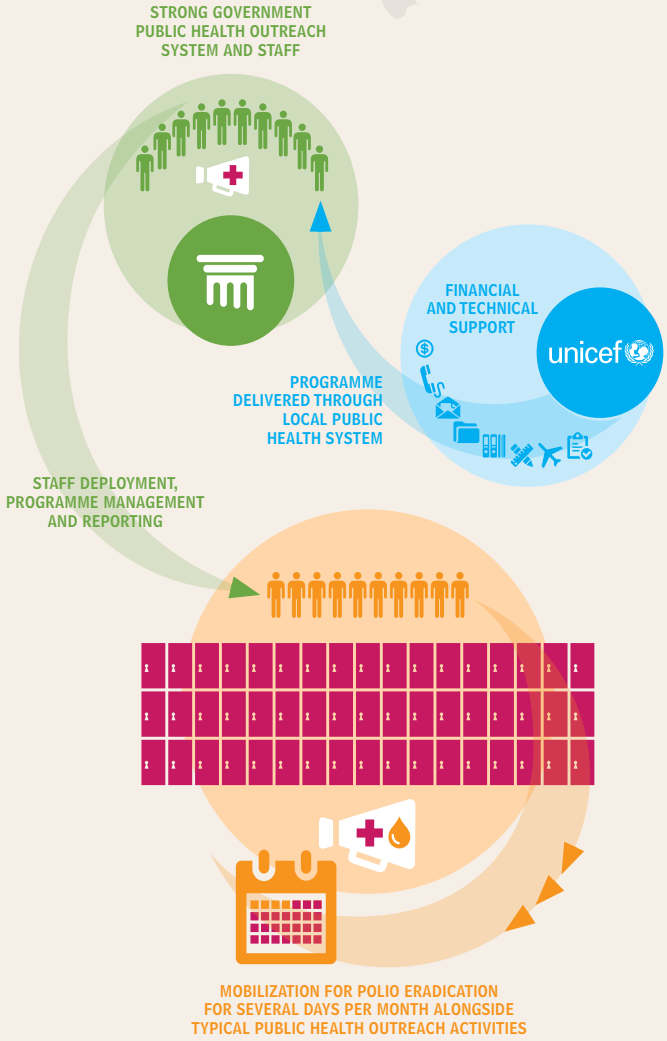
Where a strong government health outreach system is already in place, there is a focus on supporting the existing workforce to promote polio vaccination alongside routine immunization and other childhood care practices. This model was first developed successfully for polio eradication in Bihar, where over 50,000 anganwadi workers—deployed throughout even the most remote areas—form the backbone of polio social mobilization efforts in the days leading up to a campaign. Because such workers already spend the rest of their month counselling mothers on all family practices, they are the most effective workforce to gain trust, identify newborns and notify the programme of household movements. Full-time SMNet workers have since been added to the programme to bolster the anganwadi workforce, mostly in urban settlements and slums.

The government health outreach model is also used in DR Congo, where 18,688 of the nation's community health relais work for polio several days a month, with technical and financial support

Lessons from India: exporting social mobilization network models

Government outreach model

Origin: Bihar
Applications: DR Congo, Chad

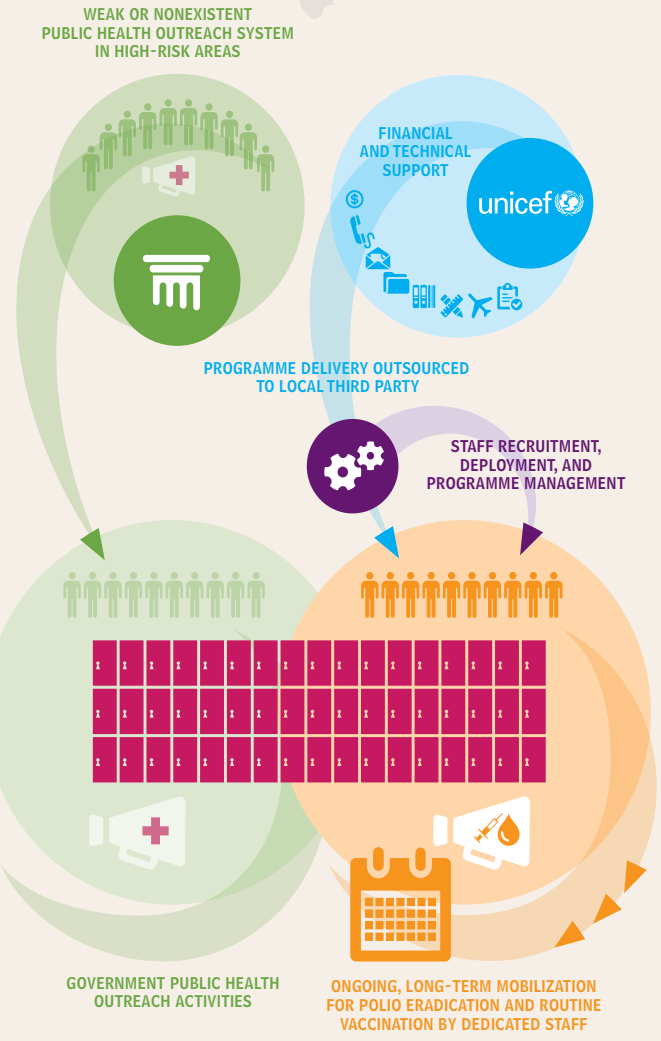


Strengths: Builds on existing national workforce to maximize investments and sustainability.

Weaknesses: Problems of supervision and quality, unless there is a strong accountability framework and effective management in place.

Parallel outreach model

Origin: Uttar Pradesh
Applications: Pakistan, Nigeria, Afghanistan

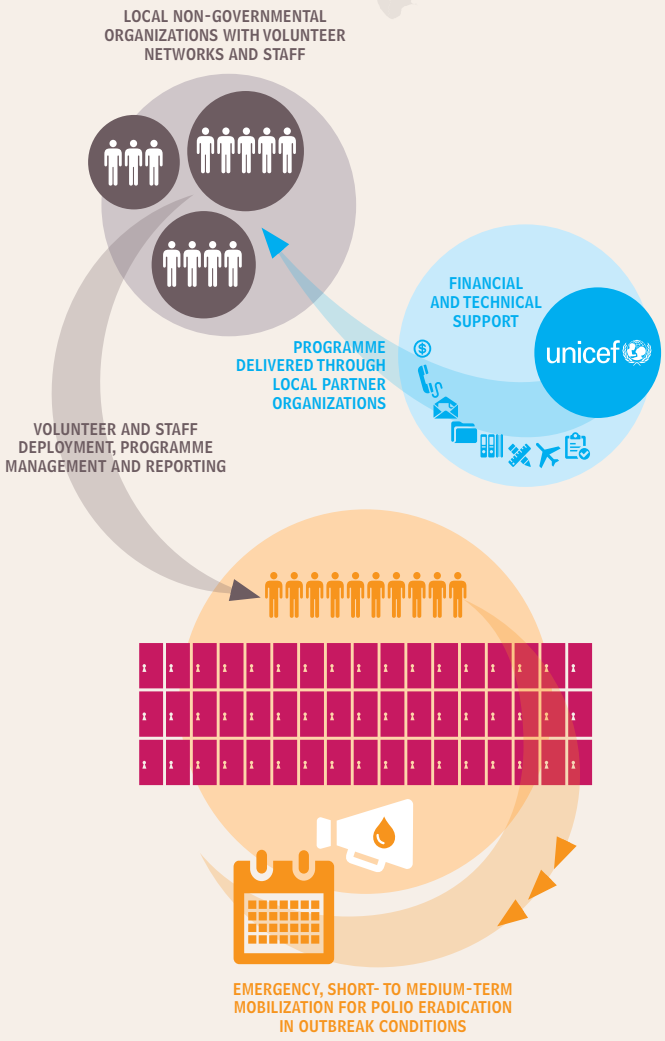


Strengths: Maximizes performance with strong third-party management, supervision and dedicated staff.

Weaknesses: Most cost and management-intensive; risks being disbanded once polio-free status is achieved, unless other programmes take over responsibility. If run by the government, strong accountability structures are needed to ensure quality.

Rapid response model

Origin: West Bengal
Applications: Pakistan (FATA, Balochistan), Angola



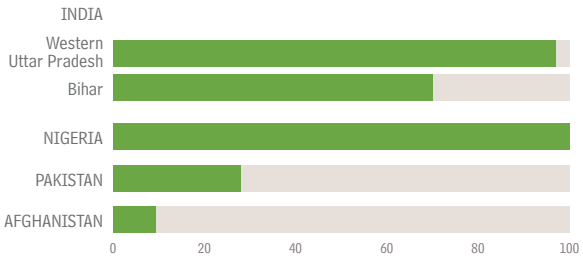
Strengths: Builds on existing skills and strong community links, making it a particularly suitable for outbreaks and rapid response.

Weaknesses: Quality of programme is entirely dependent on the local executing partners and reflects their strenghts or weaknesses.

UNICEF/2012/V PETIT

FIGURE 19 | SOURCE: UNICEF DATA

Female social mobilizers as share of total (%), October 2012



Note: Afghanistan data is for the southern region.

BOX 7

Woman to woman: the work continues

We must continue to scrutinize the gender makeup of mobilizer and vaccination teams, setting concrete targets for hiring female workers who are better suited to reaching and building trust with mothers in certain areas.

A decade ago, a polio-eradication workforce composed exclusively of Muslim women of Uttar Pradesh was unthinkable. Today, the Social Mobilization Network (SMNet) in Uttar Pradesh is 97% female, and these 6,000 women have proven to be the cornerstone of India's polio-eradication success.

If the same is to be achieved in the remaining priority countries, ways of building similar female networks in all of them must be fully explored. While Nigeria's mobilizers are exclusively female, hiring women is considerably more difficult in Pakistan and Afghanistan, where only a respective 28% and 9% of social mobilizers are women.

Afghanistan has begun to identify approaches for attracting women to some of the most difficult southern areas and slowly increasing the proportion of female mobilizers since last quarter. In Pakistan, the female-to-male ratio is decreasing, even in the more liberal Sindh and Punjab provinces where women are able to work more freely than elsewhere.

from UNICEF. Additional workers and working days have been added to the existing system in the areas of north Katanga and Maniema where the virus persists. Chad also has plans to strengthen its community relais using this model in the coming months.

Parallel outreach model

Where the health outreach system is not yet strong enough or cannot meet the rigorous demands of the programme, UNICEF has invested in a parallel system focusing almost exclusively on polio and routine immunization. This model began in Uttar Pradesh, India, where community resistance to OPV was so entrenched that it required concentrated long-term efforts. SMNet was recruited to perform intensive mobilization functions for polio, on a scale large enough to saturate the highest-risk areas of the state.

This parallel model is now being scaled up in Pakistan and Nigeria, where UNICEF has created a dedicated network of mobilizers—recruited through third-party contractors—who work throughout the month to generate support for polio and broader immunization services. While Nigeria's mobilizers intensively cover households in each settlement, Pakistan's workers cover a larger area and rely on a mix of household interaction and community meetings to engage with caregivers.

Afghanistan's Immunization Communication Network is a hybrid of the government and outreach models. In three regions, UNICEF technically and financially supports dedicated volunteers for polio and immunization outreach, but they are contracted through the government. Their responsibilities are limited only to polio and immunization, and they work only in the days leading up to and during polio campaigns. For the remainder of the month, they serve as teachers, mullahs or private citizens.

Rapid response model

Another outreach model also originated in India, this time in West Bengal, following the Murshidabad outbreak in 2011. This model, utilizing local non-governmental organizations (NGOs) already on the ground, is built upon a principle of rapid response and the opportunities that come from drawing on local resources already in place. This mobilization model also allows for rapid scale down when there is no longer a need for such intense operations.

Building on the strength of existing NGOs and civil society organizations, this model is used in areas of FATA and Balochistan, where workers from the NGO NRDF mobilize religious leaders based on their extensive social networks and experience with this group. It is also used in Angola, where over 10,000 religious leaders are engaged through NGO networks in and around Luanda.

network models

In each country, a social network model is selected based on its potential to maximize the available human and financial resources, while achieving the greatest impact in the required geographical areas.

TABLE 3 | SOURCE: UNICEF MONITORING

Social mobilization field workers in place, October 2012

COUNTRY		TARGET (NUMBER OF `PEOPLE)	MOBILIZERS IN PLACE (NUMBER OF PEOPLE)	MOBILIZERS IN PLACE (NUMBER OF TARGET, %)
Afghanistan		1,917	1,917	100%
DRC		18,688	18,688	100%
India	Uttar Pradesh	5,634	5,398	96%
	Bihar	1,440	1,348	100%
	West Bengal	1,320	1,320	100%
Nigeria		2,500	2,053	82%
Pakistan		1,182	1,059	90%

Note: West Bengal mobilizers are deployed through NGOs.

TABLE 4 | SOURCE: UNICEF MONITORING

Social mobilization network presence in high-risk areas, October 2012

COUNTRY	SOCIAL MOBILIZATION NETWORK	HIGH-RISK AREAS TARGETED (NUMBER)	HIGH-RISK FIELD WORKERS (NUMBER)	HIGH-RISK AREAS WITH NETWORK FIELD WORKERS (SHARE OF TARGET, %)
Afghanistan	Polio/ Immunization Communication Network (P/ICN)	194	142	73%
Nigeria	Volunteer Community Mobilizers (VCM)	2500	1827	73%
Pakistan	Communication Network (COMNet)	900	789	88%
DR Congo	Relais Communautaires	9344	9344	100%
India				
Uttar Pradesh	Social Mobilization Network (SMNet)	6330	3380	53%
Bihar	Social Mobilization Network (SMNet)	1591	673	42%
West Bengal	Social Mobilization Network (SMNet)	149	149	100%

Note: Areas reflect lowest-level settlements in each country, and therefore reflect only coverage of community-level social mobilizers. Additional communications staff are in nearly all high-risk districts and sub-district level in all countries.

BOX 8

India's Learning Exchange

The January 2012 IMB report called on the India polio-eradication programme to support endemic countries through the application of lessons learned. "If India knew 10 years ago what it knows now, it would have been able to stop transmission more quickly," the report said. "We hope that the programme can now find some energy to assist other countries' programmes."

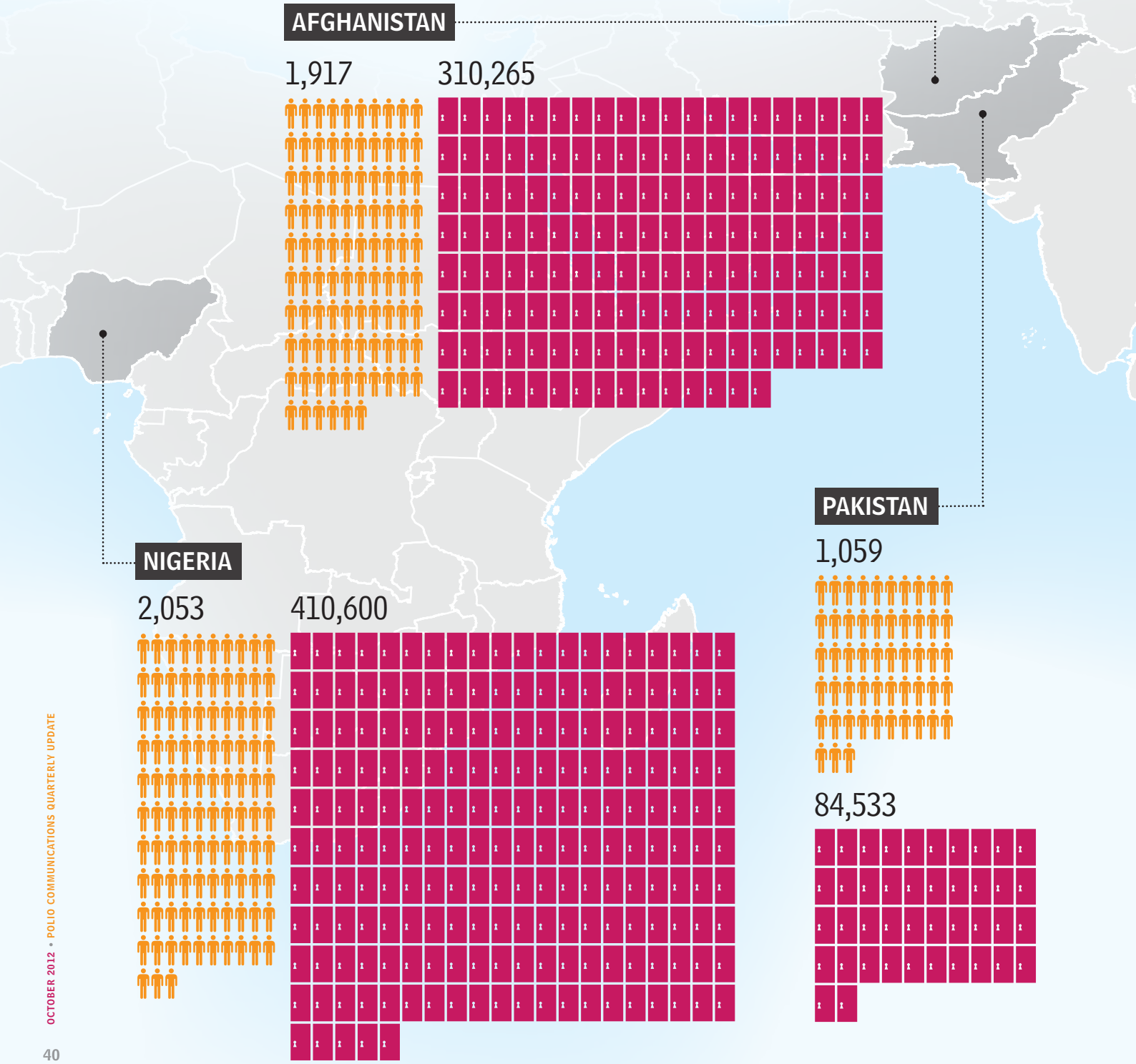
The India programme has responded by establishing the India Learning Exchange (ILE), which offers materials and technical expertise to other countries. ILE offers three forms of assistance: telephone consultations and materials sharing; in-country training for teams from other countries; and the deployment of India programme staff to other countries to help develop their local capacities.

The establishment of ILE has resulted in both the World Health Organization and UNICEF sending support missions to Nigeria, Kenya, Uganda, Pakistan, and Afghanistan in order to share best practices. Since January, UNICEF has undertaken 11 missions to and from the endemic countries. Additional technical support through remote assistance and sharing of tools has helped teams in Angola, Central African Republic and Chad build on India's experiences and learnings to accelerate progress in their programmes . A team from Nigeria is due to visit India before the end of the year.

UNICEF/2012/T. GEORGESON

In the 3 polio-endemic countries, 5,029 social mobilizers knock on more than 799,218 doors every month to mobilize demand for OPV.

= 20 mobilizers = 2,000 doors



Investing in mobilizers helps raise awareness, reduces refusals and increases coverage.

MOBILIZERS IN THE FIELD

=20 mobilizers

2,028 IN 2011

5,029 IN 2012

CAREGIVER AWARENESS OF POLIO CAMPAIGN

=1%

71% IN 2011

78% IN 2012

CHILDREN UNDER 5 MISSED DUE TO REFUSALS

=1%

1.0% IN 2011

0.7% IN 2012

UNICEF/2012/P. GEORGESON

Use of social data

Collection and analysis of social data are all vital to developing a better understanding of the reasons for missed children and the needs of the families and communities where they live. While data is being collected and used for national-level strategic planning, large gaps remain on the front lines—which is where the use of lessons learned from social data analysis can help plan interventions that improve awareness and demand before each vaccination round. Targeted communications plans are critical to reach the right caregivers with the right information, and to provide the most relevant and persuasive facts needed to decide whether or not to vaccinate. However, without adequate data informing messages that are tailored to each community, communications plans will remain unable to penetrate deeply entrenched local beliefs.

Of great concern is the continued lack of progress in the use of social data at district levels and below. **India** has been a leader in this area and has shared lessons during the last quarter. In **Nigeria**, **Pakistan** and **DR Congo**, performance is better than elsewhere

FIGURE 20 | SOURCE: UNICEF MONITORING

Social data systematically used for communications planning, March–October 2012

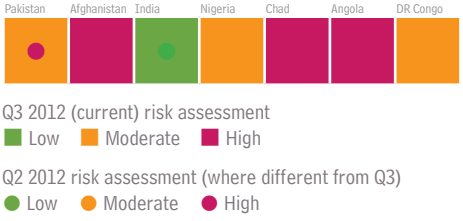
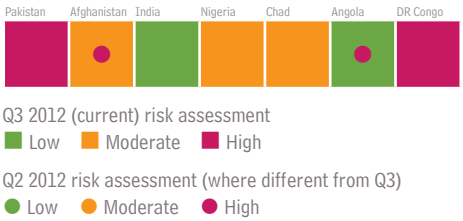


FIGURE 21 | SOURCE: UNICEF MONITORING

Percentage of high-risk areas that receive timely communication/social mobilization funding, March–October 2012



but quality is neither consistent across the board nor sufficient to ensure all socially at-risk children are being identified and reached. The remaining countries, including **Afghanistan**, have made little progress since the beginning of 2012, although new technology is being piloted to exchange data using mobile texting (Short Message Service [SMS]). Once implemented, texting will facilitate quicker exchange of information and action, with the additional benefit of addressing the capacity challenges of filling out and submitting paper-based forms.

The most critical data challenge is its continued lack of adequate reliability for use in decision-making and resource planning. Although collective decisions have been made to improve data quality, Independent Monitoring data has yet to incorporate the minimum social indicators that would enable the programme to develop stronger micro-plans and ultimately reach more children. LQAS data does not yet offer an alternative data source to reveal where the programme is not reaching parents with campaign messages, and special investigations do not yet explore the most chronically missed children, except in Nigeria. The tools are all in place; global decisions have been made to implement them; all that remains is the will and the leadership to put them to use.

Finances

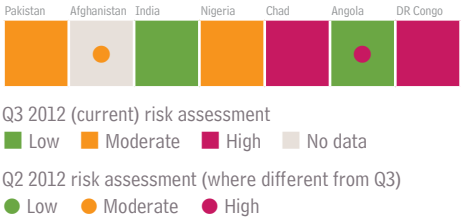
The timing of funding disbursement to the districts has improved, largely due to troubleshooting by the new UNICEF global finance and programme management team. **Nigeria** and **Pakistan** continue to face challenges resulting from funding shortfalls at national levels, though the latest incidents were resolved just before operations had to be suspended in July. Still, the situation created a backlog of contracts and payments that took several months to process and also affected fieldwork, as demonstrated by fewer activities being held and lower proportions of converted refusals in some areas.

Despite polio eradication's priority as an emergency programme, administrative procedures—particularly for financial portfolios as large as that of social mobilization networks—remain cumbersome, and additional staff is needed to manage such work. Operational procedures for eradication programmes must be given emergency status if the programme is to function at the speed and flexibility required to stay ahead of the epidemic.

In **DR Congo**, ensuring accountability for social-mobilization activities is a challenge in a context that lacks financial transparency. Due to the many oversight checks that must take place before clearing a payment, it is difficult to do so while leaving sufficient time before the next round. A new funding framework for communication activities will be piloted in Katanga and Equateur in November. Publishing team-deployment plans is expected to increase transparency and fair distribution of payment for work conducted.

FIGURE 22 | SOURCE: UNICEF MONITORING

Percentage of planned activities that took place in high-risk districts or Local Government Areas, March–October 2012



The way forward

Priorities have not drastically changed since the last quarter. Every quarter, some progress is made, but more remains to be done. What is imperative now is that swift action on the ground is finally taken to actually implement decisions made at country and global level. It is similarly urgent to implement the recommendations arising from analysis of the most recent data. In sum, the communications programme must:

- **Act on previous decisions to improve data quality on the global scale.** Ensuring adequate, quality data is available to programme managers after each polio case, and after each campaign, is essential to addressing challenges and improving the quality of the programme. We have run out of time to wait much longer for the critical information required to advance the programme. It is time to implement agreed upon decisions on data quality.

- **Continue to invest in social accountability alongside political accountability.** With mass media campaigns currently running in Afghanistan and Pakistan, these countries must raise campaign awareness more quickly in the highest risk areas. All countries, including Nigeria, must move beyond simply raising awareness towards igniting self-sustaining social movements for collective action against polio at every level. A range of influential spokespersons from both national and local realms must be continuously cultivated and expanded whenever possible.

- **Prioritize efforts among highest-risk areas and families.** Based on the current epidemiology, endemic countries should reprioritize high-risk areas afresh and establish performance dashboards—not only for the highest-risk districts, but also for the chronically missed communities and families. Special investigations are immediately needed to explore the areas and children who continue to be unprotected due to socio-cultural barriers or management challenges, particularly in northern Nigeria and Pakistan's Quetta Block.

- **Identify new strategies to reach children absent during vaccination-team visits.** While strategies to reach children beyond the doorstep exist in some areas, those that have proven to work best must be harnessed and quickly scaled up through jointly implemented plans.

- **Profile frontline workers and invest in their skills and motivation.** Each country and sanctuary should more aggressively scrutinize its frontline team makeup against minimum criteria of age, gender, linguistic fluency and any additional factors that may be pertinent to projecting competence in the local context and conducive to establishing trust with caregivers. Interpersonal skills training for all frontline workers must be rolled out in each priority country before the end of the year.

- **Establish standard operating procedures for all joint teams in the field.** Clear guidelines outlining the responsibilities and accountability for field-team functions must be established in Nigeria and Afghanistan. In all countries—including Pakistan, which has already developed such procedures—new guidelines should be launched via joint orientation sessions and monitored to ensure field use.

PolioInfo
Strengthening communications for Polio Eradication

Polio Communications Data Profiles

UNICEF/2011/G. Crouch

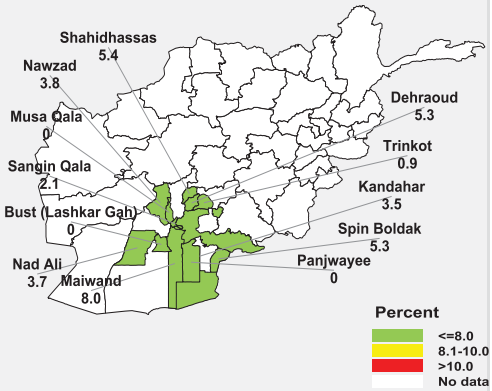
UNICEF/2012/G. CROUCH

Afghanistan

Global Communications Indicators
April–August 2012

PolioInfo
Strengthening communications for Polio Eradication
www.polioinfo.org

Missed children due to refusal (%) June



Source: Post-Campaign Assessment

Risk Assessment (Q3)

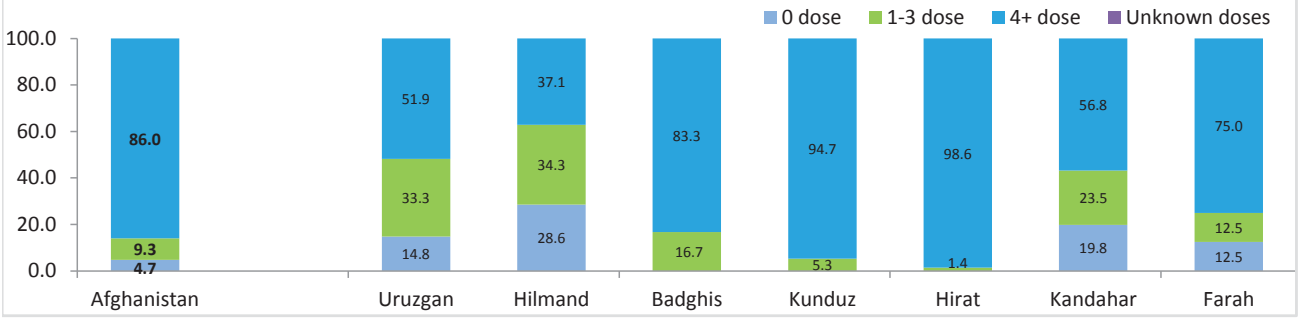
	Level of risk
Impact	
Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Low
Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	Medium
Outcome	
Trends in missed children due to refusal to accept OPV nationally and in HR areas	Low
Trends in missed children due to all social barriers to accept OPV nationally and in HR areas	High
Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	High
Source of information from those caregivers who report having heard any campaign message	Medium
Process	
Social data is systematically used for communication planning	High
Percentage of planned activities that took place in High Risk districts or LGAs that reported timely receipt of funding	High
Inputs	
Percentage of identified polio communication personnel in place in a country programme	Low
Percentage of identified polio communication field personnel in place	Low
Percentage of designated high risk areas with polio communication field personnel	Medium
Percentage of HR areas that receive timely communication / social mobilization funding	Medium

Source: UNICEF monitoring

IMPACT

Percentage of non-polio AFP cases (Children 6-35 months) with 0 and ≥4 doses of OPV*

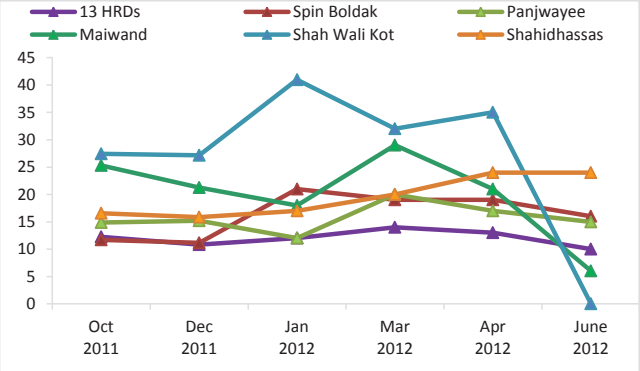
19 Sep 2011 - 18 Sep 2012



Source: WHO-HQ as reported in the GPEI Status Report, 3rd quarter. *Data has been included for select areas that have reported>15 non-polio AFP cases

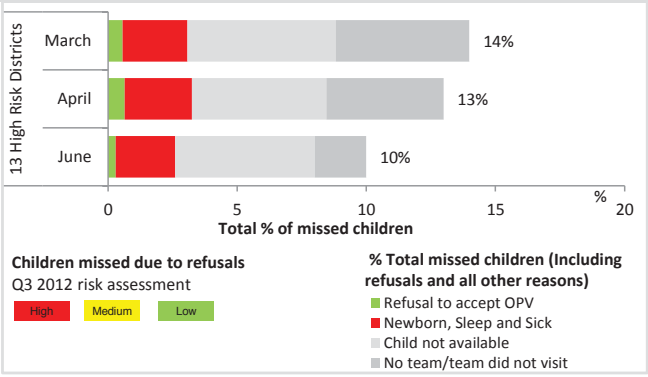
OUTCOME

Percentage of missed Children



Source: Post-Campaign Assessment

Reasons for missed children (%)



Source: Post-Campaign Assessment

Afghanistan

Global Communications Indicators
April–August 2012

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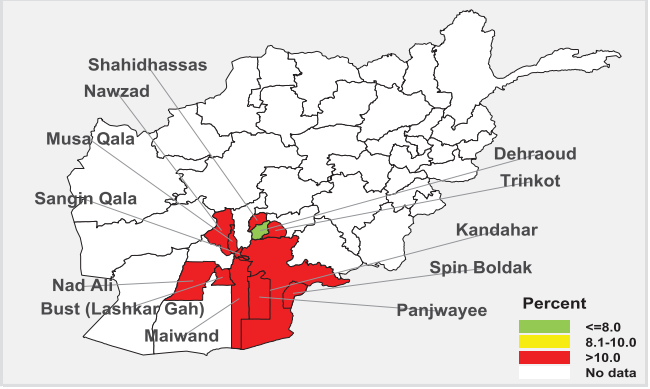
OUTCOME CONT-D

Missed children due to refusal (%)

Area	Mar	Apr	June
Afghanistan	3	3	6
13 High Risk Districts	4	5	3
Dehraoud	1	0	5
Bust	1	1	0
Kandahar City	3	0.4	3
Maiwand	3	5	8
Musa Qala	9	9	0
Nad Ali	3	8	4
Nawzad	6	7	4
Panjwayee	0	0	0
Sangin Qala	3	5	2
Shah Wali Kot	6	7	-
Shahidhassas	4	2	5
Southern Region	5	5	4
Spin Boldak	14	11	5
Trinkot	2	1	1

Source: Post-Campaign Assessment

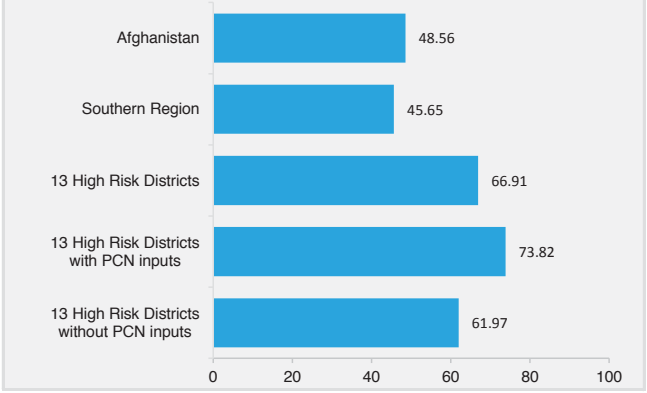
Percentage of missed children due to social reasons*(%) June



Source: Post-Campaign Assessment

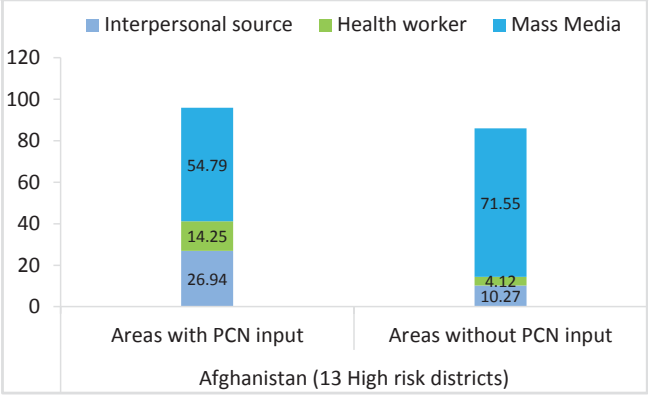
*Percentage of missed children due to 'refusals' and 'newborn, sick and sleeping'.

Parents aware of campaign dates (%) July



Source: Post-Campaign Assessment

Source of information on polio campaigns (%) June



Source: Post-Campaign Assessment

PROCESS

Social data is systematically used for communication planning

	Apr	May	June
National and sub-national plans incorporate social data (Yes/No)	No	No	No

Source: UNICEF monitoring

Percentage of planned activities that took place in HR areas

	Apr	May	Aug
Kandhar	-	-	-
Helmand	-	-	-
Urozgan	-	-	-

Source: UNICEF monitoring

INPUTS

Identified polio communication personnel in place in a country programme (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Afghanistan	4	4	100	4	4	100
Regions	4	4	100	4	4	100

Source: UNICEF monitoring

Identified polio communication field personnel in place (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Afghanistan	2068	2067	99.8	1920	1917	99.8
Provinces	47	47	-	-	-	-
Eastern Region - Province	3	3	100	3	3	100
ER - District	11	11	100	11	11	100
ER - Cluster	829	829	100	994	994	100
Southern Region - Province	3	3	100	3	3	100
SR - District	24	23	100	25	25	100
SR - Cluster	1151	1151	100	878	878	100

Source: UNICEF monitoring

*ER-Eastern Region, SR-Southern Region

Designated high risk areas with polio communication field personnel (%)

Area	Dec	Mar	Aug
Afghanistan	61	58	98.6
Southern Region - Province	100	100	100
SR - District	87.5	91	91
SR - Cluster	24.7	26.8	73

Source: UNICEF monitoring

* SR-Southern Region.

HR areas that receive timely communication / social mobilization funding (%)

Area	Jan	Mar	July
Afghanistan	0	0	100

Source: UNICEF monitoring

Angola

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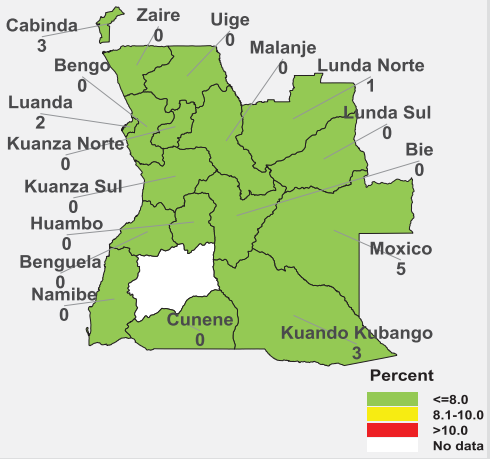
Missed children due to refusal (%) June



Source: Independent Monitoring data

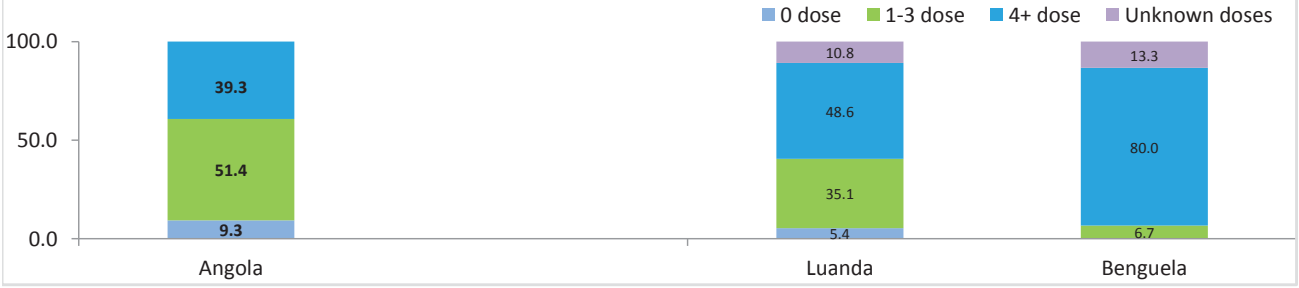
Risk Assessment (Q3)

	Level of risk
Impact	
Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Medium
Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	High
Outcome	
Trends in missed children due to refusal to accept OPV nationally and in HR areas	Low
Trends in missed children due to all social barriers to accept OPV nationally and in HR areas	Medium
Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	Medium
Source of information from those caregivers who report having heard any campaign message	Low
Process	
Social data is systematically used for communication planning	High
Percentage of planned activities that took place in High Risk districts or LGAs that reported timely receipt of funding	Low
Inputs	
Percentage of identified polio communication personnel in place in a country programme	Low
Percentage of identified polio communication field personnel in place	Low
Percentage of designated high risk areas with polio communication field personnel	Low
Percentage of HR areas that receive timely communication / social mobilization funding	Low

Source: UNICEF monitoring

IMPACT

Percentage of non-polio AFP cases (Children 6-35 months) with 0 and ≥4 doses of OPV* 19 Sep 2011 - 18 Sep 2012

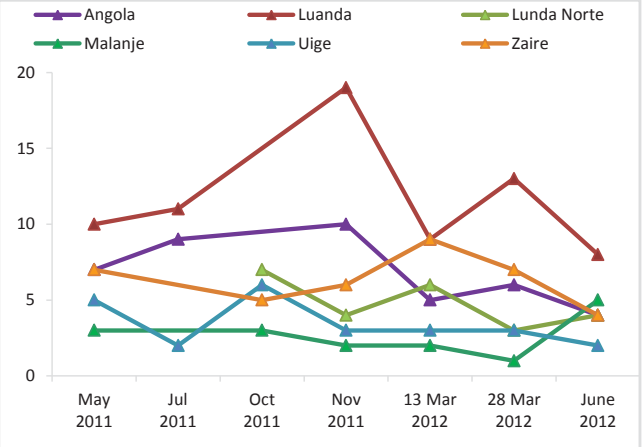


Source: WHO-HQ as reported in the GPEI Status Report, 3rd quarter.

*Data has been included for select areas that have reported>15 non-polio AFP cases

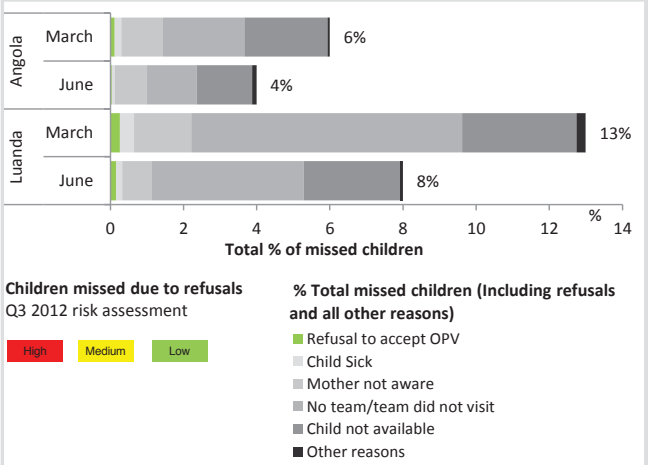
OUTCOME

Percentage of missed Children



Source: Independent Monitoring data

Reasons for missed children (%)



Source: Independent Monitoring data

Angola

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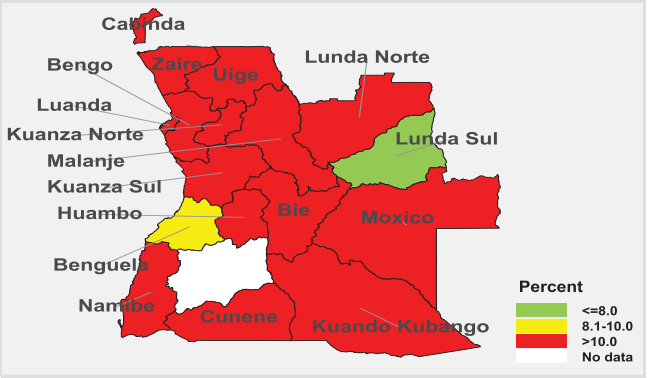
OUTCOME CONT-D

Missed children due to refusal (%)

Area	Mar*	Mar**	June
Angola	1	2	1
Cabinda	4	0	3
Cunene	0	1	0
Kuando Kubango	0	0	3
Luanda	1	2	2
Lunda Norte	2	3	1
Lunda Sul	6	0	0
Malanje	0	0	0
Uige	0	0	0
Zaire	0	0	0

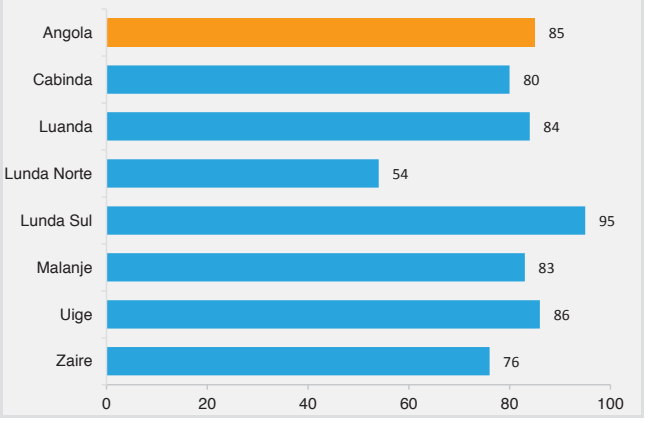
Source: Independent Monitoring data
*Data belongs to the date 13 Mar 2012/**28 Mar 2012

Percentage of missed children due to social reasons* (%) June



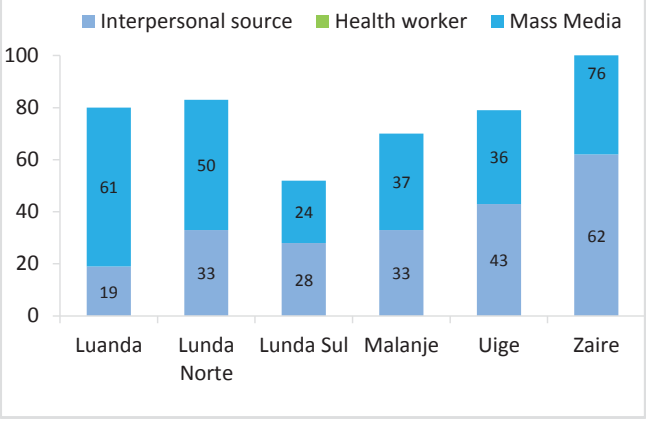
Source: Independent Monitoring data
*Percentage of missed children due to 'mother not aware' and 'child sick'.

Parents aware of campaign dates (%) June



Source: Independent Monitoring data

Source of information on polio campaigns (%) June



Source: Independent Monitoring data

PROCESS

Social data is systematically used for communication planning

	Apr	May	June
National and sub-national plans incorporate social data (Yes/No)	No	No	No

Source: UNICEF monitoring

Percentage of planned activities that took place in HR areas

	Mar	Apr	Aug
Social mapping	100	-	100
Training	100	-	100

Source: UNICEF monitoring

INPUTS

Identified polio communication personnel in place in a country programme (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Luanda	29	26	90	31	25	81
Benguela	-	-	-	-	-	-
Lunda Norte	11	10	91	11	10	91
Lunda Sul	6	5	83	6	5	83

Source: UNICEF monitoring

Identified polio communication field personnel in place (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Luanda	-	3649	-	4050	-	-
Benguela	-	-	-	-	-	-
Lunda Norte	-	554	-	1890	-	-
Lunda Sul	-	217	-	460	-	-

Source: UNICEF monitoring

Designated high risk areas with polio communication field personnel (%)

Area	Mar	Aug
High Risk Area	100	100

Source: UNICEF monitoring

HR areas that receive timely communication / social mobilization funding (%)

Area	13-Mar	28-Mar	June
Angola	0	0	100

Source: UNICEF monitoring

Chad

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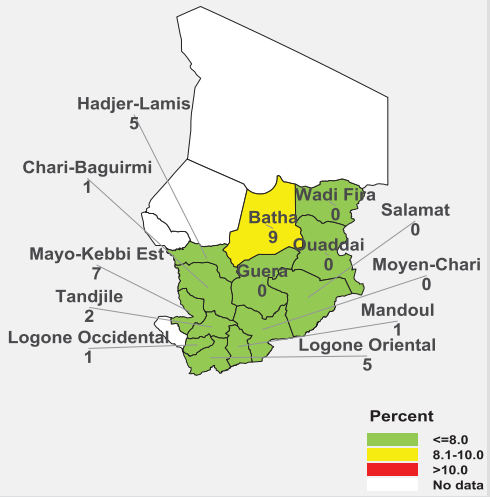
Missed children due to refusal (%) June



Source: Independent Monitoring data

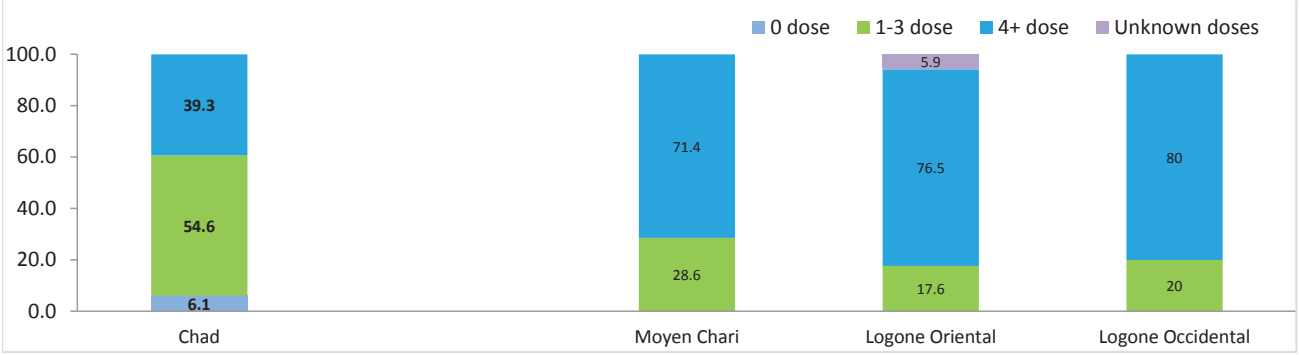
Risk Assessment (Q3)

	Level of risk
Impact	
Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Medium
Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	High
Outcome	
Trends in missed children due to refusal to accept OPV nationally and in HR areas	Low
Trends in missed children due to all social barriers to accept OPV nationally and in HR areas	Medium
Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	High
Source of information from those caregivers who report having heard any campaign message	Medium
Process	
Social data is systematically used for communication planning	High
Percentage of planned activities that took place in High Risk districts or LGAs that reported timely receipt of funding	High
Inputs	
Percentage of identified polio communication personnel in place in a country programme	Medium
Percentage of identified polio communication field personnel in place	High
Percentage of designated high risk areas with polio communication field personnel	High
Percentage of HR areas that receive timely communication / social mobilization funding	Medium

Source: UNICEF monitoring

IMPACT

Percentage of non-polio AFP cases (Children 6-35 months) with 0 and ≥4 doses of OPV* 19 Sep 2011 - 18 Sep 2012

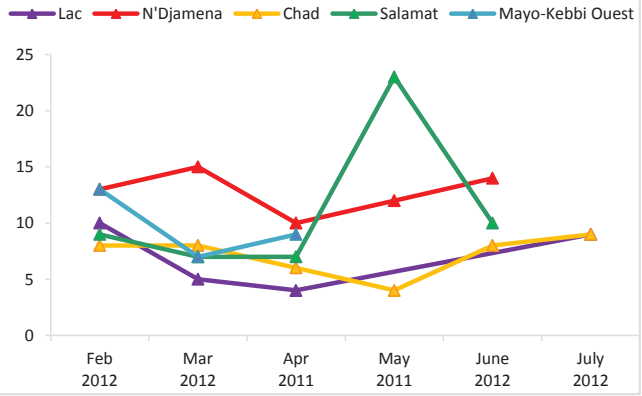


Source: WHO-HQ as reported in the GPEI Status Report, 3rd quarter.

*Data has been included for select areas that have reported>15 non-polio AFP cases.

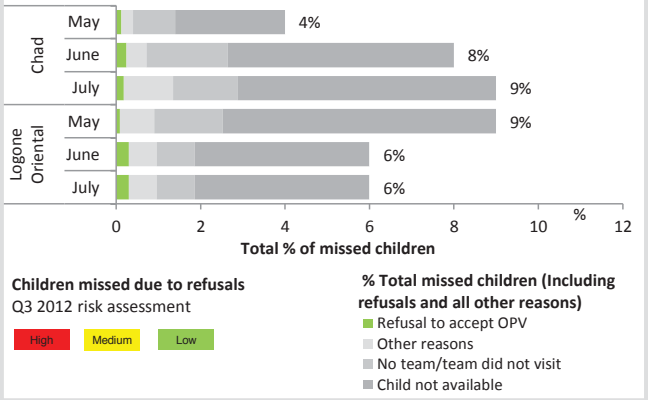
OUTCOME

Percentage of missed Children



Source: Independent Monitoring data

Reasons for missed children (%) July



Source: Independent Monitoring data

Chad

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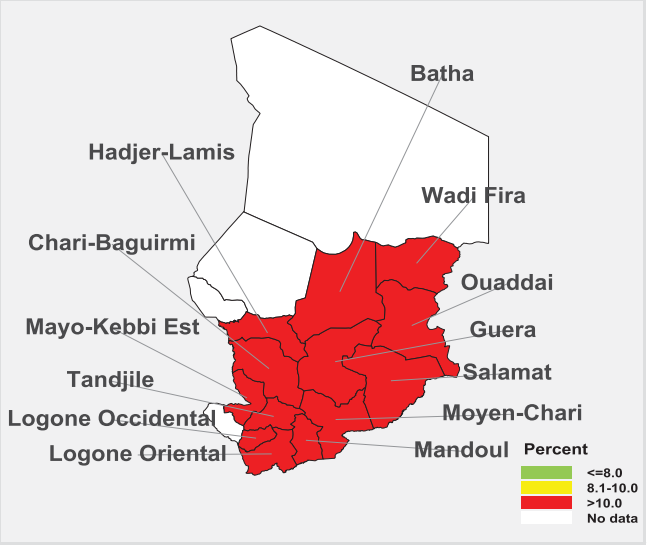
OUTCOME CONT-D

Missed children due to refusal (%)

Area	May	June	July
Chad	3	3	2
Batha	0	9	-
Chari-Baguirmi	-	1	-
Guera	0	0	-
Kanem	-	-	-
Lac	-	-	2
Logone Occidental	1	1	-
Logone Oriental	1	5	-
Mandoul	6	1	-
Mayo-Kebbi Est	13	7	-
Mayo-Kebbi Ouest	-	-	-
Moyen-Chari	-	0	-
N'Djamena	7	6	-
Ouaddai	-	0	-
Salamat	0	0	-
Sila	-	-	-
Tandjile	0	2	-
Wadi Fira	0	0	-

Source: Independent Monitoring data

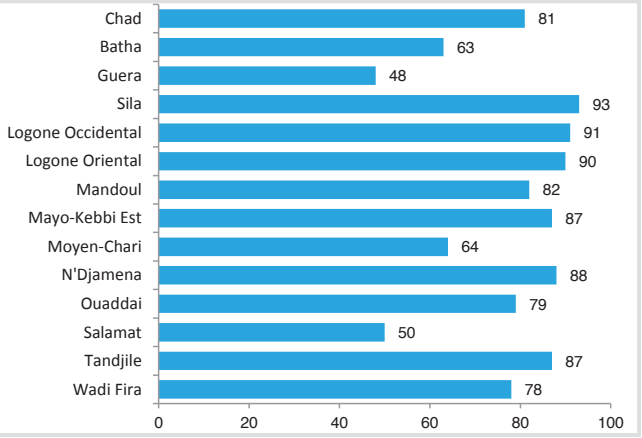
Percentage of missed children due to social reasons*(%) June



Source: Independent Monitoring data

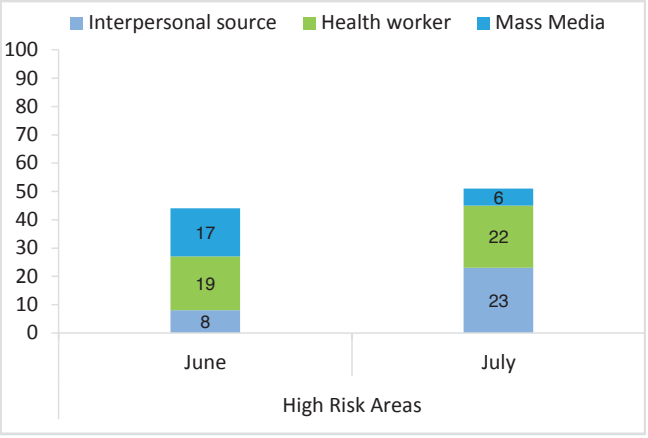
*Percentage missed children due to 'refusals' and child not 'available'.

Parents aware of campaign dates (%) June



Source: Independent Monitoring data

Source of information on polio campaigns (%)



Source: Independent Monitoring data

PROCESS

Social data is systematically used for communication planning

	Apr	May	June
National and sub-national plans incorporate social data (Yes/No)	No	No	No

Source: UNICEF monitoring

Percentage of planned activities that took place in HR areas

	Mar	June	Aug
Community relais	100	-	-
Advocacy plan led by local authorities	67	-	-
School strategy	100	-	-

Source: UNICEF monitoring

INPUTS

Identified polio communication personnel in place in a country programme (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Chad	11	7	64	12	8	67

Source: UNICEF monitoring

Identified polio communication field personnel in place (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Regional Level	145	114	79	145	139	96

Source: UNICEF monitoring

Designated high risk areas with polio communication field personnel (%)

Area	Dec	Mar	Aug
District Level	100	44	51

Source: UNICEF monitoring

HR areas that receive timely communication / social mobilization funding (%)

Area	May	June	July
Chad	86.4	86.4	86.4

Source: UNICEF monitoring

DR Congo

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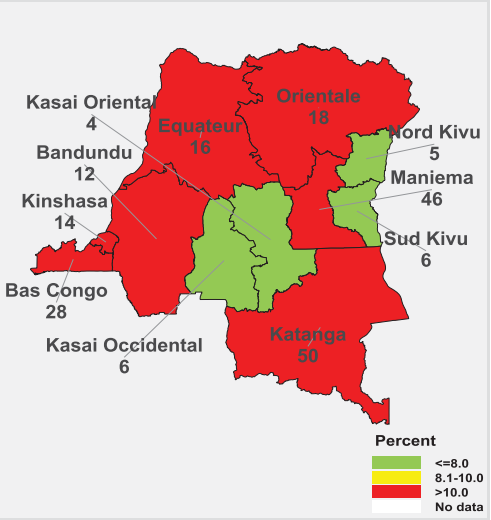
Missed children due to refusal (%) June



Source: Independent Monitoring data

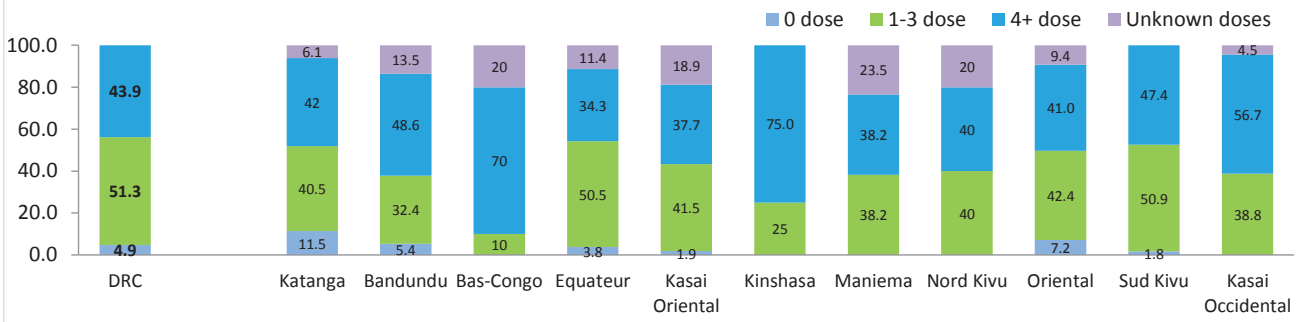
Risk Assessment (Q3)

	Level of risk
Impact	
Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Low
Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	High
Outcome	
Trends in missed children due to refusal to accept OPV nationally and in HR areas	HIgh
Trends in missed children due to all social barriers to accept OPV nationally and in HR areas	High
Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	Low
Source of information from those caregivers who report having heard any campaign message	Low
Process	
Social data is systematically used for communication planning	Medium
Percentage of planned activities that took place in High Risk districts or LGAs that reported timely receipt of funding	High
Inputs	
Percentage of identified polio communication personnel in place in a country programme	Medium
Percentage of identified polio communication field personnel in place	Medium
Percentage of designated high risk areas with polio communication field personnel	Low
Percentage of HR areas that receive timely communication / social mobilization funding	High

Source: UNICEF monitoring

IMPACT

Percentage of non-polio AFP cases (Children 6-35 months) with 0 and ≥4 doses of OPV* 19 Sep 2011 - 18 Sep 2012

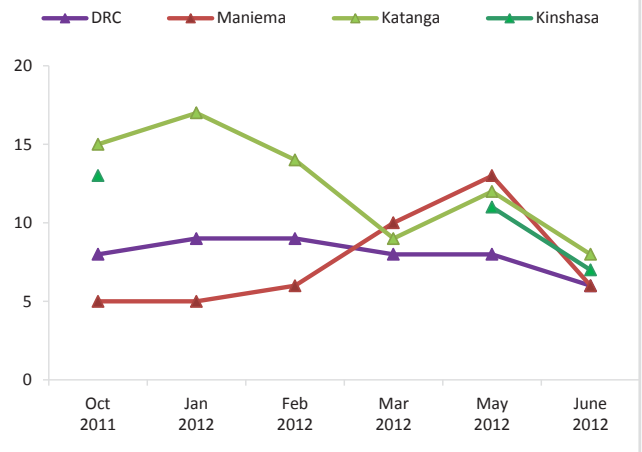


Source: WHO-HQ as reported in the GPEI Status Report, 3rd quarter.

*Data has been included for select areas that have reported>15 non-polio AFP cases.

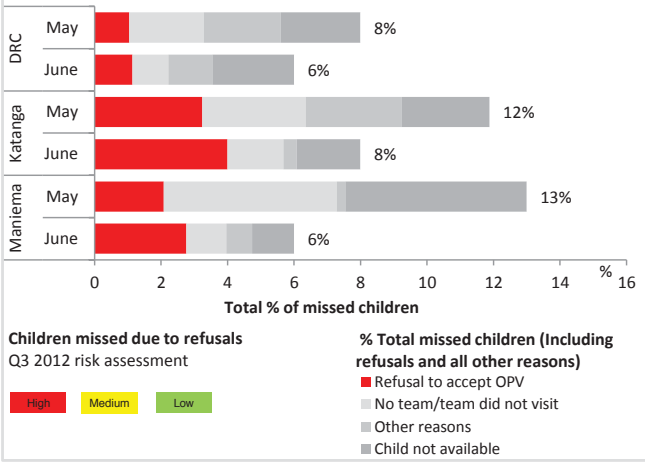
OUTCOME

Percentage of missed Children



Source: Independent Monitoring data

Reasons for missed children (%)



Source: Independent Monitoring data

DR Congo

Global Communications Indicators
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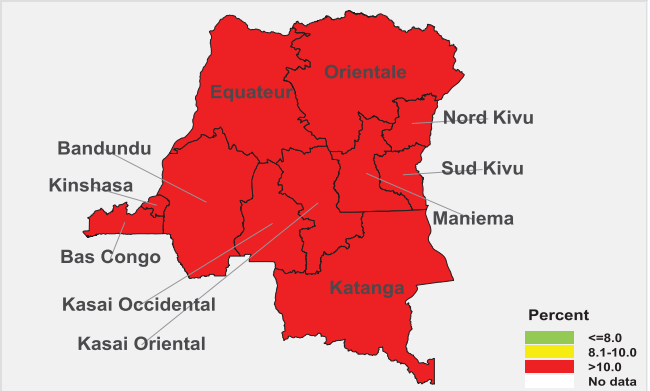
OUTCOME CONT-D

Missed children due to refusal (%)

Area	Mar	May	June
DRC	44	13	19
Bandundu	-	5	12
Bas Congo	-	22	28
Equateur	-	6	16
Kasai Occidental	-	7	6
Kasai Oriental	27	8	4
Katanga	41	27	50
Kinshasa	-	7	14
Maniema	50	16	46
Nord Kivu	-	0	5
Orientale	-	13	18
Sud Kivu	-	4	6

Source: Independent Monitoring data

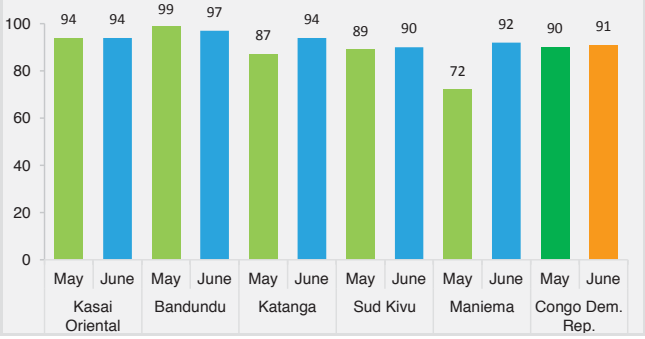
Percentage of missed children due to social reasons* (%) June



Source: Independent Monitoring data

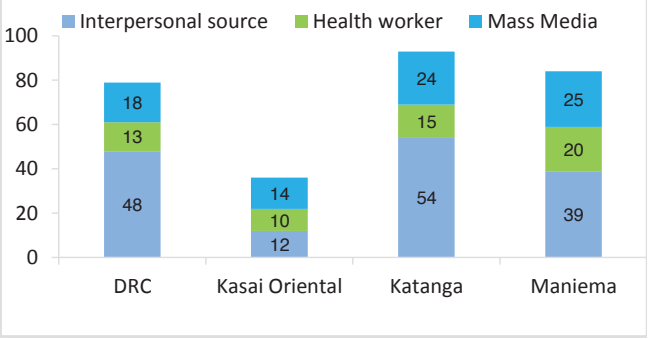
*Percentage missed children due to 'refusals' and 'other'.

Parents aware of campaign dates (%)



Source: Independent Monitoring data

Source of information on polio campaigns (%) June



Source: KAP

PROCESS

Social data is systematically used for communication planning

	Apr	May	June
National and sub-national plans incorporate social data (Yes/No)	Yes	Yes	Yes

Source: UNICEF monitoring

Percentage of planned activities that took place in HR areas

	Dec	Mar	Aug
Kinshasa	-	100	100
Bandundu	-	100	100
Bas Congo	-	50	100
Katanga	-	100	100
Maniema	-	60	95

Source: UNICEF monitoring

INPUTS

Identified polio communication personnel in place in a country programme (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
DRC	16	8	50	13	8	62
Provinces	10	5	50	8	5	63
Kinshasa	6	3	50	5	3	60

Source: UNICEF monitoring

Identified polio communication field personnel in place (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
High Risk Provinces	7	5	71	7	5	71
High Risk Districts	19	10	53	19	19	100
Social Mobilizers	-	-	-	18668	18668	100

Source: UNICEF monitoring

Designated high risk areas with polio communication field personnel (%)

Area	Dec	Mar	Aug
High Risk Districts	6	6	11
Aire de Santé	100	100	100

Source: UNICEF monitoring

HR areas that receive timely communication / social mobilization funding (%)

Area	Mar	May	June
DRC	20	9	55

Source: UNICEF monitoring

India

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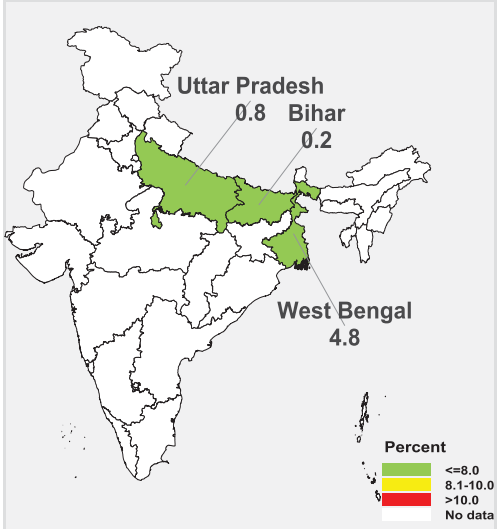
Missed children due to refusal (%) June



Source: Independent Monitoring data

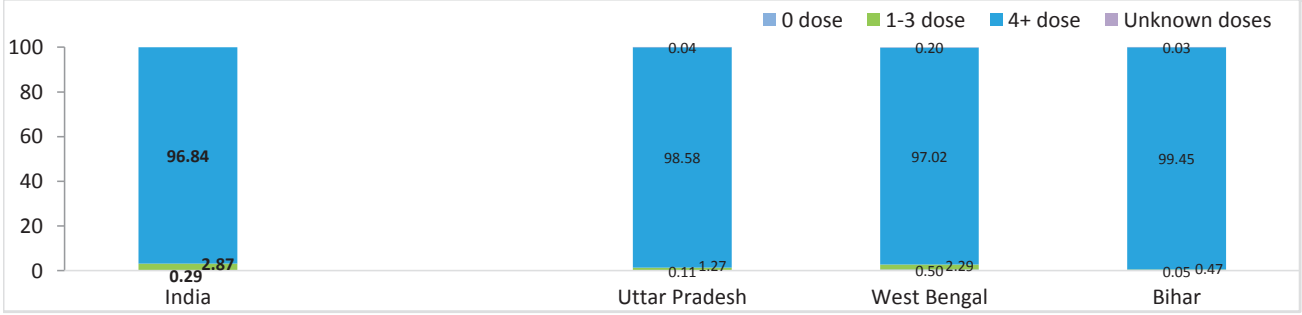
Risk Assessment (Q3)

	Level of risk
Impact	
Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Low
Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	Low
Outcome	
Trends in missed children due to refusal to accept OPV nationally and in HR areas	Low
Trends in missed children due to all social barriers to accept OPV nationally and in HR areas	Low
Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	Low
Source of information from those caregivers who report having heard any campaign message	Low
Process	
Social data is systematically used for communication planning	Low
Percentage of planned activities that took place in High Risk districts or LGAs that reported timely receipt of funding	Low
Inputs	
Percentage of identified polio communication personnel in place in a country programme	Low
Percentage of identified polio communication field personnel in place	Low
Percentage of designated high risk areas with polio communication field personnel	Low
Percentage of HR areas that receive timely communication / social mobilization funding	Low

Source: UNICEF monitoring

IMPACT

Percentage of non-polio AFP cases (Children 6-35 months) with 0 and ≥4 doses of OPV* 19 Sep 2011 - 18 Sep 2012

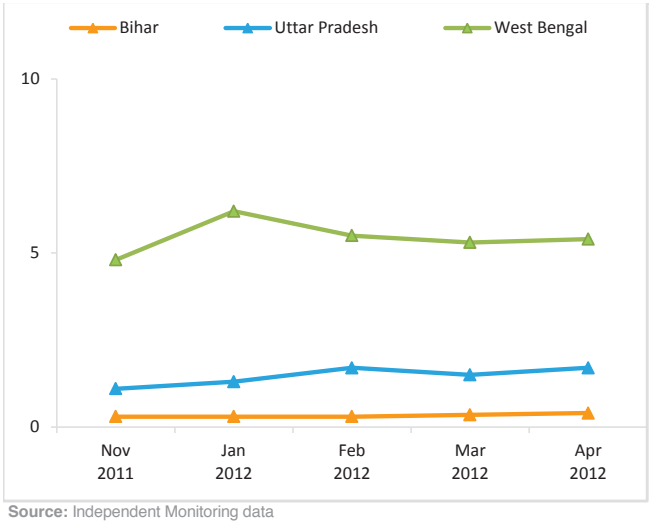


Source: WHO-HQ as reported in the GPEI Status Report, 3rd quarter.

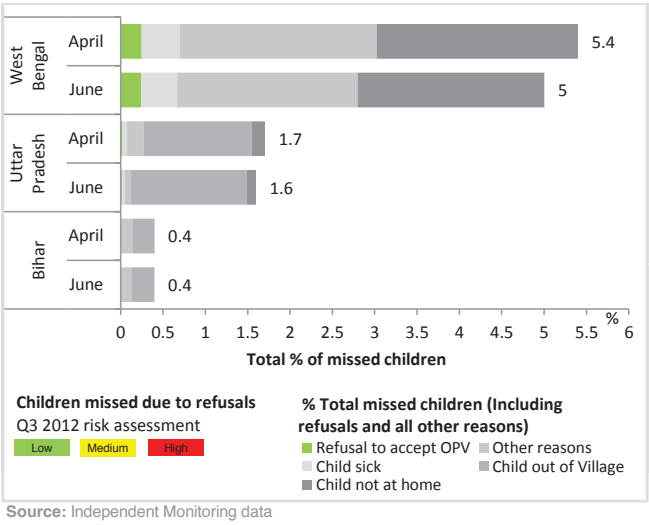
*Data has been included for select areas that have reported>15 non-polio AFP cases.

OUTCOME

OUTCOME



Source: Independent Monitoring data



Source: Independent Monitoring data

India

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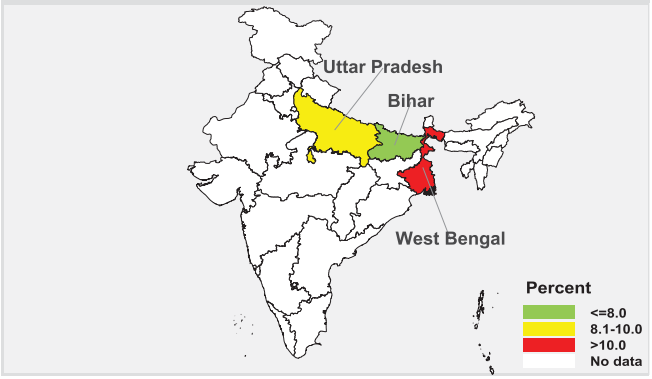
OUTCOME CONT-D

Missed children due to refusal (%)

Area	Mar	Apr	June
India	3.1	3.5	2.9
Bihar (CMC areas)	0.2	0.2	0.2
Uttar Pradesh (CMC areas)	1.1	1.2	0.8
West Bengal (UNICEF areas)	5	4.6	4.8

Source: Independent Monitoring data

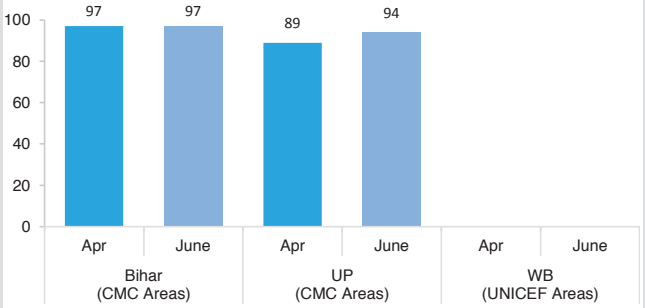
Percentage of missed children due to social reasons* (%) June



Source: Independent Monitoring data

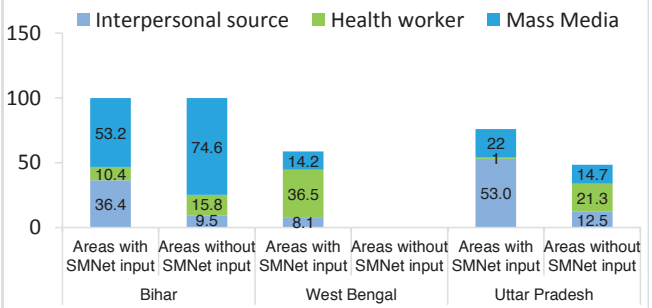
*Percentage of missed children due to 'refusals', 'child sick' and 'child not at home'. In Bihar, 'child sick' is replaced with 'other'.

Parents aware of campaign dates (%)



Source: Independent Monitoring data

Source of information on polio campaigns (%) June



Source: Independent Monitoring data

PROCESS

Social data is systematically used for communication planning

	Apr	May	June
National and sub-national plans incorporate social data (Yes/No)	Yes	Yes	Yes

Source: UNICEF monitoring

Percentage of planned activities that took place in HR areas

	Dec	Mar	Aug
Uttar Pradesh	-	98	98
Bihar	-	87	86
West Bengal	-	97	98

Source: UNICEF monitoring

INPUTS

Identified polio communication personnel in place in a country programme (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
India	26	26	100	26	26	100
Delhi	13	13	100	13	13	100
Bihar	6	6	100	6	6	100
Uttar Pradesh	7	7	100	7	7	100
West Bengal	-	-	-	-	-	-

Source: UNICEF monitoring

Identified polio communication field personnel in place (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
India	50007	47404	95	48640	45774	94
Bihar (UNICEF workers)	1464	1402	96	1440	1348	94
UP (UNICEF workers)	5634	5500	98	5634	5398	96
WB (NGO workers)	1608	1608	100	1326	1326	100
Government workers(AWW)	41301	38894	94	40240	37702	94

Source: UNICEF monitoring

Designated high risk areas with polio communication field personnel (%)

Area	Dec	Mar	Aug
Bihar: Districts	56	100	100
Blocks	100	100	100
HRAs	38	38	42
Uttar Pradesh: Districts	39	100	100
Blocks	80	100	100
HRAs	57	52	53
West Bengal: Districts	44	100	100
Blocks	92	100	100
HRAs	80	100	100

Source: UNICEF monitoring

HR areas that receive timely communication / social mobilization funding (%)

Area	Mar	Apr	June
India	93	100	100

Source: UNICEF monitoring

Nigeria

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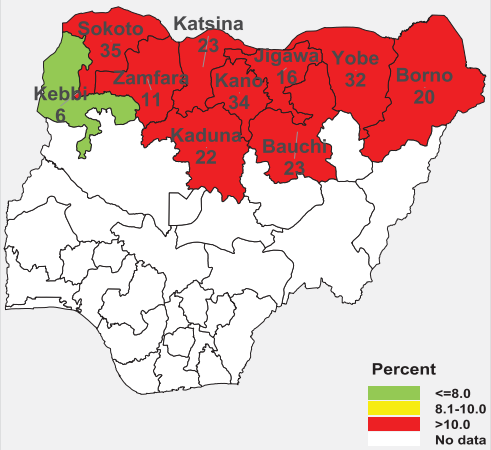
Missed children due to refusal (%) July



Source: Independent Monitoring data

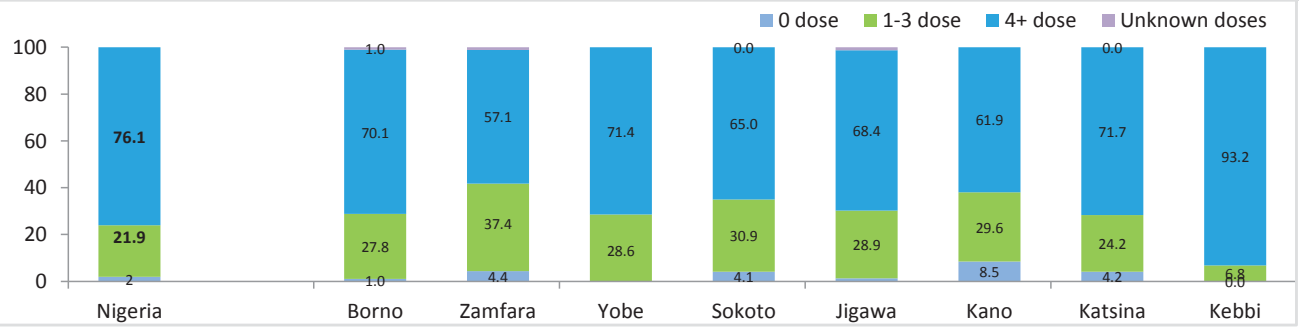
Risk Assessment (Q3)

	Level of risk
Impact	
Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Low
Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	High
Outcome	
Trends in missed children due to refusal to accept OPV nationally and in HR areas	HIgh
Trends in missed children due to all social barriers to accept OPV nationally and in HR areas	High
Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	Low
Source of information from those caregivers who report having heard any campaign message	Medium
Process	
Social data is systematically used for communication planning	Medium
Percentage of planned activities that took place in High Risk districts or LGAs that reported timely receipt of funding	Medium
Inputs	
Percentage of identified polio communication personnel in place in a country programme	Low
Percentage of identified polio communication field personnel in place	Medium
Percentage of designated high risk areas with polio communication field personnel	Medium
Percentage of HR areas that receive timely communication / social mobilization funding	Medium

Source: UNICEF monitoring

IMPACT

Percentage of non-polio AFP cases (Children 6-35 months) with 0 and ≥4 doses of OPV* 19 Sep 2011 - 18 Sep 2012

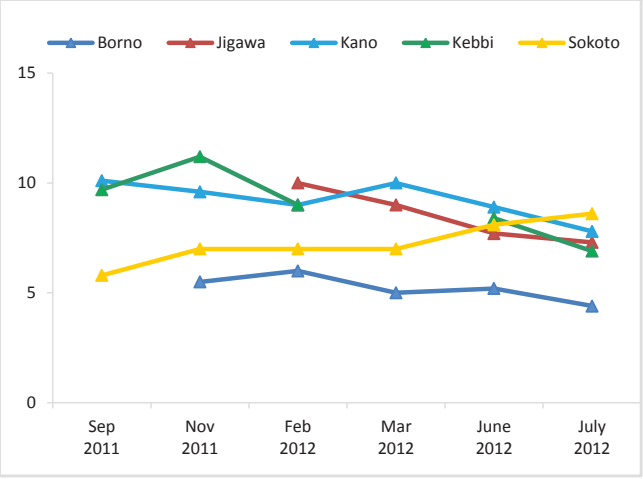


Source:WHO-HQ as reported in the GPEI Status Report, 3rd quarter.

*Data has been included for select areas that have reported>15 non-polio AFP cases.

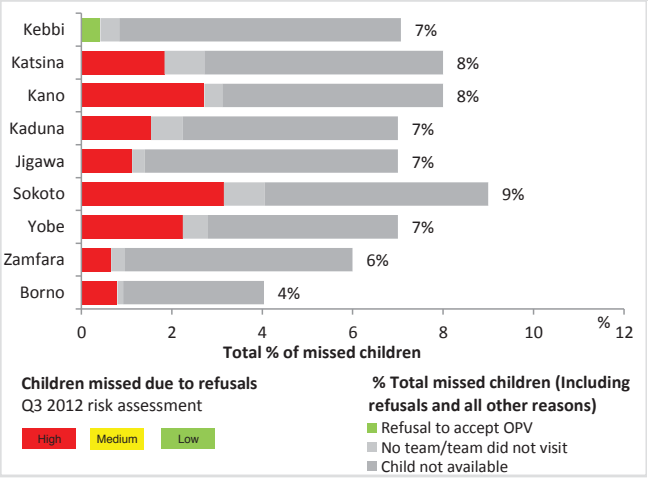
OUTCOME

Percentage of missed Children



Source: Independent Monitoring data

Reasons for missed Children (%) July



Source: Independent Monitoring data

Nigeria

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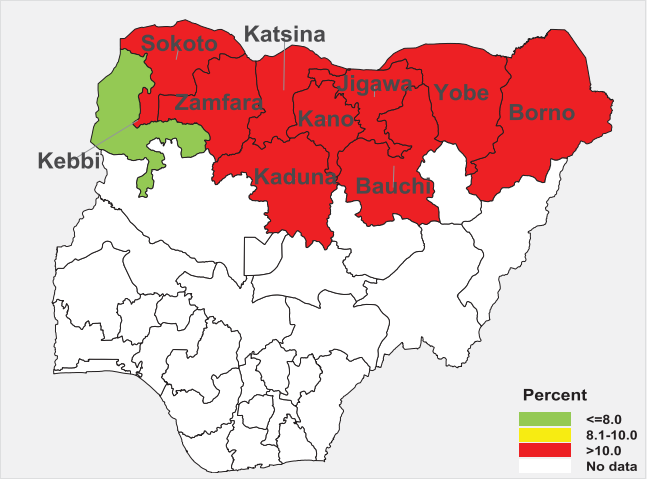
OUTCOME CONT-D

Missed children due to refusal (%)

Area	Mar	May	July
Nigeria	26	24	24
Bauchi	33	20	23
Borno	22	21	20
Gombe	22	-	-
Sokoto	29	37	35
Katsina	18	18	23
Kebbi	-	5	6
Zamfara	10	8	11
Jigawa	22	18	16
Kano	32	33	34
Yobe	34	34	32

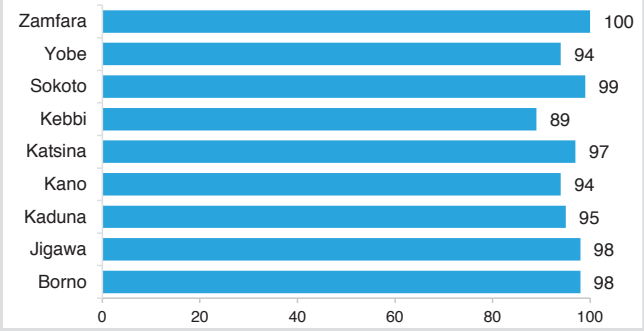
Source: Independent Monitoring data

Percentage of missed children due to social reasons* (%) July



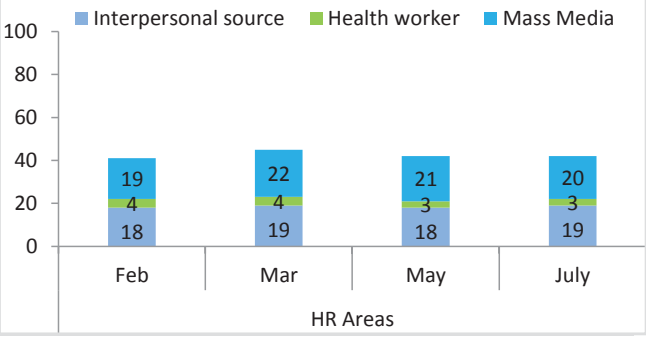
Source: Independent Monitoring data
*Percentage of missed children due to 'refusals'.

Parents aware of campaign dates (%) July



Source: Independent Monitoring data

Source of information on polio campaigns (%) July



Source: Independent Monitoring data

PROCESS

Social data is systematically used for communication planning

	Apr	May	June
National and sub-national plans incorporate social data (Yes/No)	Yes	Yes	Yes

Source: UNICEF monitoring

Percentage of planned activities that took place in HR areas

	Feb	Mar	Aug
Nigeria	-	87	70

Source: UNICEF monitoring

INPUTS

Identified polio communication personnel in place in a country programme (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Nigeria	15	15	100	15	14	93.3
States	58	58	100	102	72	71

Source: UNICEF monitoring

Identified polio communication field personnel in place (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
HRLGAs	1146	1142	99.7	2501	2099	83.9
UNICEF Staff	1100	1096	99.6	2455	2053	83.6
Government Staff	46	46	100	46	46	100

Source: UNICEF monitoring

Designated high risk areas with polio communication field personnel (%)

Area	Dec	Mar	Aug
High Risk Settlements	0	38	73

Source: UNICEF monitoring

HR areas that receive timely communication / social mobilization funding (%)

	Nov	Feb	Mar
Nigeria	100	98	98

Source: UNICEF monitoring

Pakistan

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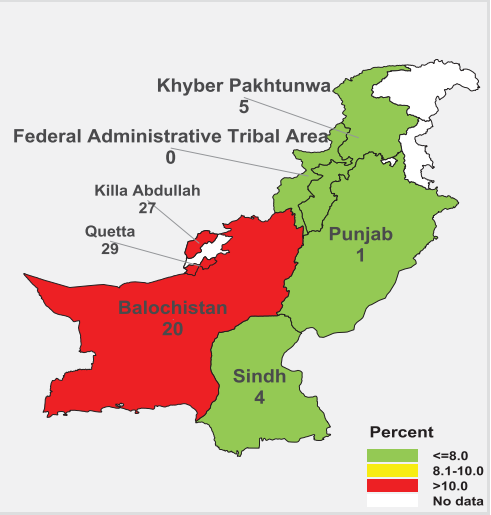
Missed children due to refusal (%) July



Source: Post Campaign Monitoring

Risk Assessment (Q3)

	Level of risk
Impact	
Percentage of children (6-35 months) with 0 doses OPV in non-polio AFP cases	Low
Percentage of children (6-35 months) with more than 4 doses OPV in non-polio AFP cases	Low
Outcome	
Trends in missed children due to refusal to accept OPV nationally and in HR areas	Medium
Trends in missed children due to all social barriers to accept OPV nationally and in HR areas	High
Percentage of caregivers aware of polio campaigns prior to the arrival of vaccinators	High
Source of information from those caregivers who report having heard any campaign message	High
Process	
Social data is systematically used for communication planning	Medium
Percentage of planned activities that took place in High Risk districts or LGAs that reported timely receipt of funding	Medium
Inputs	
Percentage of identified polio communication personnel in place in a country programme	Low
Percentage of identified polio communication field personnel in place	Medium
Percentage of designated high risk areas with polio communication field personnel	Medium
Percentage of HR areas that receive timely communication / social mobilization funding	High

Source: UNICEF monitoring

IMPACT

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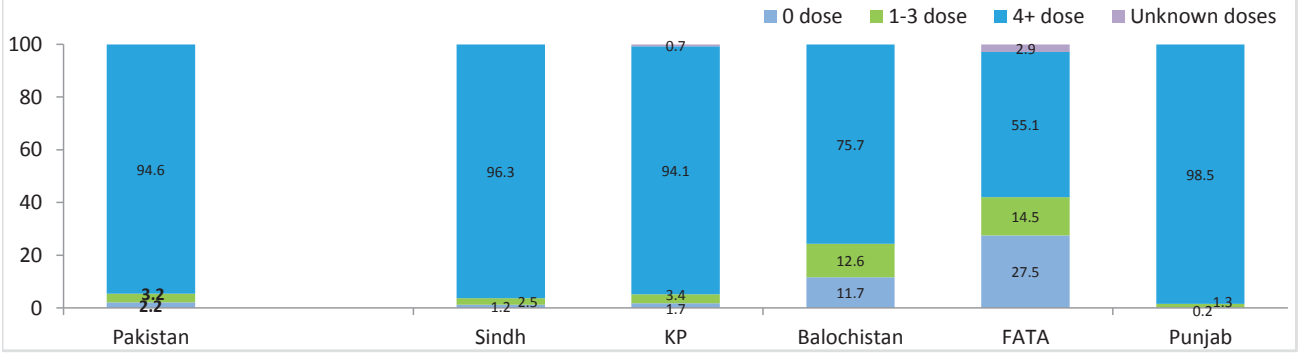
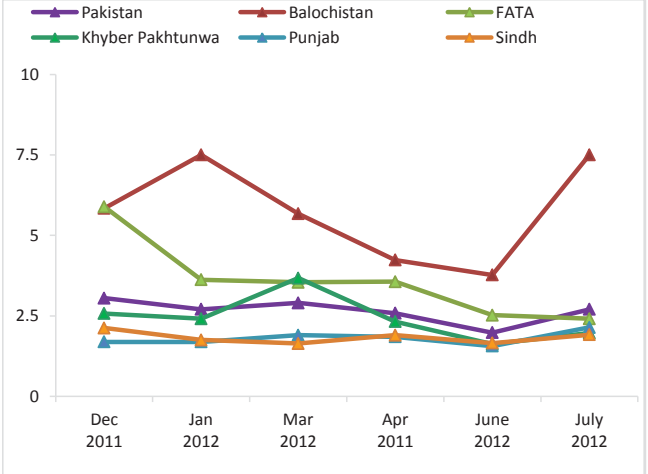


Source: WHO-HQ as reported in the GPEI Status Report, 3rd quarter.

*Data has been included for select areas that have reported>15 non-polio AFP cases.

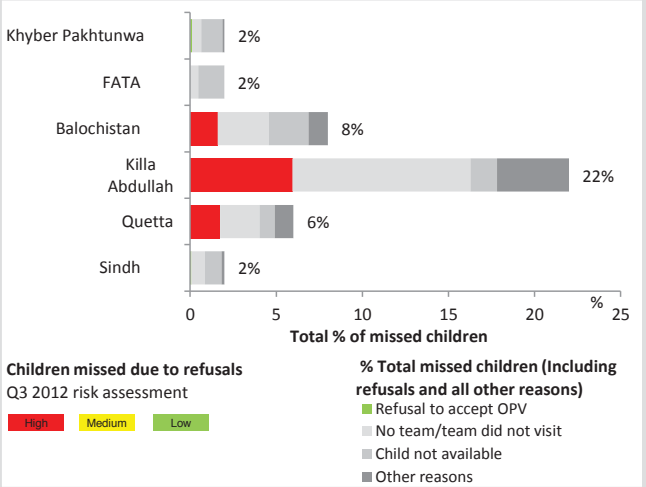
OUTCOME

Percentage of missed Children



Source: Post Campaign Monitoring

Reasons for missed children (%) July



Source: Post Campaign Monitoring

Pakistan

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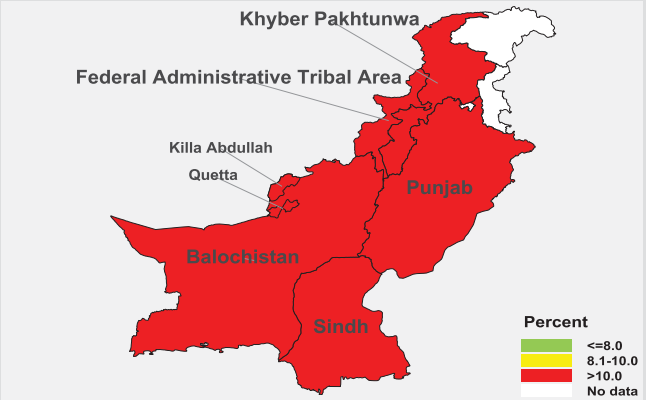
OUTCOME CONT-D

Missed children due to refusal (%)

Area	Apr	June	July
Pakistan	5	6.4	8
Punjab	1	1.9	1
FATA	1	3.4	0
Khyber Pakhtunwa	12	10	5
Balochistan	7	13	20
Quetta	-	23	29
Killa Abdullah	-	-	27
Pishin	-	-	-
Sindh	7	5.6	4
Karachi	15	12	-

Source: Post Campaign Monitoring

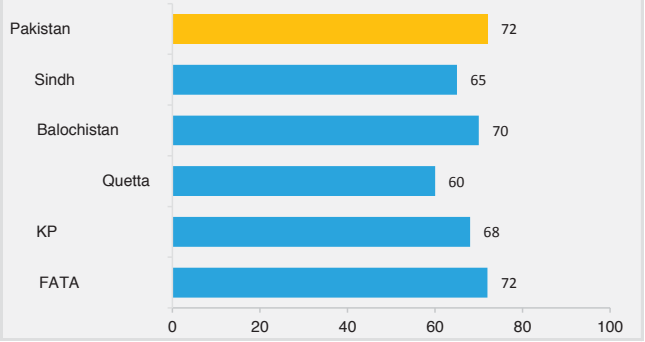
Percentage of missed children due to social reasons* (%) July



Source: Post Campaign Monitoring

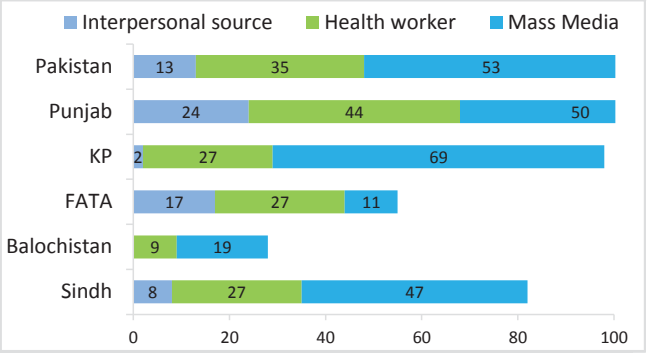
*Percentage missed children due to 'refusals' and 'no team'.

Parents aware of campaign dates (%) July



Source: Post Campaign Monitoring

Source of information on polio campaigns (%) July



Source: Post Campaign Monitoring

PROCESS

Social data is systematically used for communication planning

	Apr	May	June
National and sub-national plans incorporate social data (Yes/No)	No	No	No

Source: UNICEF monitoring

Percentage of planned activities that took place in HR areas

	May	June	Aug
Pakistan	84	84	89

Source: UNICEF monitoring

INPUTS

Identified polio communication personnel in place in a country programme (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Pakistan	52	46	88	56	54	96
Balochistan	6	6	100	7	7	100
FATA	6	5	83	6	6	100
Islamabad	22	19	86	22	22	100
Khyber Pakhtunwa	6	4	67	7	6	86
Punjab	6	6	100	7	7	100
Sindh	6	6	100	7	6	86

Source: UNICEF monitoring

Identified polio communication field personnel in place (%)

Area	Mar			Aug		
	Target	In place	% In place	Target	In place	% In place
Pakistan	1195	753	63	1182	1059	90
High Risk Districts	48	48	100	48	48	100
High Risk Areas (UC)	247	184	74	234	222	95
High Risk Areas	900	521	58	900	789	88

Source: UNICEF monitoring

Designated high risk areas with polio communication field personnel (%)

Area	Dec	Mar	Aug
Pakistan	66	66	90
High Risk Districts	100	100	100
High Risk Areas (UC)	94	94	95
High Risk Areas	58	58	88

Source: UNICEF monitoring

HR areas that receive timely communication / social mobilization funding (%)

Area	Feb	Mar	Apr
Pakistan	20	11	70

Source: UNICEF monitoring

Polio Communications

QUARTERLY UPDATE • MAY 2012

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For more information

Susan Mackay
Senior Communications Advisor
smackay@unicef.org

Sherine Guirguis
Communications Specialist
sguirguis@unicef.org

Children of Zamfara, northern Nigeria's nomadic Kanuri tribe are among the world's most difficult to reach—and the most vulnerable to being missed with the oral polio vaccine immunitzation (WHO/2011/T. Moran)

Report editing and graphic design by Suazion, Inc.