POLIO AND ROUTINE: A Case Study from India, 2014

Polio Vaccination Strengthening Routine Immunization Efforts

In a post-polio India, the polio eradication infrastructure is now working to support the country’s routine immunization system. The polio network is now helping to increase awareness and build demand for routine immunization, assisting with development of microplans, monitoring outreach sessions and vaccine availability, and tackling drop-outs, including those related to fear of adverse effects following immunization (AEFIs).

POLIO’S INFRASTRUCTURE HELPS ROUTINE IMMUNIZATION EFFORTS

In a country that has one third of the world’s unimmunized children, where 27 million children are born each year, and where the national average of fully immunized children is just 61%, building a robust Routine Immunization (RI) system remains a real and present challenge.

In this context, the innovative strategies and lessons learned from a decade of intense polio eradication activities – where >95% of children have regularly been reached in India’s polio immunization campaigns – are relevant to be scaled up to protect eligible children against all vaccine-preventable childhood diseases.

India declared 2012-2013 as years of intensification of routine immunization, and stated that its key objectives included reaching children in remote and often inaccessible rural areas as well as in urban slums, updating microplans, conducting special immunization drives in pockets of low coverage; improving IEC for demand generation, and placing a special focus on migrant and mobile populations. In these areas, the polio programme has been well placed to assist.

GPEI ASSISTS WITH MICROPLANNING, SUPPORTIVE SUPERVISION, AND REACHING THE ‘LAST CHILD’

The Global Polio Eradication Initiative is now providing support to state and national health systems across a range of areas, including the preparation of RI microplans based on the polio model, RI session implementation, supportive supervision, social mobilization, capacity development, and monitoring.

 perhaps most importantly, the lessons learned from polio in reaching the ‘last child’ – mobile and migrant families, children living in slums, brick kilns, nomadic settlements or on construction sites – has helped to identify large populations of unimmunized children and include them in RI microplans, many for the first time. More than 400,000 high-risk sites enumerated for polio are now being integrated with RI microplans. In Bihar, of the 4,000-plus brick kiln sites contained in the 43 high-risk polio blocks, more than 90% are now included in RI microplans, and in many cases, the polio programme is facilitating RI outreach sessions to bring the vaccines to the children.

Task forces for immunization at state and district levels are being established on the polio model for regular review of RI programme quality, to identify programmatic gaps and suggest corrective actions. In polio-focused areas, polio personnel are identifying vaccine availability gaps and assisting with appropriate vaccine distribution along the known polio population profiles.
MONITORING, TRAINING & COMMUNICATION

An intensive monitoring system, much along the lines of that used for polio immunization, was put in place for RI. The Surveillance Medical Officers and Field Volunteers of WHO-NPSP, together with UNICEF’s Social Mobilization Network personnel, are actively engaged with monitoring RI sessions and real-time corrective feedback from these visits is being shared at the district Taskforce meetings for immunization. Each month, WHO and UNICEF’s polio staff monitor more than 15,000 RI sessions in four states: UP, Bihar, West Bengal and Jharkhand.

To assist with building the quality of the RI sessions, intensive state-level training of trainers (ToTs), using a training module and Inter-personal Communication training tool jointly prepared by WHO-NPSP and UNICEF has been rolled out, with 1.2 million frontline workers trained in operations and IPC skills for RI.

The polio programme was tasked with developing a new communications campaign for RI, including a new logo, posters, and TV and radio PSAs. In order to tackle the two key reasons for RI drop-outs – fear of Adverse Events Following Immunization (AEFI) and parents being unaware of the session date - UNICEF’s social mobilizers have included RI sessions in their workplans, mobilizing parents ahead of RI sessions according to their due lists and newborn lists, and on the day of the RI session itself.

The Social Mobilization Network continues to lead community efforts to mobilize religious and community leaders to support the RI programme, conducting mothers meetings and identifying and counseling reluctant households. More than 4,500 mosques have given announcements in support of RI sessions or weeks.

THE KOSI RIVER EXAMPLE

Before the first polio worker arrived at Shiva Brick Kiln, near Khagaria, deep in the heart of the hard-to-access Kosi River Basin in central Bihar, the community living in rows of tiny, cramped brick rooms had never been visited for polio immunization. It had never had a Routine Immunization outreach session. It had never been visited by a health worker, or a midwife. And all for one simple reason: it wasn’t even on a map.

In 2009, polio’s focused pursuit of every last child – the children of slum dwellers, migrants and nomads, construction and brick kiln workers - saw a surge in technical human resources capacity drill down into every high-risk corner of the polio-endemic Uttar Pradesh and Bihar states.

The polio programme’s achievement in mapping and immunizing the ‘last child’ in India is set to have an enduring impact on the country, because the transition of the polio infrastructure to support the rapid intensification of Routine Immunization (RI) activities is not a distant legacy plan – it is very much a present-day reality.