Mid-Level Management Course for EPI Managers

Communication for immunisation programmes

MODULE 3
Mid-Level Management Course for EPI Managers

Block I: Introductory Modules

Module 3

Communication for Immunisation Programmes

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For more up-to-date information and documentation related to immunisation training, please:
• visit our website: http://www.who.int/vaccines-diseases/epitraining/
• refer to the CD “Resources for Immunization Managers” version 2 (WHO/HQ, 2002).

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# Mid-Level Management Course for EPI Managers: List of the Modules

## BLOCK I: Introductory modules (0-3)
- **Module 0:** Introduction
- **Module 1:** Problem-solving approach to immunisation services management
- **Module 2:** Role of the EPI manager
- **Module 3:** Communication for immunisation programmes

*Reference: Communication Handbook for Polio and Routine EPI*

## BLOCK II: Planning/organisation (4-6)
- **Module 4:** Planning immunisation activities
- **Module 5:** Increasing immunisation coverage
- **Module 6:** Reduce drop-out and missed opportunities

*Reference manual: Revised EPI Planning Guide*

## BLOCK III: Logistics (7-14)
- **Module 7:** Planning, monitoring and supervising EPI logistics
- **Module 8:** Cold chain management
- **Module 9:** Vaccine management
- **Module 10:** Immunisation safety
- **Module 11:** Transport management
- **Module 12:** Logistics management for supplemental immunisation
- **Module 13:** Logistics for surveillance
- **Module 14:** Maintenance

*Reference material: Product Information Sheets, WHO/UNICEF, 2000*

## BLOCK IV: New vaccines (15)
- **Module 15:** New vaccine introduction

## BLOCK V: Supplemental immunisation (16-17)
- **Module 16:** How to organise effective polio NIDs
- **Module 17:** How to conduct mass campaigns with injectable vaccines (measles, YF, TT)

*Reference manuals:*
1. Field guide for supplementary activities aimed at achieving polio eradication (revised version, 1996)
2. Guidelines for improving the quality of NIDs
3. AFRO field guide for quality measles SIAs

## BLOCK VI: Disease surveillance (18-19)
- **Module 18:** How to manage cases of priority disease
- **Module 19:** Integrated disease surveillance and response (see IDSR modules)

*Reference manuals:*
1. Technical guidelines for integrated disease surveillance and response in the African Region
2. District health team surveillance data analysis

## BLOCK VII: Monitoring and evaluation (20-23)
- **Module 20:** Monitoring and data management
- **Module 21:** Supportive supervision by EPI managers
- **Module 22:** Conducting EPI coverage survey
- **Module 23:** Conducting assessment of the immunisation programme


## BLOCK VIII: EPI training materials (24)
- **Module 24:** Facilitator’s guide

*Other Training Tools and Guides*
- EPI training kit
- Course director’s guide
# Table of Contents

Abbreviations and Acronyms .......................................................................................................... v
Glossary ........................................................................................................................................ vi

1. Introduction .................................................................................................................................. 1
   1.1 Context ................................................................................................................................. 1
   1.2 Purpose of the module .......................................................................................................... 1
   1.3 Target audience .................................................................................................................. 2
   1.4 Learning objectives ........................................................................................................... 2
   1.5 Content of the module ........................................................................................................ 3
   1.6 How to use this module ....................................................................................................... 3

2. Communication and role of the EPI manager .......................................................................... 5
   2.1 Communication and EPI ..................................................................................................... 5
   2.2 Barriers and challenges for communication in EPI .......................................................... 7
   2.3 Target audiences for communication ................................................................................. 8
   2.4 Organisational structures for communication .................................................................... 10
   2.5 Role of EPI manager in managing immunisation communication .................................... 11

3. Planning communication interventions ................................................................................... 17
   3.1 Developing the communication plan ................................................................................ 17
   3.2 Monitoring communication activities ............................................................................... 20
   3.3 Evaluating communication programmes .......................................................................... 23

4. Communication skills for immunisation staff ........................................................................ 25
   4.1 EPI manager and health staff interpersonal communication ........................................... 25
   4.2 EPI staff communication via mass media ........................................................................ 25
   4.3 Communication on immunisation with communities ....................................................... 26
   4.4 Health worker communication with caregivers ............................................................... 28

5. Communication in support of EPI ............................................................................................ 31
   5.1 Addressing dropout and Reaching Every District ............................................................. 31
   5.2 Addressing hard-to-reach populations ........................................................................... 33
   5.3 Communication for disease surveillance ........................................................................... 37
   5.4 Communication for supplemental immunisation activities ............................................. 38
   5.5 Communication for immunisation safety ........................................................................... 40
   5.6 Communication for introduction of new vaccines and auto-disable syringes ............... 41

References ....................................................................................................................................... 44

Annex 1: Knowledge and skills to be acquired from immunisation communication training ................................................................................................................................. 45
Abbreviations and Acronyms

A-D Auto disable (syringe)
AEFI Adverse Events Following Immunisation
AFRO WHO Regional Office for Africa
AIDS Acquired Immunodeficiency Syndrome
BASICS Basic Support for Institutionalising Child Survival
CBO Community-based Organisation
CHANGE The Behavior Change Communication Project (USAID)
CVP Children’s Vaccine Programme
DTP Diphtheria, Pertussis, Tetanus
EPI Expanded Programme on Immunisation
GAVI Global Alliance for Vaccines and Immunisation
Hib *Haemophilus influenzae* type b vaccine
ICC Interagency Co-ordination Committee
IDSR Integrated Disease Surveillance and Response
IPC Interpersonal Communication
KAP Knowledge, Attitudes, and Practices
MOH Ministry of Health
NGO Non-governmental Organisation
NID National Immunisation Day
OPV Oral Polio Vaccine
RED Reaching Every District
SIA Supplemental Immunisation Activity
STD Sexually Transmitted Diseases
VIPP Visualization in Participatory Programmes
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
WHO World Health Organization
# Glossary

**Advocacy:** a process comprised of activities to gain and maintain the support of opinion and decision-makers for a programme.

**Behaviour change:** bringing about and sustaining the desired action in an individual or group. (In immunisation, the main behaviour promoted is to take children for immunisation according to the schedule until all immunisations are completed.)

**Community surveillance:** surveillance where the starting point is a health event occurring in the community and reported by a community worker or actively sought by investigators while interviewing community members. This is particularly useful during an outbreak when syndromic case definition can be used to obtain more information on the health event.

**Focus group discussion:** a focus group discussion consists of a small group of individuals brought together under the guidance of a facilitator to discuss a particular subject of common interest in a free and open manner. Focus group discussions are used primarily to collect qualitative data.

**Interpersonal communication:** this is a process of exchanging information whereby the communicator is face to face with the individual or a group of people.

**Mass media:** channels of disseminating information that are capable of reaching many people at once. They include conventional channels (print, radio, television) and contemporary (such as the Internet in which information can be provided and/or exchanged).

**Mission:** a continuing task or responsibility that an organization is destined or specially called upon to undertake. For example, the EPI mission is to immunize target population in order to control or eradicate diseases preventable by immunisation.

**Programme communication:** a research-based process comprised of activities to provide information to address knowledge, attitudes and behaviour needs of different groups.

**Social mobilization:** a process of gaining and sustaining the involvement of all stakeholders to take action to attain a common goal.

**Visualization in participatory programmes:** an interactive facilitation method that uses cards to collect group ideas that are then grouped accordingly and discussed. It facilitates active brainstorming and participatory learning.
1. Introduction

1.1 Context

One of the five components of the immunisation system is advocacy and communication. Many terminologies describe activities concerned with informing, educating and bringing about desired behaviour in different groups in health programmes. In this module, the term Communication is used as a wide descriptive term encompassing: advocacy to raise resources and commitment; social mobilization for wider participation and ownership; and for bringing about changes in knowledge attitudes and behaviour among specific groups.

Effective communication helps to mobilize resources for the immunisation programme and encourages other actors and organisations from various sectors and the community to participate in immunisation activities. EPI programme staff should maintain permanent dialogue not only with vaccination and health staff but also with the communities, including caregivers and traditional and religious leaders, to enhance their understanding of the importance of immunisation for the protection and quality of life of children.

The EPI manager is responsible for planning and managing all immunisation programme components, which include advocacy with decision-makers, social mobilization, and building the capacity of health workers to communicate better in their work with communities. Communication can also help to dispel the misinformation and doubts that often surround immunisation. In managing these activities, EPI managers and immunisation programme staff need communication skills, particularly in interpersonal relationships, to perform their duties well. To support effective communication, EPI managers and programme staff need to collaborate with communication and behaviour experts who can contribute their expertise in planning and implementing communication activities.

1.2 Purpose of the module

This module provides managers with a general overview of the communication component within the EPI, as well as communication skills needed to support the programme. It is designed to help prepare EPI managers to address communication needs at national and district levels, and to work with behaviour change and communication experts to integrate and manage communication strategies for different EPI components and various target groups. EPI managers also need a solid basic understanding of how to plan, implement and evaluate activities relating to communication at all levels in order to achieve overall EPI objectives.
This module also contains case studies and exercises to enhance immunisation staff’s ability to plan and implement communication on specific EPI topics, including injection safety, new vaccine introduction, Reaching Every District, etc. Several issues discussed in this module will recur in other MLM modules, e.g. planning, assessment, and increasing immunisation coverage. This reinforces the importance of integrating communication with all other EPI components. By gaining an overall understanding of communication for EPI, participants will be better placed to apply the principles and skills needed to do this effectively.

1.3 Target audience

This module is intended primarily for immunisation programme managers at national, regional and district levels. It can also be adapted for use in countries to provide other health care staff with basic communication skills to enhance their role and performance in the immunisation programme. The module should also be useful for communication specialists who are working with immunisation programmes.

1.4 Learning objectives

After completion of this module, the participants should be better able to:

- Describe the role and importance of communication in EPI
- Describe the role of the EPI manager and immunisation programme staff in EPI communication
- Mobilize human, financial and material resources for effective EPI communication planning and implementation
- Ensure that the communication component is integrated into EPI plans and with service delivery, including plans for communication training and capacity building
- Facilitate formative research and use of research findings in EPI communication programming
- Ensure that EPI communication activities are effectively managed, implemented, monitored and evaluated to address priority barriers or problem areas
- Use the acquired skills in communication for improved advocacy, programme promotion and quality.

In addition to the objectives above, Annex 1 outlines specific knowledge and skills to be acquired by the participants as a result of the training.
1.5 Content of the module

This module includes the following sections, which comprise the various elements of a communication programme for EPI. They are:

- Communication and role of EPI manager
- Planning communication interventions
- Communication skills for EPI staff
- Communication in support of EPI

1.6 How to use this module

This module is one in a series of Mid-Level Management Modules for use in the MLM course training. It also serves as a reference document for EPI managers at various levels to use on the job. It describes how the communication component of the EPI programme is to be planned and managed in countries.

Users should first read the narrative content of each chapter, clarify issues if necessary and proceed to the exercises and case studies as group work. Trainers can adapt these case studies and examples for role-plays or suggest other interactive training methodologies. The output of exercises and group work can then be discussed with colleagues and facilitators.
2. Communication and Role of the EPI Manager

2.1 Communication and EPI

Communication to improve service delivery

If service delivery is of good quality and active in its outreach to the population, effective communication will assist in ensuring and sustaining demand and acceptance of vaccination services. If there are significant deficiencies in service delivery, communication can complement, enhance and explain service improvements.

Various communication interventions are discussed in this module, including advocacy with decision-makers, communicating with the public and parents, and planning and implementing activities that influence behaviours related to immunisation.

Well-planned communication activities can help EPI programmes to achieve:

- High coverage rates for all antigens and reductions in missed opportunities, a reduction in the number of unreached children and drop-out rates by mobilizing other sectors and resources from national to community levels to support immunisation
- The reduction of morbidity and mortality due to vaccine preventable diseases by facilitating community commitment and participation
- Higher awareness, acceptance and demand for vaccination from caregivers and communities, and improved participation in and ownership of immunisation
- Implementation of immunisation policies and action plans through effective communication, providing evidence-based information on burden of vaccine preventable diseases as well as intensive lobbying and advocacy to ensure support of leaders and communities
- Better understanding between the EPI manager and the ICC, MOH, NGOs, the community of financial backers, and provincial or district officers
- Improved quality of services to meet demand, ensure good interaction of health workers and communities, and address safety of injections.
The following diagram illustrates the various components of an immunisation programme, including the communication component:

![Diagram of immunisation programme components]

Communication efforts are inextricably linked with other technical issues, including the provision and quality of services, availability of vaccines and logistics, health worker capacity building, as well as disease reporting and surveillance.

Effective communication programmes respond to EPI programme needs through advocacy, social mobilization and communication activities for behaviour change.

Communication programme management involves:

- strategic communication plans (with clear objectives, activities, targets)
- monitoring tools and indicators (including clear definitions and methods on how these indicators are to be applied)
- a supportive supervisory system for performance improvement
- a package of communication-related tools (e.g. immunisation cards with information for caregivers, counselling cards for health workers, advocacy and media guides, key immunisation messages, guidelines for community involvement, and others).

As with the other elements of an EPI plan, the communication component needs to be explicit, based on data and qualitative research, and include an appropriate timeframe and budget. Communication aspects need to be planned early to secure the necessary funds for materials, training, activities, transport, support and operational costs, etc. An immunisation communication plan should be comprehensive, addressing all aspects of EPI (routine, surveillance, and disease control).

**Communication components in EPI tools**

The communication activities must be included in the overall EPI plans, training manuals and other tools. *The communication component should be part and parcel of:*

- multi-year EPI plan
- annual EPI action plans, specifying the schedule of communication activities
- EPI budget (prepared in time in order to allow for disbursement of the necessary funds to cover expenses on communication material production, transport, equipment, training, organisation of meetings etc)
- EPI training materials and technical guidelines (with section on communication, social mobilization and advocacy)
- EPI assessment protocols with specific indicators on communication
- immunisation record forms, health and immunisation cards and other informational tools for caregivers.

2.2 Barriers and challenges for communication in EPI

As with other community-oriented programmes, immunisation programmes sometimes face barriers and challenges to effective implementation. This can be because the community is not involved in programme planning and implementation or information explaining the benefits of immunisation is lacking. For example, some policy makers or community leaders may not be aware of immunisation services or may not view immunisation as a priority. Mothers may also not be aware that they need to bring the child back for additional vaccinations, particularly if the health worker has not carefully explained the vaccination schedule to them. It is, therefore, important to be aware of potential barriers to communication that may be related to:

- Insufficient information to caregivers on immunisation dates, side effects after vaccination, etc
- Poor communication skills or poor practices of health care workers, community leaders or policy makers
- Confusing messages on immunisation
- Insufficient attention to communication in EPI meetings, plans, budgets or activities
- Few agencies, communication specialists or institutions, and/or community partners that are involved in communication in support of EPI
- Problems with compliance or perceived resistance to immunisation, due to lack of community involvement and interaction in planning
- Lack of human, financial and material resources
- Insufficient communications infrastructure and means (radio stations, radios, paved roads, publishing capabilities).

Barriers to the communication process may relate to service delivery, interaction with communities, channels of communication or content and clarity of the messages. These barriers occur at all levels: national, provincial, district and health-facility levels and
can also be institutional. The EPI manager should ensure that such communication barriers and challenges are addressed.

The starting point for planning an immunisation programme should be a situation analysis that identifies and involves key stakeholders. A comprehensive plan that ensures sensitisation and advocacy with stakeholders regarding the immunisation programme should be strictly implemented. These stakeholders may include religious, traditional and political leaders.

**Exercise 1**

In your groups, brainstorm barriers and challenges to communication in an immunisation programme that you have experienced in your work as EPI manager. Allow the brainstorming to have both rural and urban scenarios.

Consolidate outcome of your group work and present it to the plenary.

### 2.3 Target audiences for communication

In the course of performing their work, the EPI manager and immunisation staff communicate with individuals and groups at various levels and with a variety of responsibilities and roles within governmental structures and communities. The information communicated and the channels used will vary depending on who is doing the communicating as well as the intended purpose and audience (i.e. informational, managerial, awareness building, educational, etc).

- **Immunisation staff:** Health workers who immunise are often the most important source of information on vaccination for mothers. The quality of interaction between them and caregivers will determine whether the mother returns for all immunisations. Health staff needs the skills, motivation, and proper work conditions to treat mothers with respect, give them essential information and answer their questions and concerns. Staff members also need feedback on whether their work is achieving EPI objectives (e.g. improving coverage) and what programme adjustments are needed to meet these objectives. The EPI manager needs to ensure that staff skills and motivation are maintained and that work conditions are upheld. It is also important to communicate new policies and technical updates to staff in a clear and timely manner. Far too often, policies change at the central level, but awareness of this does not reach the periphery.

- **Provincial, district and health facility senior staff:** Communication between national EPI staff and officials at these levels often involves assigning tasks and conveying plans, guidelines and policies, supervising, and ensuring feedback. To avoid delays in implementing interventions, EPI managers should communicate information in a timely and clear manner. An example is timely communication to districts about immunisation days. In addition, mechanisms should be in place to enable provincial and district officers to engage in effective communication with the national EPI manager.
Politicians, policy makers: The EPI manager and his senior staff often communicate with individuals at a high levels (for example, the Secretary-General or the Minister of Health), concerning planning and reporting on activities. This audience may need technical data or a general and informative overview of activities and status of the EPI.

As African countries are participating in global initiatives such as Polio Eradication, Measles and Neonatal Tetanus Elimination, etc., this audience needs continuous technical updates to mobilize resources to achieve national and global targets.

In addition, immunisation and health staff at provincial and district levels often need to communicate with local politicians and other government officials in their provinces and districts.

Health education services: Health education programmers and specialists may be directly involved within the EPI or public health service or utilized for periodic technical input. Their services are needed for planning, implementing, and evaluating communication activities; mobilizing and advocating with communities and the public; and designing and disseminating messages and communication materials.

Medical schools and nursing care services: Communication activities with these institutions and groups may involve skills development on how to communicate with clients; technical information on vaccines and their administration (including safe vaccine handling and injections); as well as orientation on how to conduct vaccination sessions and work with communities. An important task for the EPI manager is to collaborate with the institutions to have them include EPI topics in their curricula.

Epidemiological and statistical services: Data from these institutions need to be analyzed, summarized, and presented to authorities and the public. Effective communication is needed to disseminate this information to the public and special audiences and to support reporting and surveillance at all levels, including the community level.

Interagency co-ordinating committees and partners: Communication is useful for planning and co-ordinating partners and government departments. It is particularly important when there is a specific task or intervention, such as immunisation days or measles epidemic response, to be planned and executed. In these cases, the EPI manager or immunisation staff utilizes communication activities to set up committees or conduct meetings that bring together representatives of various departments and partners. Communication is also used to find solutions to a given problem, for example, formulating a plan for the production of materials or a social mobilization plan.
- Public and private sectors (including private doctors, missionary groups, and NGOs): These target groups are important for planning and conducting immunisation activities and interfacing with the communities in which they work. They can assist in advocating with and mobilizing populations as well as raising resources. In addition, they are crucial for ensuring acceptance of services and assisting with service delivery.

- Community leaders: This is an important target group for communicating health messages, including immunisation to families and encouraging them to complete all vaccinations and to help mobilize the community to support immunisation activities.

- Media: Journalists and other media personnel are targets for communicating immunisation information to the public. The EPI manager needs to ensure that media representatives are regularly briefed on immunisation issues and progress so that they can support the programme in disseminating technically correct information. Support of a correctly briefed media is especially important during epidemics or when the health staff is confronted with AEFI (Adverse Event Following Immunisation).

- Caregivers (mothers, fathers): Parents, particularly mothers and other caregivers like grandparents, are the primary audience for immunisation communication. The EPI manager and programme staff need to ensure effective communication with caregivers so that children are taken for all the vaccinations at the correct age and time, and for caregivers to understand key information such as the purpose of the immunisations and what to do when an AEFI has been noticed.

2.4 Organisational structures for communication

- Interagency Co-ordinating Committee (ICC)

  Responsibility for overseeing the quality of communication activities should be part of the terms of reference of the ICC. The ICC should ensure that a communication specialist is member of the team and participates in ICC meetings to assist with EPI programme planning and public relations. Many countries have created a separate Communication/Social Mobilization Committee to address the communication issues and to provide input as a sub-committee of the ICC. These committees express a technical opinion and formulate strategies for advocacy and communication for EPI.
○ Sub-national communication structures

The EPI manager should work with existing communication structures to be sure that planning and agreements from the national level are communicated to sub-national levels. Communication structures at sub-national levels should also be engaged in EPI microplanning. One option is that social mobilization/communication committees at the community and district level work with the community and health service to ensure that communication on EPI is effective.

○ Focal point for communication

A focal person or organisation, preferably a member of the EPI office or team, should be appointed to co-ordinate and move communication activities forward in collaboration with other ICC team members. As a member of the ICC, the communication focal point will be responsible for the organisation, implementation, and evaluation of EPI communication activities. He or she will also provide input on communication issues and develop and guide the necessary strategies and activities to boost and maintain demand for immunisation.

2.5 Role of EPI manager in managing immunisation communication

The EPI manager and the ICC should ensure that communication is integrated into EPI plans. In order to have communication activities effectively incorporated into EPI and the ICC’s schedule of meetings, communication specialists should be involved and effective management structures and tools be in place that address communication. EPI managers need to communicate with their staff, government officials, donor agencies, and the public. In addition, they should work with communication specialists to:
Include communication planning into overall EPI plans (annual, multi-year, microplans, etc)
Ensure that a communication specialist is a member of the ICC and participates in ICC meetings to assist with EPI programme planning and public relations
Verify that staff are implementing the communication activities as defined in the strategic plan and their terms of reference or job description
Ensure that staff periodically monitors programme quality and availability to address priority barriers and problems and makes necessary adjustments.
Provide training to and build capacity of personnel of participating organisations, health workers, and volunteers who may need skills to participate in communication for EPI
Supervise implementation of communication activities
Verify that educational materials and other immunisation informational tools, such as immunisation records, are distributed and are available where they are required
Ascertained that the implementation of the communication component is synchronised with other immunisation programme interventions
Monitor the implementation of communication activities and expected outcomes according to specific communication indicators, and make programme improvements, as needed
Hold meetings with immunisation partners and with the media to communicate progress or constraints
Communicate monitoring and evaluation results and conclusions to staff, the media and the public
Involve the public and the community at all levels in planning and implementation of immunisation activities to ensure their acceptance, involvement and support.

Planning and managing resources for communication

Effective planning and management of resources for communication are important for the immunisation programme. The role of the EPI manager is to identify and access the human, material and financial resources needed to support activities at national, provincial, and district levels. The EPI manager may access these resources not only from traditional channels but also through decentralized community and local administrative structures, other associations, and/or CBO and NGO resources. For example, as part of the Reaching Every District (RED) approach, efforts should be used to convince partners and collaborators to become engaged in EPI. The appropriate allocation of these resources to priority activities will influence the effectiveness of the programme.

For planning and managing communication resources EPI manager should:
- identify existing resources (human, material and financial)
ensure adequate budget for priority communication activities

- balance resource allocation for various components of the programme (logistics, surveillance, programme management, service delivery and communication)

- maximize resources where activities are taking place

- respond to staff requests for resources.

**Resources used to assist with communication**

**Human Resources**

- Health workers: Health workers interact with the caretakers and play an important role communicating immunisation messages to parents.

- Influential leaders (religious, political, cultural, administrative, civil society, community, traditional, volunteers): They should be sensitised to inform and mobilize the population to accept and use the programme. Their credibility will facilitate relations between health professionals and parents and contribute to responding to rumours or resistance.

- Local and national intersectoral committees: They should be identified to determine the appropriate competency and role they can play in immunisation communication, especially to integrate health services with other programmes.

- ICC: The ICC comprises key partners whose comparative advantage and experience in communication can be used for advocacy and mobilizing resources.

- Private sector health care providers: The private sector plays an important role in financially and materially supporting communication activities and private health care providers in communicating with their clients.

- Ministries:
  - Information and Communication: Advocacy should be done with this ministry to provide free production and dissemination of radio and TV programmes/spots
  - Culture: The ministry can provide theatre groups, performers and artists to contribute to the design and production of communication activities, materials, etc.
  - Education, Youth and Sports: This ministry sponsors and works with children, especially in rural areas. The Ministry of Education offers the possibility of integrating communication activities into the school system and into community-based literacy programmes

- Women’s associations: These groups can mobilize, advocate with, and sensitise communities to encourage their acceptance and use of services.

- NGO/CBO and community associations: These groups assist with mobilizing, sensitising, and referring the population to accept and utilize services over the long term. They also can assist with training health care providers, and they have the capacity to produce and disseminate communication materials.
Training institutions: They contribute training venues, facilitators, training materials and other resources that can meet specific needs within the EPI programme.

Financial Resources
Apart from the national EPI budget, the EPI manager should be aware of other financial resources that can be accessed. These may include:

- Financial resources from NGOs and other partners
- Health committees and decentralised community budgets
- Associations (e.g. women and youth) and clubs (Rotary, Lion’s, etc.)
- Private sector organisations and companies
- Local initiatives and organisations.

Material Resources
A successful communication programme should have sufficient material resources. EPI staff should carry out an inventory to see if available materials match with communication needs of the programme. Possible material resources include:

- Radio and TV broadcasts
- Newspapers and journals
- Print materials (brochures, leaflets, etc), t-shirts, other promotional materials
- Drama groups
- Materials produced by health education units and training institutions
- Reports on research and professional publications
- Audio-visual materials
- Communication materials at health information and resource centres
- Websites for technical information and for preparation of communication materials, and others.

Working with communication specialists
To ensure that communication elements are adequately addressed in the programme, the EPI manager needs to work closely with communication specialists.

Communication specialists include professionals involved in health communication programmes such as health educators, communication officers, social scientists and journalists. Communication specialists can also be recruited from communities who use traditional methods of communication such as theatre and singing groups. Preference should be given to those individuals and institutions already involved in EPI. A rapid situation analysis would reveal availability of different communication specialists and ensure that the right people are consulted to provide professional support to the communication component of the EPI.
The EPI manager needs to determine how the range of communication specialists may assist in such tasks as:

- Developing and implementing communication plans
- Conducting assessments and research
- Designing and testing messages and tools
- Selecting and developing monitoring indicators
- Resolving communication issues when confronted with service delivery problems
- Providing feedback on programme achievements, results, and needs
- Monitoring, supervision and evaluation.

Subcontracting opportunities

Some communication activities requiring specific expertise can be subcontracted to specialist organisations, such as university departments and advertising agencies, to ensure a high quality of communication products. Activities that can be subcontracted include research, training, preparing and pre-testing materials, etc. The work of subcontracted specialists should be monitored to ensure it complies with the needs and specifications of the programme. The following points and arrangements can assist the EPI manager and communication focal point in the subcontracting process:

- Determine what needs to be done and the stages necessary to complete the work
- Prepare well-outlined terms of reference for the work
- Estimate costs involved and identify the source of funding
- Determine the availability of an expert in a timely manner
- Draw up a contract that clarifies the duration, required output, the expected date of completion and submission of the product and travel requirements, if any
- Provide technical orientation to experts on objectives and context of the expected work
- Supervise the quality of subcontracted work and refocus the performance in case some issues are sidelined
- Evaluate the quality of the products delivered
- Keep a record of effective consultants and specialists in communication for future reference.
Case Study 1: Support for district-level immunisation activities

Although communities in Kulwazi Republic were active with the NIDs in previous years, the ICC has determined that more financial resources are needed to support district-level routine immunisation activities to improve coverage and reduce drop-out rates. Only a few district immunisation managers have developed district-level co-ordinating committees.

Some districts have expressed an interest in mobilizing the communities to support an immunisation month to focus on low coverage areas and boost attendance for routine immunisation sessions. One higher performing district, Matapa, has encouraged support for immunisation through information meetings that the district EPI manager and health educator have begun conducting with the district health assembly, mayors, and religious leaders.

These meetings have encouraged their support for immunisation, evidenced by more finances being budgeted for outreach services, announcements on immunisation in mosques and churches, and discussions of health care at district government meetings. The district is also implementing immunisation training for its health staff, including sessions on communication with caregivers and communities as well as on the use of child health records as data management and counselling tools. A few community leaders are providing immunisation information, but the district-level health staff has requested additional technical information to encourage the support and involvement of community leaders.

Exercise 2

Answer the following questions from the case study:

1. What efforts have already been implemented to encourage further awareness for immunisation?
2. Which audiences need to be targeted for additional resource support?
3. What are some other ways that these target audiences can be given information on why/how to support the immunisation programme?
3. Planning Communication Interventions

3.1 Developing the communication plan
3.2 Monitoring communication activities
3.3 Evaluating communication programmes

The planning process for multi-year and annual plans of EPI activities is described in sections 3-6 of the module on Planning Immunisation Activities at National, Regional and District Levels. The module on Conducting Assessment of Immunisation Programmes, sections 3-5, outlines the planning and implementation process for EPI assessments. Previous sections of this module also highlight the importance of communication planning for an EPI programme (see Figure 1).

3.1 Developing the communication plan

Although the development of the communication plan is often entrusted to the communication focal point or to a health education unit, the EPI manager should still ensure that a comprehensive communication component is included in the EPI plan so that communication activities directly support EPI programme objectives.

Figure 1: Integrated EPI programme and communication planning

To create and sustain demand for immunisation services, reach target audiences and increase coverage rates, immunisation programmes and service delivery need to be combined and supported by well-planned communication strategies and activities.
Consulting with the community, using participatory planning techniques, will engage key local partners in the programming process from the start. This will allow focus on certain critical activities during the planning phase before the start of the programme. For example, undertaking an assessment of the public health situation should include a review of the social environment, identifying current and potential health behaviours, and addressing programme resources and constraints. This assessment would bring out communication issues relevant to the proposed intervention, particularly local means of information dissemination, persuasion and social exchanges, all of which are important socio-cultural issues.

Planning and implementation of integrated communication for immunisation strategies involves the following process:

**Table 1: Planning and implementation process for communication**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Conducting situation analysis</strong></td>
<td>- Review the status of routine or supplemental immunisation programmes, related communication interventions, and recently conducted socio-cultural studies&lt;br&gt;- Determine priority problem behaviours relevant to immunisation that will be addressed&lt;br&gt;- Review available human, material and financial resources for communication activities</td>
</tr>
<tr>
<td><strong>B. Setting objectives</strong></td>
<td>- Analyse factors underlying main problem behaviours: the people who adopt these behaviours, their socio-cultural environment&lt;br&gt;- Formulate communication objectives and measurable targets</td>
</tr>
<tr>
<td><strong>C. Determining strategies and activities</strong></td>
<td>On the basis of results from the previous steps, select key communication strategies (advocacy, social mobilization and behaviour change communication) and develop their components, including:&lt;br&gt;- Activities, media, messages and materials to be used&lt;br&gt;- Training and capacity-building plan&lt;br&gt;- Budget</td>
</tr>
<tr>
<td><strong>D. Developing action plan for implementation and monitoring</strong></td>
<td>- Draw up an implementation plan of action with timeframe&lt;br&gt;- Include monitoring indicators and data collection activities and modify inputs and timeframes, as necessary</td>
</tr>
<tr>
<td><strong>E. Evaluating communication activities</strong></td>
<td>- Select and develop evaluation indicators&lt;br&gt;- Use indicators for evaluation&lt;br&gt;- Make recommendations based on the results of evaluation</td>
</tr>
</tbody>
</table>

Situation analysis

Usually the data collected for EPI programme situation analysis provide sufficient information for communication planning. EPI managers must ensure that all EPI assessments include questions/sections on communication. (Refer also to Module 5, Increasing Immunisation Coverage, Step 2.1 for additional guidance on problem analysis). In some circumstances, it may be necessary to carry out small-scale additional research (formative, qualitative).
Setting communication objectives

Communication objectives should be developed in conjunction with EPI programme objectives. Communication objectives should focus on the specific behaviours that the programme wants to change or promote, as identified in the situational and behavioural analyses. Well-formulated communication objectives will have the following characteristics:

**Specific:** What is the expected result?

**Measurable:** Costs/quality/quantity can be determined

**Appropriate:** Cultural and local acceptability

**Realistic:** Achievable within the allotted time and resources available and given the situation

**Time defined:** Clear and appropriate timeframe outlined for achievement of the objective

Each objective, if properly formulated and worded, should address the following questions:

**Who:** Individuals called upon to change their behaviour and/or complete the action

**What:** Action, change in behaviour or healthy habits to be promoted

**When:** Period and/or end date within which the behaviour should have been changed

**How many:** Range of conditions to be met: percentage change, number of individuals influenced, etc.

Communication monitoring indicators should track planning, implementation and results of these objectives. Refer to Annex 2: Setting Immunisation Objectives, in Module 5 on Increasing Immunisation Coverage.

**Determining communication strategies**

In addition to capacity building, which is a common strategy in the overall immunisation programme, the communication programme applies three other strategies to support EPI: advocacy, social mobilization, and behaviour change communication.

**Advocacy** focuses on gaining and maintaining the support of decision-makers. This can include political, resource, and policy support. An example of a programme action for advocacy is to produce a briefing package for use with national government officials on the importance of supporting routine immunisation.

**Social mobilization** aims to gain and maintain the involvement of a broad range of groups and sectors at different levels and in the community in supporting immunisation activities. These groups can include private companies and commercial enterprises, other government sectors, non-governmental organisations (NGOs), civic groups, and local community groups. Social mobilization also involves informing and motivating the public to participate in immunisation activities.
Behaviour change communication encourages behaviour change among target populations in ways that directly support higher and better quality immunisation coverage and other disease control actions, e.g. health workers treating mothers with respect and giving essential information clearly and caregivers bringing children for each immunisation as soon as they are eligible.

In many settings, the most important, and most used, channel for health information is the health worker. To be effective, caregivers and the community must trust the health worker. Therefore, strengthening the interpersonal communication channel, by training health workers as communicators and by giving them good materials to use with parents and the community, is the bedrock of a good immunisation communication strategy. All other media should support and reinforce the interpersonal health education provided by clinic staff. Other groups in the community providing education and motivation to caretakers such as community health workers need to have interpersonal communication skills included in their orientation.

The traditional communication channels add value to immunisation programmes, especially when the channels used are credible, and when they are combined with messages transmitted through service delivery. Examples include communication between communities and health staff on the dates and times of vaccination, interpersonal communication between health workers and caregivers on the child’s vaccination schedule, etc. Programmes can also use traditional communication channels to collect and disseminate information, as they offer opportunities for participation by local people. This should be combined with modern methods of information dissemination, such as radio and television.

The materials and messages used for the immunisation programmes as well as the means of communicating this information will vary depending on the target audience and the desired behaviours or actions. Consider the target audience when determining which form of media or communication channel will be utilized to disseminate messages.

Determining communication activities for the workplan

The EPI manager should ensure that an implementation plan is based on information gathered in the planning steps. This plan should include: deadlines and time frames, the distribution and dissemination of materials, capacity building (including training, workshops, meetings, and supervisory activities), required resources for the activities, role of partners and other stakeholders, an implementation schedule for communication activities that is harmonised with the EPI workplan.

3.2 Monitoring communication activities

Although collecting monitoring data helps identify programme strengths and weaknesses, monitoring alone cannot fix a problem. For example, outcome data may show that mothers’ knowledge about immunisation is high, but impact data show that
desired behaviour is low (no change in drop-out rates). Thus, monitoring has correctly identified a programme weakness that should signal further inquiry about why the programme objective (lowering drop-out rate) has not been achieved. It may be a communication issue, service delivery, supply, or management issue – but it is not faulty monitoring that has caused the gap.

Monitoring communication should be done in conjunction with other EPI monitoring, adding communication indicators to existing immunisation monitoring forms at all levels. Communication specialists follow many indicators specific to the communication process, so EPI and communication partners/officers will need to identify which indicators are meaningful and feasible to integrate into EPI monitoring activities.

**Principles for selecting indicators**

Following are some principles to follow when identifying indicators:

1. Before selecting an indicator, the universe from which comparisons will be made should be defined. Second, this universe must be feasible to measure on a monthly or quarterly basis. In the following example, note that every indicator is expressed as a fraction, the denominator defining the universe:

   Activity being monitored: Religious leaders mobilized (meeting, pamphlet) to promote EPI in weekly sermons over the next two months.

   \[
   \frac{\text{# of religious leaders attending meeting}}{\text{# of religious leaders in district/state}} \quad \text{output indicator}
   \]

   \[
   \frac{\text{# of religious leaders who mention EPI in ¾ of sermons}}{\text{# of religious leaders attending meeting}} \quad \text{outcome indicator}
   \]

   \[
   \frac{\text{# of men attending mosque/church who support EPI}}{\text{# of men attending mosque/church}} \quad \text{outcome indicator}
   \]

2. The communication contribution to programme objectives (improved coverage, lower drop-out rates, etc.) should be inferred only at the level where communication activities are being implemented. Thus, district-wide communication activities can contribute to district immunisation programme improvements.

3. The usefulness of monitoring data is to show trends over time. Taking measures only once is not useful at all because there is no point of comparison.

**Types of indicators**

There are four types of indicators and all four need to be tracked and their data analysed in order to see strengths and weaknesses of a communication activity. In other words, tracking four types of indicators will foster data-based decision making. To avoid confusion, specify which type of indicator is being discussed. Each type captures a different point in the communication process and what results are expected.
INPUT: measures capacity/planning. These indicators will demonstrate to what extent a country is committed to produce communication support for immunisation through allocating national resources (human, material and financial).

OUTPUT: measures activity implementation. Tracking these indicators should be specific to what communication activities were planned.

OUTCOME: measures results of communication activities. These indicators focus on: performance of communicators and social mobilizers, behaviour change of caretakers and family, knowledge of caretakers, etc.

IMPACT: measures achievement of programme objectives. Communication’s contribution can only be inferred because many other factors influence programme impact.

Communication output and outcome indicators are activity based, thus one set of indicators may not be relevant across countries. Even within a country, identifying these indicators will depend on what communication activities are being implemented and at what level. (For example, district-level activities are monitored on district forms, facility or village-based activities need to be monitored and data used at that level.)

Table 2 illustrates indicators that track typical communication activities at the district and facility level. Input, output and outcome indicators measure communication directly. Impact indicators are those currently being tracked by the programme and reflect contribution to their change but not direct impact. In addition, from these monitoring data, it is not feasible to conclude that one activity is more influential than another.

**Table 2: Indicators for tracking communication activities at district and facility level**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Input</th>
<th>Output</th>
<th>Outcome</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilize religious leaders (RL) to promote polio vaccination in weekly sermons during month before NID</td>
<td>Funding Pamphlet Facilitators</td>
<td># RL attending meeting # RL in district/state</td>
<td># RL promoting NID ½ sermons # RL attending meeting # men positive/knowledge of NID # men attending mosque/church</td>
<td>Decrease in no. of incorrectly marked houses Increase in no. of vaccination attendance sites</td>
</tr>
<tr>
<td>Train HWs in IPC during vaccination to improve completion of vaccination series</td>
<td>Funding Training module Trainers</td>
<td># HW scoring 3/5 on IPC checklist # HW trained</td>
<td># mothers who know when to return # mothers attending clinic</td>
<td>Decreased drop-out rates</td>
</tr>
<tr>
<td>Community volunteers mobilized to track late children for routine EPI</td>
<td>Facility register EPI service Health Worker</td>
<td># children visited # children on facility list</td>
<td># children vaccinated # children visited</td>
<td>Decreased drop-out rates</td>
</tr>
</tbody>
</table>
3.3 Evaluating communication programmes

At the end of a specified planning period, communication interventions need to be evaluated as part of the overall programme evaluation. Like all evaluations, this will enable you to see the impact and outcome of your efforts and how they have influenced quality and quantity of the immunisation services. Evaluation of the communication component can be carried out within overall EPI evaluation exercises or separately to have a more comprehensive view of the role of communication for improving coverage and quality of services.

The evaluation can be conducted internally by the EPI staff and externally with participation of experts, which ensures the objectivity of the exercise. Make sure the evaluation team has a communication specialist to make an in-depth analysis of the communication component.

The evaluation should be based on impact and outcome indicators to measure overall progress and achievement of goals and objectives in relation to changes in knowledge and behaviour. It is not possible to specifically measure impact of communication activities as an isolated achievement, but communication contributes to the change in programme outcomes: increased immunisation coverage, reduction in drop-outs rates, drop in number of cases and deaths from vaccine-preventable diseases, etc.

The evaluation report should provide recommendations to improve programme performance and suggest the way forward towards new challenges in the next planning period.
Exercise 3

Following is a chart of the main steps of EPI programme planning, as used by EPI managers. Each group is asked to reproduce the chart on a flipchart or on VIPP cards. In the envelope you have been given is a set of cards with the main steps of the communication planning process. Match each communication planning card with the corresponding EPI programme planning card, indicating that both steps should be conducted jointly.

Based on your experience, what obstacles are you anticipating that could prevent you from integrating a specific communication planning step (to be specified) in the corresponding EPI programme planning step. In discussions in your group, suggest one or two actions that may help avoid or overcome these constraints.
4. Communication Skills for Immunisation Staff

4.1 EPI manager and health staff interpersonal communication

Interpersonal communication is a process of exchange of information whereby the communicator is face to face with an individual or a group of people. Although used at all levels and in many settings, interpersonal communication is of particular importance between health care providers and caregivers, because communication could either encourage or discourage caregivers to bring children back for other immunisations.

The EPI manager also communicates regularly with various persons at all levels regarding management and implementation of programme activities. Consequently, for the EPI staff to function as a team, good interpersonal communication must be ensured at all levels: the EPI manager should communicate effectively with his or her staff. The communication channels between health staff at different levels should be open and supportive.

4.2 EPI staff communication via mass media

Below are some suggestions on how the EPI manager and programme staff can work with the media to communicate information effectively on the immunisation programme and activities:

<table>
<thead>
<tr>
<th>Some suggestions on using the mass media (e.g., television, radio, newspapers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Develop an informed media network for accurate reporting and to be an ally</td>
</tr>
<tr>
<td>◆ Inform the media in advance about programme activities, specifying the date, place and participants so that these activities may be given wide media coverage</td>
</tr>
<tr>
<td>◆ Sponsor the media to observe immunisation activities and events so they can cover stories and broadcast information</td>
</tr>
<tr>
<td>◆ Provide the media with human interest and success stories from the programme</td>
</tr>
<tr>
<td>◆ Prepare and issue regular press releases for the media to use in their broadcasts or articles</td>
</tr>
</tbody>
</table>
Organise regular interviews with the media, involving different advocates of the programme (e.g. leaders, experts, etc.)
Advocate with media allies for regular and varied programmes on EPI (such as phone-ins, talk shows, panel discussions)

4.3 Communication on immunisation with communities

EPI success requires community involvement and support. For community participation and a more effective programme, define the community with which one has to work and ascertain that community needs and interests are catered for. Social mapping to identify community resources is an important basic activity. The steps below outline the process for community engagement.

1. Determine and establish contacts with the social networks in the community.
   Health staff should contact traditional chiefs, religious leaders, opinion leaders, social leaders, custodians of tradition, pioneers, and other sectors and organisations of the community. Advocacy should be strong with these groups to enable them to serve as advisors, mobilizers, and supporters with the community. Most communities already have established structures, e.g. health development committees and village health workers, which should be oriented to promote immunisation.

2. Define the communication and service delivery needs of communities (assess with immunisation programme managers)
   - What are the services offered by the programme?
   - Are the communities being provided with information related to the EPI programme?
   - Are the communities aware of these services and where they are provided?
   - How is the information given to the community?
   - How do community members perceive the programme?

3. Provide information and feedback on EPI to communities
   People can participate only when they are well informed and when the health care provided meets their expectations and needs. The immunisation staff’s mission, in collaboration with the communication specialists, is to establish and consolidate dialogue with the different sectors of communities to let them know programme achievements and constraints and how they can contribute to the further development of the programme.

4. Working with the community
   - Define and satisfy the community’s information needs
   - Involve the community in planning activities
   - Train other members of the community, such as village health workers, traditional chiefs, counsellors, teachers and agricultural extension workers, so they can encourage caregivers to have children immunised
- In collaboration with the community, define immunisation programme needs and monitoring and evaluation indicators
- Carry out periodic evaluations with the communities. Communicate the data collected to all the stakeholders, for example, coverage rates and difficulties encountered.
- Agree with the community on how to improve aspects of the programme and services
- Maintain regular contact with the community for sustainable support for EPI.

Immunisation issues that could be addressed in communication between the service delivery and communities are noted in Table 3.

**Table 3. Identifying immunisation problems and causes during discussions with health staff and communities**

<table>
<thead>
<tr>
<th>Problems</th>
<th>Possible causes of problems</th>
</tr>
</thead>
</table>
| Many children get some immunisations but do not complete the basic series (utilization problem, which may reflect a service accessibility or quality problem) | 1. Health workers have not clearly explained to parents what vaccinations are due, when they are due and why they are needed  
2. Health workers do not understand what vaccinations are due, when they are due and why they are needed  
3. Barriers discourage parental return, e.g. hours of clinic operation, cost, distance and long waits  
4. Health workers do not clearly explain to parents when vaccinations are administered at the clinic  
5. Health workers have not shown parents respect or conveyed an interest in the child’s health  
6. Vaccination services are unreliable (vaccine shortages, etc.) and/or (when given via outreach or mobile units) not offered frequently |
| Children and mothers are not immunised when coming to the clinic for sick visits (service problem) | 1. Health workers forget to check records or ask about what vaccines and doses a child/mother has received  
2. Health workers do not understand or accept such programme policies as immunisations may be given to mildly ill children  
3. Health workers fail to explain to parents that it is often acceptable to immunise a mildly ill child  
4. Immunisations are not available on that day  
5. Immunisation supplies are not available  
6. Mothers (and possibly health workers) fear a child getting “too many” vaccinations in the same visit |
| Health workers cannot determine what immunisations a child has received (service and/or utilization problem) | 1. Health workers forget to remind parents to bring the immunisation card  
2. Clinic records are not organised so that it is easy to find a child’s records  
3. Some mothers lose or forget to bring the immunisation card  
4. There is a shortage of immunisation cards |
| Pregnant women do not seek immunisation for tetanus (service and/or utilization problem) | 1. Health workers failed to use every contact with women of childbearing age to explain the need for, and importance of, tetanus toxoid immunisation (particularly when they bring their children to get immunised)  
2. Barriers discourage women from seeking immunisation, e.g. cost, gender and cultural issues (they believe immunisation may cause infertility) |
4.4 Health worker communication with caregivers

Interpersonal communication skills of health workers and district EPI managers are important when providing vaccination services and communicating with communities. Caregivers often rely on vaccinators to provide them with needed information regarding their child’s health and vaccination status as well as when and where to receive additional vaccinations. Country experiences have shown that the role of the vaccinator as a communicator is a critical element, with improved service delivery, to lowering drop-out rates and reducing missed opportunities for vaccination. The district manager needs to work with the health facility teams to ensure that immunisation skills, including communication, are regularly monitored and updated. Table 4 provides some guidance on how and what vaccinators should communicate with caregivers:

### Table 4: Example of health worker communication skills in practice

Below is a description of how vaccinators, in ideal circumstances, should interact with caregivers (who are usually, but not always, mothers). Every programme should adjust these recommendations based on a realistic assessment of the feasibility of implementing them in a given setting (in light of the time available for patient visits, number of people waiting for services and other factors).

The most essential elements of every immunisation encounter are that the vaccinator treats the caregiver with respect, explains when and where to return for the next vaccination, and advises on possible side effects and what to do.

The ideal health worker/caregiver interaction:
1. The health worker welcomes, greets and thanks the caregiver in a friendly manner for coming for vaccination and for her patience if she had to wait.
2. The health worker explains to the caregiver in simple terms and the local language the disease(s) against which the vaccination protects.
3. The health worker mentions possible minor side effects (which are normal reactions to vaccines) and explains how to handle them. Health worker also mentions that in extremely rare cases serious post-vaccination reactions may occur that should be reported immediately to the health facility for assistance.
4. If the child has a common mild illness, the health worker explains that vaccination is still safe and effective and important, and administers it.
5. After the vaccination is given, the health worker writes the date of the current vaccination(s) and other details on the immunisation card.
6) If the vaccine received is one in a series (e.g. DPT, 2 or 3, OPV, 2 or 3; or HepB, 2or 3), the health worker explains to the caregiver the need for the child to complete the series to be fully protected against the disease(s). The health worker uses the vaccination chart on the immunisation card as an instruction guide. Where SIAs are conducted, the vaccinator may have to explain that, in addition to the routine doses on the card, all children under age five (or older, depending on the SIA) are urged to get extra doses during special SIA vaccination days to be protected further from vaccine-preventable diseases.

7) The health worker writes the date for the next vaccination on the immunisation card and tells the caregiver about it. If appropriate, the health worker associates the date with a “trigger” such as a holiday or seasonal event that will help the caregiver remember to bring the child back for vaccination. The health worker asks the caretaker to repeat the date, to be certain it has been understood.

8) The health worker explains to the caregiver that if she and/or the child cannot come on the return date, they can obtain the next vaccination at another location or another date close to the due date.

9) The health worker reminds the caregiver that she should bring the immunisation card to the location where the child receives the next vaccination.

10) The health worker congratulates the caregiver if the child is fully vaccinated.

11) The health worker asks the caregiver if she has any questions and politely answers all questions.

12) If special supplementary vaccination campaigns are planned in the coming months, the health worker informs the caregiver about the date of campaign, what vaccination is being given, and (if known) where she should bring the child for the supplemental vaccination. The health worker should ask to see the mother’s vaccination record in order to determine her tetanus toxoid (TT) status and advise her accordingly.

14) If vitamin A is being given, the health worker explains to the caregiver that it is important to bring the child back in six months (and give the date) for subsequent vitamin-A supplementation to help protect the child from infections.

Table 5 describes the knowledge that caregivers should have on immunisation, based on a criteria of essential, useful, and important information provided. The list can help guide health workers and the EPI programme on which messages to emphasize most in situations where the health worker does not have time to discuss all relevant topics with caregivers.

### Table 5: Caregiver knowledge on immunisation

<table>
<thead>
<tr>
<th>Essential</th>
<th>Useful</th>
<th>Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>- How old my baby is (or when she was born)</td>
<td>- What diseases my child was protected against today</td>
<td>- Specific information on vaccine-preventable diseases</td>
</tr>
<tr>
<td>- The need to bring to the health facility or other vaccination site the child health or vaccination card</td>
<td>- My child may have fever and soreness but these should go away soon. I can treat fever with paracetamol (etc.)</td>
<td>- There are no vaccines given to protect against AIDS, malaria, or cholera</td>
</tr>
<tr>
<td>- When and where my child needs to return for the next dose(s)</td>
<td>- The immunisation schedule</td>
<td>- How immunisation works</td>
</tr>
<tr>
<td>- Vaccines and immunisation are safe</td>
<td>- How many visits are needed to get the child fully immunised</td>
<td></td>
</tr>
<tr>
<td>- Vaccines and immunisation protect children against a number of serious diseases</td>
<td>- Why children need vitamin A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Why women of child-bearing age need tetanus shots</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Why people need to participate in all NIDs</td>
<td></td>
</tr>
</tbody>
</table>
Case Study 2: Low immunisation coverage in Balajani District

Read the following example and answer the questions in Exercise 4.

A recent immunisation analysis of coverage data in the Republic of Kulwazi showed that several districts had low routine immunisation coverage. One district, Balajani, had coverage for BCG at 70% and DPT3 at 57%, which is lower than surrounding districts. Apart from some rural villages within Balajani, where access is difficult during rainy season, outreach activities are conducted quarterly and no vaccine shortages have been reported. However, there have been stock-outs of child health cards, in which vaccination status is recorded.

The new district immunisation focal point arrived in Balajani 6 months ago. Upon his arrival, he conducted a short study with the sub-district health teams and found that most of the health staff had not received immunisation training in the last 5-6 years. The study also found that health workers were not completing the return date on child health cards, when available, and were not informing caregivers when to bring the child back for subsequent vaccinations.

The district manager met with the district health education specialist to discuss Balajani’s coverage and drop-out data. He was surprised to learn that the health education specialist had not seen the vaccination coverage figures and monitoring charts. The health education specialist was, however, familiar with polio NIDs coverage data. She explained that during the NIDs in 1999, Balajani had only 80% coverage, but with intensive social mobilization activities and house-to-house strategies, the coverage was reported at 95% in 2000. She noted that some community and religious leaders had been recruited as mobilizers during the NIDs. She also described the visits that she and the previous immunisation manager had made to Balajani in 2000 to the local traditional chief’s compound before each NID round to provide information on the campaigns. The leader had welcomed them to his home, received the information on the campaigns and informed his community through local criers about the dates for the NIDs. During the meetings with the leader, however, they had not discussed routine immunisation; and the only message on routine immunisation provided during the campaigns had been “be sure to bring your child for his or her other vaccinations”.

Exercise 4

In your respective groups discuss and answer the following questions:

1) What type of interpersonal communication occurred in Balajani District?

2) Are there any barriers or challenges that are similar to those that you noted in Exercise 1 (refer to section 2)?

3) What audiences should be targeted in this example for improved interpersonal communication?

4) What are some communication activities that the new district immunisation manager could focus on with his health team and the health education specialist to improve coverage in Balajani?

5) What additional support could the national EPI and ICC provide to assist the district level with its immunisation communication activities?
5. Communication in Support of EPI

5.1 Addressing drop out and Reaching Every District

Assessing communication for drop out

Drop-out problems could be a result of poor quality of service delivery and/or lack of awareness of or demand for immunisation in the community. Because these problems are often linked, the programme needs to address both delivery and communication aspects to reduce the drop-out rate and ensure compliance with the immunisation schedule. The process for determining the reasons for drop out should follow the process outlined in the WHO document: “Increasing immunisation coverage rates by reducing drop-out rates.” Following are the key steps and suggestions on possible communication support that could assist with the analysis:

- Assess whether all children in the district/health facility catchment area have access to immunisation services
  
  From the communication point of view, this would include interviews or focus group discussions with community members to determine whether facility-based and outreach services are regularly available and held according to schedule.

- Review drop-out rates
  
  Examine health facility reports and immunisation monitoring chart to find out drop-out rates: DTP1 to DTP3 or DTP1 to measles. In addition to determining drop-out rates by health facility, look at child health registers and determine whether they are available, being kept by caregivers or health staff, and recorded and utilized correctly.

- Identify priority areas and reasons for low coverage and high drop-out rates
  
  Identify possible service delivery problems (vaccine shortages, problems in cold chain, lack of outreach services, use of immunisation data monitoring tools, etc.). In addition, examine possible communication-related reasons. Do health workers know the immunisation schedule? Do health workers screen properly and use
every opportunity to immunise to reduce missed opportunities? Do they complete child health cards correctly (including reminder dates)? Do health workers meet with community leaders to build awareness about immunisation and discuss immunisation services and outreach schedules? Are caregivers informed of the number of contacts necessary to complete the vaccination schedule? (refer to Table 3 for additional information).

- Define and implement corrective measures

When reviewing the immunisation workplan and microplanning with health facility staff, also ensure that communication activities are included in these plans. If health worker training is to be conducted, include interpersonal communication skills with caregivers as a component of the training. Encourage health staff to negotiate schedule, time, and location with communities during joint planning.

**Communication support for Reaching Every District approach**

The Reaching Every District (RED) approach is outlined in the WHO/UNICEF/ CVP/ USAID/ BASICS document, “Progress Report: Reaching Every District: Building national capacity to reach every district with immunisation services within the context of health sector priorities”. The document describes ways in which links can be made to provide a range of priority interventions using the immunisation platform. The essential component of the RED approach is a simple plan of action developed in every district using immunisation data from that district and implemented by their health workers. At each level, the steps that are put in place must aim to build the capacity of the district to make an annual plan and microplan, implement and monitor their progress. The RED approach is broken down into five main operational components, which are presented in Table 6. The table also lists some examples of how communication can be used to support implementation of these operational components.

**Table 6: Operational components and communication support for RED**

<table>
<thead>
<tr>
<th>Operational Components (RED)</th>
<th>Examples of Communication Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-establish outreach vaccination</td>
<td></td>
</tr>
</tbody>
</table>
  - Engage community in planning of immunisation outreach sessions  
  - Negotiate with and disseminate information on outreach visits to communities (e.g. dates, times, location)  
  - Encourage health worker to inform communities about services (e.g. build health worker interpersonal communication skills during training and supervision)  
  - Inform the community that the outreach visit will include immunisation and other services such as IMCI, malaria, HIV/AIDS, vitamin A, etc.  
  - Broadcast outreach schedule through local media and use local contacts to inform community on visits  
  - Share reports with decision-makers to show how outreach improves coverage and can reduce disease burden |
| Supportive supervision | · Ensure that health workers are communicating appropriate messages to caregivers and completing child health records correctly during vaccination sessions  
· Include communication questions in supervisory checklists and during exit interviews  
· Observe communication between health workers and caregivers during vaccination sessions and provide feedback  
· Discuss key immunisation messages and how to improve interaction between the health worker and the community during supervisory visits  
· Praise the health workers for the job well done |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Links between community and service | · Enhance community ownership by ensuring community involvement in planning and utilization of immunisation services (e.g. conduct planning meetings with community, provide community with status on immunisation indicators)  
· Improve interaction of health workers and clients at every point where services are provided to the public  
· Identify and develop links/partnership with community structures (e.g. religious groups, women’s groups, NGOs, traditional leaders)  
· Strengthen capacity (through training, supervision, planning meetings) of health workers/vaccination teams to communicate effectively with clients and the community |
| Monitoring for action | · Ensure that data analysis includes details on communication and behaviour-related reasons for dropout and refusals  
· Share immunisation data with health educators and involve them in data analysis, microplanning, workplan development and supervision  
· Include a communication component as part of the monitoring plan, to address quality of planning and service delivery in links with community  
· Insert key communication indicators as part of the list of district and facility immunisation indicators that are being tracked and reported |
| Planning and management of resources | · Advocate for resources to support communication skills-building for health workers and for training of health educators to support immunisation communication  
· Include key activities for communication in overall EPI workplan and as part of EPI programme activities  
· Include communication line-item in EPI budget (based on communication component in EPI workplan) |

5.2 Addressing hard-to-reach populations

Delivery, supply, quality and demand issues all influence the use of immunisation services, as noted in the module on Increasing Immunisation Coverage, Annex 3, Table 3: Analysis of causes and solutions for an area with high drop out and poor access. For a variety of reasons, certain groups of people remain unreached by immunisation services, reject them, or drop out of the immunisation programme. Reasons can range from religious and traditional beliefs and practices, to difficult access due to infrastructure and terrain, to economic and/or political situations that have caused populations to migrate, among others. Table 7 identifies some special groups and outlines possible communication strategies to reach them. In all cases, communication planning should begin early; should be sensitive to people’s beliefs, practices and constraints; should utilize interpersonal communication to the extent possible; and should be co-ordinated with delivery of services.
Table 7: Communication strategies for unreached populations

<table>
<thead>
<tr>
<th>Population groups</th>
<th>Proposed communication strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nomadic/migratory groups and families</td>
<td>Determine dates, entry and exit points and locations where large numbers of this population will come together, then plan/implement relevant activities. Utilize members and former members of these communities as mobilizers and vaccinators. Prepare/use mobile teams in border areas, carry out planning and co-ordinated actions with the neighbouring jurisdiction.</td>
</tr>
<tr>
<td>Ethnic or other minority groups (e.g. Pygmies)</td>
<td>Visit the sites with someone from that community. Brief traditional leaders to encourage their support. Put in place a team of local mobilizers/educators to work with these communities.</td>
</tr>
<tr>
<td>Families that fear contact with government (e.g. lack proper documents)</td>
<td>Work with local NGOs that provide assistance to these families and use local mobilizers/educators and community groups/leaders to provide information. Visit the families to explain the initiative, the importance of vaccination, and that the government will not be registering their child or asking for their papers.</td>
</tr>
<tr>
<td>Groups with difficult physical/geographical access</td>
<td>Ensure transport to reach these groups (organised with service delivery). Visit the sites with someone from that community who is familiar with the terrain and culture. Put in place a team of local mobilizers/educators to work with these communities.</td>
</tr>
<tr>
<td>Religious or traditional sects that refuse vaccination</td>
<td>Identify and brief the leader(s) of the sect or religion to encourage their support and discuss their concerns. With the participation of their leader, meet with members to inform/educate them about the initiative and vaccination. Use attractive communication tools (e.g. mobile cinemas, pamphlets in local languages, songs and drama on immunisation, etc.) Plan and implement activities with their community groups/leaders at locations and dates that do not conflict with cultural/religious events.</td>
</tr>
<tr>
<td>Refugees</td>
<td>Visit camps to explain the initiative and the importance of vaccination. Work with local NGOs that provide assistance to these families. Identify leaders among the refugee populations and organizations in the camps, and then try to convince them to advocate for and educate on vaccination.</td>
</tr>
<tr>
<td>Wealthy/elite groups and related staff</td>
<td>Use high-level political and/or society leaders (local Rotary clubs, diplomatic missions, etc.) as advocates — credible, knowledgeable and respected people in that community. Provide educational materials explaining the initiative and outlining the benefits and public health importance of immunisation. Engage private doctors and health officials as advocates, educators and vaccinators. Provide information through mass media and interpersonal communication targeted at these individuals.</td>
</tr>
<tr>
<td>Homeless families or families in dense urban areas; street children</td>
<td>Visit their communities and individual dwellings to explain the initiative and the benefits and importance of vaccination (co-ordinate with service delivery). Use community mobilizers to provide information in the neighbourhood, particularly at common gathering places (markets, water sources, and others). Identify and engage any leaders, organisations and women’s groups that can act as advocates, mobilizers and educators.</td>
</tr>
</tbody>
</table>

**Analysing and addressing resistance and building public confidence in immunisation**

The reasons for resistance require analysis to determine the extent to which the resistance is a refusal of services and the degree to which it is due to service delivery problems or vaccination efforts poorly negotiated or planned with communities. Table 8 can be used as a guide to analyse the issues related to the resistance and some possible actions that
could be taken to address this. Additional information can be found in the UNICEF document, “Building Alliances with Religious Groups, Guidelines for Immunisation Programmes”.

Table 8: Addressing immunisation resistance

<table>
<thead>
<tr>
<th>Source of resistance</th>
<th>Options for addressing resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Does the resistance represent mainstream thinking</strong>? If so, consider OPTIONS 2, 4 and 6.</td>
<td><strong>OPTION 1</strong> – <em>Avoid drawing attention to the source of the resistance</em>. Take action to reduce resistance indirectly by increasing the flow of correct information on immunisation.</td>
</tr>
<tr>
<td><strong>B. Are they outcasts or radical elements</strong>? If so, consider OPTIONS 1, 3 and 5.</td>
<td><strong>OPTION 2</strong> – <em>Develop allies, approach leaders of the same group who are not in the resistance</em>. Avoid giving the impression of driving a wedge between group members. Keep the emphasis on the health and survival of children.</td>
</tr>
</tbody>
</table>

**Underlying issues of resistance**

Is doctrine represented as opposing immunisation? Is opposition used to further a political agenda? If an agenda is broader than objection to immunisation, consider OPTIONS 1, 3 and 5.

**What impact does resistance have on community’s use of immunisation services**? Despite the objections voiced by a religious group, the community’s behaviour may be significantly affected. If so, consider OPTIONS 1 and 5.

**Are people reacting to real or perceived dangers of immunisation**? If due to an actual negative event, consider OPTIONS 3, 5 and 7. If due to perceived or rumoured dangers, consider OPTIONS 5 and 6.

**Distinguish between the active resistance of a group and an underserved population that happens to belong to that group**

Addressing an underserved group will take a different strategy from one where the group is actively resisting immunisation. If an underserved population, consider OPTIONS 2, 3 and 7.

**Coping with rumours**

People with vested interests (for example, traditional healers, medical or general press, politicians/political groups, anti-vaccine groups, religious/cultural objectors, and sometimes health workers) may start rumours about immunisation programmes. The
spread of rumours may reflect inadequate or inaccurate knowledge, a mistrust of government, or ulterior motives such as greed or a desire for publicity. Examples of rumours include: OPV or tetanus vaccines are contraceptives to control population or to limit the size of a certain ethnic group; OPV is contaminated by the AIDS virus or mad cow disease; children are being experimented on with AIDS vaccines during polio and measles campaigns, etc.

- **Responding to rumours**
  
  Analyse the situation. Move quickly to respond to rumours, but first:
  
  - Clarify the extent of the rumour or misinformation (type of messages circulating, source, persons or organizations spreading the rumour)
  - Determine the motivation behind the rumour (e.g. lack of information, questioning of authority, political or religious opposition)
  - Turn the rumour around. Go to the source and ask what the solution is. Acknowledge existing shortcomings if necessary. Offer the source an opportunity to be part of the solution.

- **Advocate**
  
  - Target key opinion leaders for meetings (politicians, traditional and religious leaders, community leaders, and health workers)
  - Launch a corrective campaign at the highest level, e.g. the minister of health, governors, district administrators, etc.
  - Meet with local leaders at sites where the individuals/groups are comfortable and can feel at ease to ask questions and have peers present.

- **Strengthen alliances.** Involve all immunisation partners through social mobilization committees, ICCs, etc. Alert and collaborate with relevant ministries and NGOs.

- **Conduct training.** Train volunteers and health workers to handle rumours. Disseminate tailored information on common misconceptions and guidelines on response. Promote positive key messages.

- **Mobilize communities.** Empower local people to address and take responsibility for the issue. “Demystify” immunisation through education, taking the initiative to the community via such channels as films, street players, schools, community seminars and discussion groups.

- **Recruit assistance from the health community.** Seek collaboration from health professionals in the public and private sectors, including doctors, nurses and vaccinators, NIDs volunteers, other members of partner organisations.

- **Contact media** - persons or groups that have already misinformed the public and provide them and other appropriate media (TV, radio, newspapers, and street theatre) with credible, factual information on the controversy. Call on previously established relationships with the media. Delegate one spokesperson to handle all media questions. Arrange for respected authorities to support the programme publicly; for example, have the First Lady or other respected female leader photographed giving OPV to her baby; interview pop idols or sports celebrities explaining the truth. Use print materials to provide answers to common questions, to correct common misconceptions and to deliver positive messages.
Preventing rumours

- Be “proactive”: budget for and implement ongoing activities to prevent and limit rumours.
- Use local NGOs, religious organisations or community groups that have the respect of these groups/individuals as mobilizers and educators
- Involve community leaders in planning and implementing health activities
- Approach communities early, and make frequent contact
- Present health issues as national social, economic and security issues
- Discuss immunisation campaigns with public and private practitioners in advance to obtain their support
- Make communication and social mobilization a continuous activity. Design strategies that establish continuity between NIDs and routine immunisation. Disseminate consistent messages.

**Case Study 3: Community resistance in Kulwazi**

Divide participants into 4 groups, ask them to read the case study and to answer the questions that follow:

*The ICC in Kulwazi has decided that in order to improve drop-out rates and address lower coverage districts, it will intensify vaccination services and activities in the poorest performing provinces early next year. Immunisation assessments and NID findings from past years revealed that some of these districts have lower coverage due to nomadic groups that have been difficult to reach and sects that have refused immunisation services for religious reasons. In addition, vaccination teams reported resistance to immunisation services during outreach sessions and during SIAs in some areas that have traditionally had lower coverage, but did not provide details.*

Have each group answer one of the following questions:

1) What communication and mobilization strategies could the ICC and immunisation staff use to reach these target groups?
2) What communication approaches could the ICC and immunisation staff use to gain the target audiences’ acceptance of immunisation?
3) What communication activities could the ICC and immunisation staff use to dispel rumours?
4) What are some possible reasons for “resistance” by these communities? What could be some misconceptions by the vaccination teams?

5.3 Communication for disease surveillance

The EPI manager and district EPI staff must ensure that data from all levels are received, analysed, and feedback provided for programme improvements between the national structure and the lower levels. Disease Surveillance Committees, which exist at central level and in some districts, can assist with this and should include an epidemiologist, a statistician and a communication expert. The epidemiologist will ensure the collection
of relevant data while the statistician will carry out an analysis of data so as to facilitate its interpretation by the EPI manager, partners and community members. The communication expert will help the EPI manager present and communicate the data to the community in a user-friendly way.

Communication methods for surveillance include:

- Dissemination of disease prevalence and morbidity and mortality data during community meetings and gatherings
- Dissemination of information through newspapers and other publications
- Radio and television news flashes on disease outbreaks and control measures
- Press conferences on diseases/outbreaks to brief the media people what health authorities are doing
- Publication of bulletins or newsletters
- Training members of communities in surveillance activities, including data collection, analysis and reporting (community surveillance)
- Electronic dissemination (e-mail, Internet) of information
- Dissemination of information on best practices in the country.

The following box includes surveillance topics that should be reflected in a communication strategy to support surveillance activities:

<table>
<thead>
<tr>
<th>Communication for surveillance</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Describe the signs and symptoms to look for, using the lay name of the disease that local people commonly use</td>
</tr>
<tr>
<td>◆ Encourage communities to report similar cases to the nearest health facility</td>
</tr>
<tr>
<td>◆ Highlight the severity of disease outbreaks (e.g. measles epidemics)</td>
</tr>
<tr>
<td>◆ Map the regions affected by outbreaks or emergence of diseases</td>
</tr>
<tr>
<td>◆ Note the number of children affected</td>
</tr>
<tr>
<td>◆ Communicate the period of outbreak of diseases (e.g. there is a high incidence of measles that begins at the end of the rainy season and continues during dry season)</td>
</tr>
<tr>
<td>◆ Mention the contribution by the community</td>
</tr>
<tr>
<td>◆ Outline the progress made or the successes recorded</td>
</tr>
<tr>
<td>◆ Advise the community on how to prevent their children from getting the disease</td>
</tr>
<tr>
<td>◆ Advise families and community on how to manage children with the disease</td>
</tr>
</tbody>
</table>

5.4 Communication for supplemental immunisation activities

This section highlights some issues related to planning communication activities for supplemental immunisation (e.g. polio, measles, MNT). As stated earlier, the EPI manager will need to ensure that a communication focal point works with the EPI team to support the development and integration of communication in SIAs plans at all levels.
Planning

- Planning should begin at least six months before the SIA
- Communication activities should be integrated in the SIA plans at all levels
- Plans should be based on an analysis of coverage data from previous rounds, including missed children
- Communication strategies should be developed for border and conflict areas
- Plans should be developed to address potential rumours and/or non-compliance
- Strategies should be in place for reaching under-served populations
- Planning should include activities for before, during and after SIAs.

Strategies

The communication strategy (messages and social mobilization) will need to be adapted, tested, and implemented to suit the type of SIA being conducted, taking into account the following:

- The disease being controlled or eradicated
- The age group being targeted for the SIA
- The SIA strategy being used – fixed, outreach, mobile, or house to house
- The region(s) being targeted and potential political, cultural, and/or religious differences.

Training

- Communication aspects need to be integrated into the training and monitoring of mobilizers, vaccinators and supervisors
- Training in interpersonal communication for vaccinators should be emphasized, particularly for house-to-house vaccination but also to ensure communication on the importance of routine immunisation
- Health workers, vaccinators and mobilizers need to know key messages for the different groups, which should be addressed in training and supervision.

Monitoring and Evaluation

The following are key elements that the EPI manager should ensure are included in the plans and monitored during the SIA:

- Advocacy with political and traditional leaders for the SIAs and to support routine immunisation
- Resource mobilization to support immunisation and SIA activities
- Intersectoral collaboration and social mobilization at the various levels
- Communication activities conducted before, during and after SIAs
- Vaccinator’s communication with caregivers.
5.5 Communication for immunisation safety

The safety of vaccines requires both sufficient and appropriate tools (supplies and equipment) and management and supervision systems that support the correct use of those tools. Regardless of good systems, however, negative reactions to the vaccines or adverse events can occur due to chance or through improper injection technique or poor handling or conservation of the vaccine. Adverse events that occur within a few days of the immunisation session can clearly be interpreted as a result of the vaccination. Consequently, it is important to prevent, control, report and carefully examine the causes and effects of adverse events following immunisation (AEFI) in order to take appropriate measures.

Messages relating to adverse events must be disseminated rapidly to prevent rumours and other wrong interpretations. AEFI can have repercussions on the entire routine immunisation programme and campaigns. Where medical interventions are necessary, they should be carried out as rapidly as possible.

Once an AEFI has occurred, the investigation should include the following communication elements:

- Communicate immediately with the Ministry of Health, the ICC and other high officials
- Provide the parents with factual information. (Remember that some parents may seek information elsewhere and you may lose credibility if you do not provide a trustworthy and technically sound response. The public and the other stakeholders have a right to know exactly what happened.)
- Reassure parents, caregivers and adults that necessary measures are being taken so that the members of the community and caregivers are informed of what is happening
- Communicate the results of the investigation to the programme managers and to the EPI officers at all levels
- If AEFI was caused by programme error, tell the public what steps are being taken to prevent similar events in the future
- Broadcast an official statement about the event on radio and television and publish a statement in newspapers
- Repeat the message to dispel all fears
- Constantly reassure the public of the safety of vaccines.

Injection safety measures to prevent the spread of hepatitis, HIV/AIDS and other viruses via contaminated needles and syringes are also critical. While injections to vaccinate represent less than 10% of all injections and generally are the safest ones, prevention of disease spread through proper handling of syringes and needles during and after vaccination sessions is critical.
5.6 Communication for introduction of new vaccines and auto-disable syringes

Introduction of new vaccines and technologies into established immunisation services is particularly important given the substantial support available for new vaccines and auto-disable (A-D) syringes through the Global Alliance for Vaccines and Immunisation (GAVI) and The Vaccine Fund. As with routine immunisation and campaigns, a communication component must be included in the process of introducing new vaccines as well as the use of auto-disable syringes.

**Improve overall immunisation services**

The introduction of new vaccines and technologies can provide an opportunity to improve overall services and re-motivate health staff and to build public demand for routine immunisation. It is always important for programmes to analyse causes of low coverage (if possible on the basis of research findings) and to address the major causes. This is especially crucial to prevent negative experiences with service delivery from damaging the reputation of new vaccines and technologies.

The addition of new vaccines and A-D syringes means that a country’s immunisation service is “improved”, since users can now be protected against more diseases (directly through immunisation and indirectly through safer injection). This idea needs to be promoted among the public and the health staff.

**Communication strategies for new vaccines and technologies**

- **New vaccines**
  
  The communication strategy should be appropriate to the characteristics of the new vaccines or technologies. If the new vaccines require no additional immunisation visits and/or no new injections (as in the case of quadrivalent or pentavalent vaccine formulations), parents and caregivers need to take no new action. In this case, the appropriate basic message for the public is that the immunisation service is now improved because it offers protection against more diseases. In many cases, this means children receive more protection (or a bonus) with no more effort (no more visits and/or injections). In addition, the new antigens are highly effective and have virtually no side effects.

  The introduction of new vaccines, however, does imply that health workers must perform new tasks. Therefore, *health workers should be the focus of much of the communication and training related to new vaccine introduction.*

  The precise type and timing of protection of the two most common new vaccines, hepatitis B and Hib, are somewhat difficult to explain to the public. In the case of hepatitis B, the effects will not be seen for a generation, since the virus is mostly manifested in liver disease in adults. In the case of Hib, the vaccine protects against *some* (but not all) pneumonia and meningitis. Given these complicated scenarios, it is probably best to describe the vaccines’ benefits only in general terms and avoid going into details that could lead to confusion. Health workers do need to understand the details regarding the new vaccines and corresponding diseases, so that they will be convinced of the new vaccines’ importance and can respond knowledgeably to questions from the public.
A-D syringes

How much and what to say about the introduction of A-D syringes depends on the level of public knowledge and concern about injection safety. In countries where injection safety is already a public issue, it is probably best to indicate how A-D syringes make safe immunisations even safer. In countries where there is low awareness of the dangers of non-sterile injections, it may be best initially to direct communication messages on this subject only to health workers to avoid creating misinterpretation among public.

Public knowledge and debate on injection safety is a two-edged sword. On the one hand, public demand for assured safety can encourage better health system and health worker performance. On the other hand, excessive concern could cause some parents to opt out of bringing their children for critical vaccinations. Where there are time and resources, it could be beneficial to carry out some small-scale but in-depth research on health workers’ and caregivers’ knowledge, attitudes, and perceptions, and to use the findings to formulate the best approach for the country’s particular situation.

Time for planning

Ideally, planning should begin at least six months in advance of the introduction of new vaccines and A-D syringes. The programme may require the following: re-design of the immunisation schedule, child health/immunisation cards and recording forms; plan the logistics of vaccine and syringe distribution, storage, and re-supply; train health workers in new technical skills and in how to respond to the public’s questions; prepare technical and training materials for health workers; establish systems to monitor health worker performance in various areas, including proper use and disposal of A-D syringes; and plan for the “launch” of the improved programme as well as for its ongoing promotion. Separate subcommittees may be needed to plan training, logistics, and communication/mobilization (launch events and ongoing promotion of the immunisation service).

Communication channels

Maximum effort should be made to receive free broadcast and press coverage of the improved immunisation service. This involves preparing press releases and briefing material and holding news conferences at the national and sub-national levels. If affordable, TV and radio can be used to reach health workers and populations.

The basic strategy for reaching rural populations is to orient local political, social, educational and religious leaders and organisations. Print materials are appropriate for health workers, but many developing country programmes should carefully consider whether they should prepare print materials addressed to the public, given the cost and the public’s ability to understand them. Remember that the most important source of information for parents is likely to be local health workers, so be certain that health workers understand the basic messages and are capable of responding to questions and concerns.
Case Study 4: Introducing new vaccines in Kulwazi

Ask participants to read the following example and proceed to Exercise 5. (Refer also to previous case studies for more information.)

The Republic of Kulwazi has received word from GAVI that its application has been approved to introduce quadrivalent DPT/Hep B vaccine next year. Although national coverage with DPT3 has increased and is reported at 80%, several districts still have access problems and approximately 40% of districts have drop-out rates higher than 15%. The country has also recently instituted case-based measles surveillance and is beginning to improve its follow-up investigation on AEFI reports related to measles vaccination. The surveillance system has improved, but a community surveillance component has not been developed, particularly in lower coverage districts. As part of SIAs and routine immunisations, Kulwazi is introducing A-D syringes. Acceptance of the new syringes has been good, but a popular local radio announcer in one of the districts has recently been broadcasting messages about vaccinations being associated with the spread of HIV/AIDS.

Exercise 5

Form three working groups and assign one of the following questions to each group to discuss and present the results to the plenary.

1) Based on the information above and previous case studies, what are some challenges for the EPI programme as regards proposed introduction of new vaccine?
2) How could communities be further engaged in surveillance activities?
3) What communication strategies are needed to address injection safety issues?
References

- Community Involvement (WHO/EPI, 1987).
- Identifying and Overcoming Obstacles to Increased Immunisation Coverage (EPI/WHO Geneva, 1997).
- Progress Report: Reaching Every District: Building national capacity to reach every district with immunisation services within the context of health sector priorities. GAVI, Draft, 30 October 2002.

Website
http://www.who.int/vaccines-diseases/epitraining
Annexes

Annex 1: Knowledge and skills to be acquired from immunisation communication training

At the end of this module, participants should have acquired specific knowledge, attitudes, and skills in communication. These are summarized in the following table.

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ways in which communication activities in programme communication, advocacy, and social mobilization can support immunisation objectives by informing, motivating, teaching, etc. The importance of communication experts participating early and fully in EPI planning, including ICC actions</td>
<td>Learn how to facilitate these contributions by lobbying and assigning sufficient human and material resources for communication planning, implementation, monitoring, and evaluation</td>
</tr>
<tr>
<td>Communication process is a science just like epidemiology, with its own proven tools and methods.</td>
<td>Learn the basic, logical sequence of steps in designing, implementing, monitoring, and evaluating effective communication activities</td>
</tr>
<tr>
<td>Communication activities are much more effective when they are information (research) based. Health staff or others should not plan communication activities simply on the basis of their personal knowledge and experience. There must be mechanisms to get participant groups’ input. Media, materials, and messages are much more appropriate and effective when based on audience information and opinions, not on the basis of what’s easiest and most convenient for decision-makers at the central level.</td>
<td>Ability to evaluate and ask appropriate questions regarding reviews of existing information, research plans, research findings, and translations of findings into strategies, activities, media, materials, and messages</td>
</tr>
<tr>
<td>Simply providing information to people rarely changes their behaviour. Usually a multi-component strategy that includes communication (and other) activities is needed.</td>
<td>Ability to use strategy formulation grids; an understanding of how to transform strategy into work plans</td>
</tr>
<tr>
<td>Use a mix of media (and don’t overuse mass media because it is easier). Engage community leaders, volunteers and organizations not just in campaigns but also in supporting routine immunisation. For this to happen, people need to know how the immunisation programme is doing (they need feedback).</td>
<td>Appropriate use of media. Ability to understand the basic concepts of developing a media plan</td>
</tr>
<tr>
<td>Never use materials and messages without testing. If they are materials to support interpersonal communication, they should be tested with users and intended audiences.</td>
<td>Ability to describe various approaches to pretesting and issues in interpreting and deciding how to use findings</td>
</tr>
<tr>
<td>There should be a national communication strategy, key messages, and materials, but the national level should also take steps so that provinces and districts have the skills and resources to develop local materials and activities.</td>
<td>Ability to describe several strategies for encouraging and supporting local communications to support the umbrella national programme</td>
</tr>
<tr>
<td>To improve coverage, programme communication activities often need to focus more on health workers than on caregivers; if immunisation services are reliable, convenient, friendly, and competent, people will use them; the health system must support local health workers if this is to happen.</td>
<td>Ability to describe the importance of IPC training as well as other activities that support better IPC (supervision, etc.) Apply IPC both to health workers and members of the community</td>
</tr>
<tr>
<td>Understand the difference between “essential” knowledge, “useful” knowledge, and “important” knowledge for caregivers.</td>
<td>Be able to tell when communication activities focus first on essential knowledge, then useful and important knowledge</td>
</tr>
</tbody>
</table>