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Maternal and Child Survival Program

Word of Mouth: Learning from Polio Communication and Community Engagement Initiatives

Insights and Ideas to Accelerate Action on Other Development Issues

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MCSP is a global USAID initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

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Acknowledgments

This paper is the outcome of a polio partners meeting focusing on communication and community engagement within the polio program held on February 1–2, 2018 with representatives from these organizations:

United States Agency for International Development (USAID)
Maternal and Child Survival Program (MCSP)
CORE Group Polio Project
The Communication Initiative
John Snow, Inc.
UN Foundation

Background

Challenges and Successes

Whether the benchmark is the Sustainable Development Goals, a national development plan, or an organizational mission, making progress on difficult development issues—such as education, health, poverty, gender, citizen engagement, the environment, HIV/AIDS, economic development, participative governance, infrastructure, and so much more—is anything but easy. These are steep hills to climb, not gentle inclines to stroll.

Key Themes/Factors in the Success of Communication and Community Engagement

- Social mobilization
- Norms and culture
- Community-based surveillance
- Use of data
- Operational oversight

This reality underscores the importance of learning from experiences addressing issues on which there has been demonstrable progress. One such issue is polio eradication. In 1988, there were 365,000 cases[1] of the wild poliovirus in 2017, there were 22.[2] The journey toward polio eradication offers 30 years of accumulated learning. As with many other development challenges, progress was rapid in a number of countries but took longer in others, where environments were extremely complex and challenging. Some of the toughest and most important lessons learned from the polio program have come from these difficult contexts.

Success in these contexts required effective communication and community engagement strategies. Unless the polio program had a really solid communication and community engagement strategy as a central element of its work, it could not have effectively engaged families, accessed communities, overcome both valid and invalid perceptions and understandings, addressed relevant social norms, supported local leadership, and brokered important relationships. This strategy took time to develop. It was, in many ways, a rough journey—one that remains incomplete. The journey's struggles, however, only deepen the relevance and the value of the learning accumulated to date.

This document seeks to share insights and ideas gleaned from the polio program's success that might inform accelerate action on other development issues.

Sharing the Learning

The learning outlined below is not presented as a directive on how to program communication and community engagement, based on what polio has learned in its journey. Rather this knowledge is shared in the spirit of supportive strategic insights and information—to be accessed and considered at the discretion of people engaged across the full range of development issues and concerns. The hope is that the reader will discover and take away what is relevant and useful in his or her own work.

This learning is derived from the work and analysis of a group of partners guided and supported financially by the United States Agency on International Development (USAID) to focus on communication and community engagement within the polio program. These partners include the: CORE Group Polio Project (CGPP); Maternal Child and Survival Program (MCSP); John Snow, Inc. (JSI); The Communication Initiative; and USAID.

In an effort to structure and organize their combined 100-plus years of actions aimed at eradicating polio, these organizations agreed on five major learning themes: social mobilization, norms and culture, community-based surveillance, use of data, and operational oversight. These themes were chosen because they evolved over time to become important aspects of their work in the most difficult situations.

In discussing the strategies used to make progress in these contexts, key questions posed by the partners included the following:

- How do we positively engage communities?
- What elements of the local culture and prevalent social norms are getting in the way, and how can we address them?
- How can we sharpen communication and community engagement with relevant data as a major contribution to strategic decisions?
- How can we ensure that this is not all a cozy and self-fulfilling process—that there is rigorous outside and inside oversight that helps to drive even better strategies and programs?

Although these questions emerged through partners' discussion of the polio program specifically, there was a sense that they are relevant across many development issues. They are also at the heart of each of the themes presented in this document.

Shared Challenges and Issues

Actions involved in polio communication and community engagement focus on and respond to priority issues and challenges that the polio program has encountered at global, country, and local levels. These issues and challenges, which are common to many development areas, include:

- **Reaching everyone** (this means reaching every child in the case of polio);
- **Tracking the key indicators** (for polio, this includes knowing exactly how many under-5 children are in each household);
- **Accessing real-time data** (for polio, this includes parental responses in the polio context);
- **Supporting and building local leadership** (in the polio context, local/neighborhood leaders were very important);
- **Strengthening the "ownership" and accountability** of governments, implementing partners, and the people working on the development issue in question; and
- **Timely detection of and response to** new information and developments (for example, polio partners have had to respond to a number of outbreaks).

These and other challenges—such as, reducing fragmentation of efforts, increasing synergy across a strategy, and improving coordination—are central to the learning that follows.

Key Challenges

Those engaged in polio communication and community engagement have had to respond to some harsh conditions and challenges. In India, for example, there was a history of forced sterilization, while polio-specific immunization was boycotted in northern Nigeria in 2003. In Pakistan, over 100 polio workers and security guards were targeted and killed.[3] Access to regions controlled by anti-government groups such as the Taliban, ISIS/DAISH, and Boko Haram had to be negotiated. In cases such as these, a way has to be found to engage in an atmosphere of lingering distrust and conflict. But from these experiences comes new knowledge and understanding. If the best steel comes from the hottest heat, then the following communication and community engagement learning themes have been strongly forged.[4–7]

Funding

Some associate the strength of polio programming with the funding and political commitment levels that polio eradication has attracted, secured, and sustained. Polio efforts have been extremely well-resourced compared with almost every other development issue or program, despite missing many eradication deadlines.

The reasons for this support and funding are subject to discussion, which often points to a variety of possible contributing factors, such as the following:

- The inherent appeal of eradication and the success of smallpox eradication, which led to a single-health-issue focus and momentum;
- The clarity of the polio eradication strategy, its partnership base, and its demonstrated progress over time based on clear data points;
- A "too late to change our minds now—too much to lose as we are so close" pitch and mentality;
- Engagement by Rotary International, a major civil society organization, with deep roots in the relevant funding and programming countries;
- Political engagement of governments, both those experiencing polio and those supporting polio action;
- The involvement of the Gates Foundation; and
- The resourcefulness of the global polio leadership in Geneva, New York, and Washington.

Despite the major investments in the Global Polio Eradication Initiative (GPEI), only a small portion of those resources initially went toward communication and community engagement efforts. However, this investment grew over time, beginning as the polio program responded to resistance issues emerging in 2000–2003.[8]

The reasons behind the high overall level of financial and staff resourcing for polio eradication, and the often-critical analysis and response of other development communities to this high-level resourcing, are important. We, the USAID partners, have considered such cost issues and implications when outlining herein the lessons learned during our journey, as well as their potential applicability to other development initiatives. We also recognize that the opportunity for polio eradication to strengthen routine immunization has not been fully realized; however, the focus of this paper is not on missed opportunities, but rather on positive lessons that could be useful to other development initiatives. (Please note that the investment case for polio is discussed elsewhere.)[9]

The five major thematic areas of learning identified by the USAID-supported polio communication and community engagement partners, as further discussed below.

Social Mobilization

The process of people connecting and organizing in formal and informal networks at local, national, and global levels is the basis for social mobilization, a powerful driver of positive development. The Social Mobilisation Network (SMNet) in India, co-developed by the CORE Group and UNICEF, was hugely important in the successful action to eradicate polio in northern India. It also inspired similar networks in Afghanistan, Nigeria, and Pakistan.

The following data from research in Nigeria demonstrate that social mobilization is important, even when there is only a general connection to the issue in question—in this case, polio.

> *"We found considerably lower levels of propensity to refuse polio vaccination in communities where women participated more actively in public meetings. We do not know whether the effect is direct or indirect. But it points to the value of women's empowerment and civic engagement as potentially powerful measures to support community engagement in public health activities. We found a similar and significant association between propensity to refuse OPV [oral polio vaccine] and male participation in public/communal meetings."*[10]

Polio-specific social mobilization strategies have paid particular attention to organizing at local levels, mapping, and cultivating a multi-pronged approach.

Emphasizing Local Engagement

Polio communication and community engagement strategies made significant efforts to facilitate dialogue with, and positive engagement of, community groups, traditional processes such as *shuras*, women's groups, local leaders, religious leaders, and key academic and other local institutions to ensure that local perspectives and knowledge are prominent in decision-making. Involving local people in local neighborhoods in program efforts ensures a connection to the local decision-making and communication processes that are vital for effective action.

Mapping for Mobilization

The process of mapping facilitates and accelerates social mobilization. Work took place with local people to draw block-by-block maps in India that included: the number of children in houses; streets and houses that had been covered by vaccination campaigns; and identification of resistant houses, places of worship, health centers, schools, other public spaces, and community leaders, among many other elements. The maps provide a tangible focal point for engaging people, not just in building the map but also in asking the important "why" questions for local analysis. For example: "Why does this block have low vaccination rates?" "Why does the local map show many more children than the formal plan?" and "Why are there so few community meetings in that district?" The answers to these and other "why" questions made a significant contribution to improving program performance.

Developing a map also provides the basis for engaging different parts of a community, all of which can contribute something—for example, mothers can be a great source of local the insights and knowledge.

Maps were also used with line lists of newborns needing to initiate vaccination, community members/households refusing oral polio vaccine (OPV), and community members absent when revisited. These line lists helped to focus efforts to resolve such issues. As just one example, in Nepal, the CORE Group's geographic information system (GIS) was used to map the Terai before satellite image mapping was available. Each time a house was passed, a team member on a bike would send the coordinates to another person with a computer, who was following in a car.

This local mapping activity was complemented by a more general use of mapping in support of social mobilization. Supervisors had to produce a daily map that drew together patterns across multiple residential blocks or communities. Later, satellite imaging helped identify settlements that had been omitted from previous plans. Particular attention was paid to those areas that straddled district/provincial borders to ensure accuracy.

Multi-Pronged Strategies

Polio communication and community engagement infused social mobilization, from all angles, during vaccination rounds. There was a planned process to ensure that the conversations undertaken, knowledge shared, and leadership roles supported were in the full range of communication opportunities and included the voices of all social groups.

The polio program sought to identify and engage with local community groups (e.g., in community and mothers' meetings), as well as at places of worship, within households, as part of political gatherings, through radio and TV (where appropriate), as an integral part of health centers, within cultural gatherings, in markets, on public transport, in barbershops, and within interpersonal conversations, wherever they take place. When consistently branded and produced with fewer words and more pictures, communication materials, job aids, social media, shared MP3 clips, mass media such as radio programs, public service announcements, and other media prompted and supported family and community conversations, learning, and decision-making.

The same principle applies to the people who are engaged in these efforts—mothers and fathers, cultural leaders, religious leaders, teachers, friends, neighbors, health workers, celebrities, athletes, journalists and other media, and politicians.[11] Engaging youth through puppet shows, jugglers, and other forms of entertainment-education helped to make the polio program more inviting, especially when the risk for "fatigue" arose after so many rounds of vaccination.

The process of mobilizing the community is not a straight line. The CORE Group, for example, sometimes returned to the same home 20 to 30 times to answer questions before permission was granted to vaccinate the children with the polio vaccine. In the context of these and other pressures and expectations, interpersonal and negotiation skills are critical for mobilizers and frontline workers.

Polio communication and community engagement strategies—with their prominent focus on local mapping and a 360-degree approach—provided crucial learning for effective development action.

Norms and Culture

One of the most challenging and important areas of focus for any communication and community engagement strategy, on any development issue, is how to demonstrate respect for local culture while working to change predominant social norms that work against public health or other goals. Challenges to a strategic communication and community engagement emerge when, for example, female vaccinators are required in a given culture, but women are not allowed to leave their own homes nor to approach other households; or when newborn vaccination is a priority, but newborn children are not to be seen by anyone outside the family for a specified period after birth. There are many other complicating factors as well. In some settings, for example, the voices of young parents might not be welcome in public forums, or the public status and prestige of doctors predominate, regardless of the quality of their knowledge or opinions.

Polio communication and community engagement have had to face these and other social-norm-related issues, many of them accentuated and amplified because they are embedded in extremely challenging social, economic, and political contexts—particularly for people coming from outside that context. Several examples of the polio program's work around such issues, along with learning insights, are presented below.

Considering Gender

Public health initiatives must address gender dynamics, but doing so is sometimes tricky. In Quetta, Pakistan, for example, to ensure household access, it was strategically important to significantly increase the number of female vaccinators. The main strategy was to establish a gender balance in the composition of vaccination teams, which created the social space for women to participate in ways that were acceptable to the community and expanded household access.

Recognizing Communication Patterns

As we have all learned from experience, there is no point trying to have a serious discussion at 6 A.M. with someone who is not a morning person. For effective development action, it is necessary to recognize embedded communication patterns. Therefore, polio communication and community engagement efforts sought to recognize and work around such patterns. Results of polio and routine immunization social media research from Ukraine[12], which has some of the lowest routine immunization rates in the world, show patterns observed from mothers when conversing about routine immunization:

- In the **morning**, the focus on social media channels is on specific checks about immunization practices. For example, "Is it OK to immunize if my child has a nose cold or high temperature?"
- In the **afternoon**, the main emphasis is on checking with other parents and the medical centers about practical issues, such as vaccine availability, and/or sharing their experiences of having their children vaccinated that morning. Some examples include reporting that their child "Cried a lot" or had a "Red blot on the skin," followed by asking, "Is that normal?"
- In the **evening**, the conversation turned to more reflective discussions on the desirability and safety of vaccination.

These patterns of communication observed on social media, among a key population group associated with immunization (young mothers), provide insights on audiences and their interests at different times that can be effectively tuned for use toward improving immunization practices.

Building Trust

There may be no more frequently used word in the development arena than "trust." Working hard to gain the trust of families, communities, and local leadership was a central part of the polio program's communication and community engagement effort.

Polio-funded research in Nigeria provided a more nuanced view of the ways in which trust works and grows. A clear correlation was found between the social norm "trust in government" (local, state, and federal) and vaccination decisions—but not in the ways expected.

> *"We expected to find that propensity to refuse OPV would be associated with lower levels of 'trust in government'. At both household and settlement level we found the reverse to be the case. Very high-risk [VHR] settlements reported systematically greater trust in government (insofar as they nominated government as most effective provider across all exemplar public services). But we also found that, compared with VLR [very low-risk] settlements, VHR communities manifested systematically lower levels of self-efficacy in terms of faith in government attentiveness or confidence in their ability to affect improvement in circumstances."*[13]

This social norm highlights the rational processes behind vaccination decisions. Not understanding the underlying thinking—and, perhaps even worse, working on the assumption that polio vaccination decisions are predominantly emotional—most likely hampered the polio strategy.

Safety

For any parent, the prospect of having a foreign object (a needle with vaccine) introduced into his or her child's body can be scary. It was therefore important to establish the norm that this procedure is very safe. Within the polio strategy, community mobilizers established trust with communities and modeled positive behaviors by having their own children publicly immunized. Seeing mobilizers vaccinating their children gave confidence to other mothers that the practice was safe and effective. The same principle applies when presidents, prime ministers, sultans, and other significant people are shown giving drops (i.e., OPV) to their own children and grandchildren.

The Role of Faith

The polio program placed great weight on engaging religious leaders and linking the necessity of immunization to religious text. This may have been important for creating the space for polio action to take place. But as the following research from Nigeria shows, the polio communication and community engagement strategy, though significant, may have overestimated the extent to which religious social norms influence vaccination decisions:

> *"The role of religion (both in terms of individual household religious and ethnic identity, and as composite index of households' 'intensity of religious observation') did not appear strongly to influence propensity to refuse OPV. At household level, the 'intensity of religious observation' index was not associated with risk of noncompliance... In fact, a higher reported preference for 'religious leader' as source of information on religious matters was associated with lower risk of OPV refusal among rural settlements (OR [odds ratio] 0.4, p = 0.000, CI [confidence interval] 0.26-0.6). Urban Sokoto – with the highest household risk for OPV refusal – recorded the lowest mean value for the 'intensity of religious observation' index."*[14]

In effect, this study found that religious leaders have influence on religious matters, but they may have very little influence on health decisions.

Leveraging Natural Spaces

Similar to many other development issues, the polio communication and community engagement strategies attempted to create the space for families and communities to be informed about the benefits and safety of the polio vaccine. There were some successes. However, the complexity and difficulty of the contexts within which the polio program needed to operate, along with the widespread adoption of mobile technology and

use of social media, has provided an opportunity to capitalize on the natural social spaces where people connect in their everyday lives.

Research on polio and routine immunization from Ukraine demonstrates this potential:

> *"[There was] discussion on those (immunization) themes amongst 2,427,431 [online] accounts in parent and city groups … Compared to 4,375 accounts in the polio- and child-health-specific online groups set up by the Ministry of Health and the leading international agencies in Ukraine such as UNICEF and WHO."*[15]

These numbers represent a ratio of 544 to 1 in favor of the natural spaces—that is, the parent and city groups. No competition.

Then there are the actual physical places where people gather. Engaging men with social mobilization and vaccination messages in places where they naturally gather, congregate, and are comfortable is very important. This effort involved working with men who are respected or listened to in the community—for polio communication and engagement, this included barbers in India and clerics and other religious men related to *iftar* (the evening meal when Muslims end their daily Ramadan fast at sunset) in Nigeria.

Based on the polio experience, we have seen that intimate knowledge of the community, its norms, and the underpinnings of those norms is essential to devising strategies that work. No one-size-fits-all approach can address the challenges inherent to development work; instead, solutions must be driven by community needs and norms.

Community-Based Surveillance

Surveillance of disease incidence and trends is normally the exclusive domain of professionals trained to monitor, gather, analyze, and report relevant data. Contrary to the professionalization of this role, the polio program sought the significant engagement of communities in the surveillance process. As a result, many countries are now using community-based surveillance, including South Sudan, Ethiopia, Nigeria, Somalia, and Kenya. These countries have established networks of key informants, including pediatricians, "informal" doctors, and shrine keepers, among others, to do weekly "zero case" reporting.

Time and Access

Community-based surveillance reduces the time from onset of disease to reporting and investigation. It can also access areas where traditional development actors, such as the government or United Nations, cannot easily go. Thus, the usefulness of this approach comes in moving beyond the reach health facilities with information that fills gaps and reduces the number of "silent areas." This reach is essential in countries with security issues, nomadic populations, limited health system capacity, and other difficult situations within which to collect relevant data.

Technologies used at the community level—such as Auto-Visual AFP Detection and Reporting (AVADAR),[16] geo-tagging,[17] rumor monitoring, and hotlines—have the ability to support local people in improving the accuracy and timeliness of data reporting. The introduction of mobile technology for community-based surveillance has allowed for quicker identification, stool sample collection, and transportation, particularly in hard-to-reach areas. Although facility-based surveillance is quicker and more thorough, community-level activities complement these and are especially important among populations that are difficult to reach and have trouble traveling to facilities.

Trust and Means

At the heart of community-based surveillance is trusting communities to engage in the process and giving them the means, empowerment, and space to support their own representation at all levels. Because people within a community understand the nuances of their own community's dynamics, they can go beyond the reach of people and organizations that are external. As such, key community informants can and do identify suspected cases of polio and other vaccine-preventable diseases. For example, in South Sudan from October 2016 to September 2017, 90.7% of validated acute flaccid paralysis cases in the CORE Group Polio Project areas were reported through community-based surveillance.[18] Well-trained and supported informants do not need to have a high level of formal education to do their job well.

Sustainability

For sustainability, community members need to be able to report cases on a regular basis, and the health system must provide an acceptable response to these cases. Furthermore, the community-based surveillance process should be fully incorporated into the overall surveillance strategy. In Ethiopia, volunteers identified and reported cases. But once those cases reached the surveillance officer, they were tracked poorly (not entered into the basic case tracking system). Cases identified through community-based surveillance require full documentation and embedding in the tracking system. The data that emerge should become part of the formal reporting process.

In the context of polio and potentially other development priorities and issues, community surveillance has been a significant communication and community engagement strategy. It is empowering for people to be directly engaged in collecting, sharing, and analyzing data related to them, their families, and their communities. These activities affirm and recognize the program's partnership with communities. And, of course, there is significant added value of communities being able to access data that are beyond the reach of the program staff.

Data-Driven Strategy

Numerical data can be an uneasy bedfellow for social processes such as communication and community engagement. Yet such data have been essential for effective communication and community engagement action as part of the overall polio eradication strategy.

Core, Common Indicators

In 2011, a 12-month plan was implemented to agree on an indicator set for polio communication and community engagement. The main polio communication and community engagement partners debated and agreed on a limited set of core indicators[19] that were applicable to all contexts and directly related to the problems being addressed, such as missed children. Impact, outcome, process, and input indicators were also established. These overarching indicators[20] allowed for and supported comparisons over time, among different parts of a country and among countries, and have been very important and helpful in external, independent reviews (as outlined in Operational Oversight, below).

Real-Time Use

Almost daily, indicators and data related to those indicators are used in real-time[21] for micro- and macro-decision-making about program actions. It is crucial that data collected in relation to the indicators are shared with frontline workers and key community members for their review, use, comment, critique, and feedback to national and district decision-makers—including those with budgetary responsibilities. The core communication indicators have been adapted and incorporated into the program coordination mechanism.

Nontraditional Approaches

Social, communication, and community-engagement strategies, actions, and impact can be difficult to capture. To do so may require the use of non-traditional communication indicators for communication purposes. Lot Quality Assurance Sampling (LQAS) is a random sampling methodology that is increasingly used for rapid data insights. LQAS was adopted across the program for localized surveys on perception and decision-making to get at the coverage realities that knowledge, attitude, and practice (KAP) surveys captured poorly. Today in Pakistan, Nigeria, and Afghanistan, every polio campaign is followed by LQAS surveys and fingermark surveys to assess campaign coverage at the local level. Data collected through these surveys should not only relate to the specific issue in question—in this case, polio—but should also support a clear understanding of relevant, overall demographic status and social trends. These detailed data can then be applied to strategy and program decisions.

Missed Children

The issue of missed children* had a significant effect on polio eradication and provides a clear example of these data-related principles in action. In the polio-endemic countries and outbreak responses, it became increasingly clear that the polio program needed to identify and track individual children. Such close monitoring can yield actionable information, such as these data from communication research:

* Definition: Chronically Missed Children (CMC): A district or equivalent area where ≥10% children have been missed during the last three consecutive polio Supplementary Immunization Activities (SIAs); OR A cluster of children (≥50 children <5 years) who are being missed from polio vaccination in at least three consecutive polio SIAs due to any reason (roughly estimated, 50 children will be living among at least 300-500 population or an area for a vaccination team for a day.); OR a district or equivalent area reported an acute flaccid paralysis (AFP) case with zero-dose of polio vaccine (RI+SIA, OPV+IPV, or combination but excluding birth dose); OR a district or equivalent area having routine OPV3/3rd dose of polio containing vaccine (OPV or IPV or combination) coverage below 80% for two consecutive years (JRF). From: Standard Operating Procedures (SOPs): Identifying and Vaccinating Chronically Missed Children - Global Polio Eradication Initiative, 2015.

> *"Across the sample, having missed children in past SIAs [supplementary immunization activities] was strongly correlated with propensity to refuse OPV vaccination in the future (urban: OR 4.63, p = 0.000, CI, 2.52–8.47; semi-urban: OR 3.1, p = 0.009, CI 1.32–7.26; rural: OR4.65, p = 0.000, CI 3.06–7.19)."*[22]

Real-time monitoring of missed children, the reasons for missed children, and the reasons for absence and refusals, along with tracking of conversion of refusals are vitally important. To develop effective communication strategies, polio staff need to know: who these children are, where they are, and what specific qualities they may share. For example, many may belong to mobile families, such as those of kiln workers in India; or they may live in the same area, such as the 107 residential blocks in northern India.[23] A data-driven strategy can assist in identifying and tracking individual children, reducing the number of missed children.

Program Incorporation

Rapid linking of the data with the strategy to improve performance is essential in the polio environment. Communication-relevant data such as tally sheets, finger-marking, and monitoring data are processed quickly and fed back to the program during the campaign for daily adjustments to the communication and engagement strategy. Such data also support quality assessment and micro-adjustments at very local levels, including the:

- Themes of evening meetings during campaigns;
- Nature of the micro-planning sessions, training content, and communication themes with influencers; and
- Ways in which political/government leaders are engaged.

Such effective collection and rapid use of key data for decision-making evolved over several years in response to the need for better targeting and understanding of local populations.

Data collected on a set of agreed-upon, core communication indicators, in real time and through methodologies that focus on at least one or two essential issues in the polio context (e.g., missed children), were all incorporated into day-to-day, strategic decision-making. This activity accelerated the vaccination of more children.

Operational Oversight

No matter the job being undertaken across any development issue and in any situation, if one gets too close to the trees, it is difficult to see the entire forest. Seeing and understanding the forest is crucial for effective and sustainable long-term development progress. The folks working day-to-day on the ground are invaluable. And their value can be enhanced through regular, consistent review by informed and knowledgeable people who are not consumed by that day-to-day work (i.e., those who can still see the forest).

Oversight Infrastructure

Over time, to ensure operational oversight, the global polio program built an oversight infrastructure that was crucial for improving program effectiveness. At the global and country levels, this infrastructure includes the Independent Monitoring Board (IMB), country Technical Advisory Groups (TAGs), a series of external country reviews, and, in some countries, Emergency Operation Centers (EOCs). Through the use of data dashboards, this infrastructure brings together government and all polio partner staff in a single work team that develops and shares a single strategy, plans and monitors together, and tracks data through sophisticated collection and analysis tools. On the ground, there are day-to-day data reviews, evening meetings, post-campaign monitoring, and review of the LQAS data. While all of this activity provides insight and guidance from the general direction offered by groups like the IMB (global) and TAGs (national and sub-national), as well as local program monitoring and assessment, deeper external assessment is often missing from key elements of the program oversight processes.

Oversight Experience

Oversight of elements of the polio program's communication and community engagement at the country level attempted to follow the model described above. Although making a significant contribution, this process was a little more ad hoc than it could have been. Had communication reviews, for example, been conducted on the same basis and with the same regularity as the surveillance reviews in high-risk countries, progress towards eradication would likely have accelerated. This lack of equivalent attention to surveillance and communication indicates reliance on a medicalized approach to health and disease, a bias that has had a negative impact on overall polio program performance.

Many countries that stopped polio transmission without significant communication efforts benefited from trust between communities and government programs, as well as from a favorable view of immunization. In such settings, public service announcements together with well-run campaigns sufficed. However, other countries struggled to end transmission of wild poliovirus cases. During the campaigns, international observers came to realize that there were many reasons for vaccination refusals. They saw that frontline workers could not answer common questions, encountered confusing information, or faced deliberate misinformation. It became clear that the medicalized model and messages originally used by the GPEI were not resonating with some communities and families. Assumptions about government trust, trust in medicines, trust in health workers, cultural and gender influences, and household decision-making were leading to ineffective programming.

Some partner organizations were too closely wed to their plans to be able to see the issue objectively or were unable or unwilling to challenge the dominant medicalized approach that was used during the early stages of the program. In this context, independent campaign observers, third party monitoring, and external reviews became invaluable components of eradication approaches adopted by the WHO and the Centers for Disease Control and Prevention (CDC). The communication component of eradication slowly became part of the data and planning reviewed by the country-specific TAGs, the IMB, and independent communication reviews that were modeled on surveillance reviews.

External Reviews

External communication reviews[24] provided an opportunity to assess the appropriateness and quality of all communication elements, including mass media, interpersonal communication, and information education and communication. Communication and community engagement strategies were critiqued and recommendations were shared with implementing partners. It was vitally important that external and independent review, which was intended to sharpen communication and engagement strategies, complemented the normal planning, review, and line management processes of the implementing partners.

This external review process was a key tool for program and organizational accountability. It also provided cross-country sharing of best practices and drew on a larger knowledge base than was resident in the country program. It took a long time for an external review process to be fully accepted; however, in the end, it was seen as invaluable. Future programs should include an external oversight and review process.

Regular Reviews

These reviews are most effective when they are repeated over time. One-off events have limited impact with no momentum and accountability. Having a mix of communication disciplines from inside and outside the country as part of the review process has improved country programs and built capacity.[25]

Know the Culture

Communication efforts benefited from review by experts who know the culture intimately, including health epidemiologists, social scientists, data analysts, anthropologists, and development practitioners—in addition to pure communication or behavior change experts. Tapping into a more extensive network of senior experts provided fresh perspectives and ideas.

Current Status and Accountability

The review teams were able to describe the present polio situation in a country/state/province/district/town and propose recommendations for improved action. The teams reaffirmed positive approaches and proposed solutions to challenges and obstacles. Donors encouraged the external review process and requested updates on the progress of implementing recommendations. Donor interest also helped with accountability. It is vitally important that the major implementing agencies own the results of the review, thus committing them to give real and serious consideration to the analysis and recommendations from the independent review process.

For many years, the global polio program was setting policy, implementing activities, and engaging in self-monitoring and self-evaluation—in short, it had limited external oversight, which led to groupthink and a fear of exposing program weaknesses. This insular dynamic had a negative impact on the program and stifled innovation. Increasing independent review, minimizing conflicts of interest, listening to low-level/bottom-up concerns, and encouraging problem solving are now considered best practices.

Avoiding Groupthink

Avoiding groupthink was a major preoccupation for the communication reviews that were undertaken. People with an outsider's perspective were invited into the process to contribute their analysis and ideas. It was important to challenge the internal, often orthodox, view of the present state-of-play with polio in a country and the effectiveness of the response, especially at the community level. Debate and conversation were supported and facilitated, not shut down. The presence of some devil's advocates to challenge any groupthink has been found to be very helpful.

Effect of Consistent Review

In the course of the polio communication and community engagement journey, there have been numerous examples of the impact of these ongoing, consistent review processes, such as the gatherings of annual or biannual communication TAGs in priority countries and regions. Additional examples of the impact of these review processes include:

- Priorities were set with timelines, and the operational agencies were held accountable in future review meetings.
- The use of GPS to monitor vaccinator teams in Nigeria made them much more accountable for actually going to and vaccinating in their assigned communities and for validating campaign coverage.
- The move from booths to house-to-house polio immunization expanded and deepened coverage, particularly among those who are hardest to reach.
- Evening meetings, timed to enable more community members to attend, were introduced during campaigns to improve accountability, local decision-making, and coordination.
- Accountability frameworks were developed and implemented in polio-endemic countries.
- External, independent review processes for surveillance and communication put a significant check on the earlier problem of falsifying data, instituting a zero-tolerance policy and response. This development held vaccinators, mobilizers, and monitors accountable for their performance in, for example, India, Pakistan, and Afghanistan.
- The India Social Mobilisation Working Group met after every campaign to identify and analyze issues, followed by the development of appropriate responses.
- The Horn of Africa TAG worked to ensure that community-based surveillance data were included in all epidemiological reports.
- Micro-planning was recommended and introduced in many countries. This allowed monitoring and tracking at the grassroots level instead of relying on overall, aggregated data at the national or state/province level.

In addition, The CORE Group organized its work in Nigeria with clear operational oversight as a central principle. As part of this effort, polio focal points from communities and villages in project areas have between five and 50 families to follow. They track information about individuals in the family during and in between campaigns. One of the things that makes this approach effective is that the responsible people at the community level receive regular supervision. There is clear and accountable oversight of the work at the micro-action level.

Also in Nigeria, but across the partnership, the use of GPS as an oversight and accountability mechanism identified a major gap in the missed children strategy, as was reported:

> *"During this period, >2500 settlements that were initially missed during the 4-day campaigns were identified by the VTS [vaccination tracking system] and targeted for mop-up. This uses GPS and GIS to create a VTS."*[26,†]

† Another paper on the use of GIS from 2013 to 2015 says: "There was a reduction in the number of settlements missed during polio campaigns in Kano, Kebbi, and Sokoto states. However, an increase in the number of missed settlements was recorded in Bauchi and Zamfara states during the same period. Jigawa and Katsina states also had a slight increase in the number missed. Also, in Table 2, the number of chronically missed settlements (i.e., settlements that had been consistently missed in the last 3 polio campaigns) decreased significantly for all states except Zamfara, which had a slight reduction between 2014 and 2015. In Kano state, the number of chronically missed settlements decreased from 1,298 in 2014 to 165 in 2015, showing a huge drop in missed settlements." Source: Touray K, Mkanda P, Tegegn SG et al. 2016. Tracking vaccination teams during polio campaigns in northern Nigeria by use of geographic information system technology: 2013–2015. *Journal of Infectious Diseases*. 213(Suppl 3): S67–S72. Accessed at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4818548/

The previous coverage reports stated that the Nigeria polio program was reaching a high percentage of the population during its campaigns, but it was a high percentage of only half of the population.

Evening meetings during the campaigns created a sense of control over what was happening in the campaigns, facilitating community ownership and problem solving, which is another vitally important principle for effective and relevant oversight. The evening meetings were led by local government officials with participation of polio focal points from implementing partners, government supervisors, and third party monitors. Each supervisor reported on the progress of the teams, any challenges, and any need for mid-course correction due to issues such as poor team performance or an uptick in refusals. This approach led to on-the-spot decisions and improvements. Immediate problem solving increased government ownership and accelerated program improvement with measurable results (more children immunized per round).

Core Question

The key question for all operational oversight processes is, "Why?" Why are there missed children? Why didn't the vaccinators visit this house? Why didn't people hear about the campaigns in advance? Why were children in transit hard to find? Why are children listed as receiving "zero dose" or never receiving a routine immunization dose? Unearthing the underlying issue and continuously asking, "Why does this issue exist?" has meant the difference in improving from good performance to excellent performance. Answering the "Why?" question has driven the strategy to reach every eligible child. By stratifying the reasons and populations for missed children, the program could develop a specific response to each concern or problem. Strategies evolved to improve vaccination for the children of the underserved, mobile/migrant, nomads, brick kiln and construction workers, those living in urban high rises, members of minority ethnic or tribal groups, and refugees and internally displaced persons.

Oversight can also come through interagency programming partnerships. The "secretariat" model developed by the CORE Group and USAID consists of national program and communication advisors who are independent of any organization and supported by the CORE Group. Working together, these advisors created a secretariat that prepares joint proposals for funding and that implements solutions to solve a health problem.[27] It has proved to be an important component of the operational oversight process in the polio eradication effort. When a number of organizations come together to form an autonomous expert group, a platform is created for: a singular focus on the issue at hand (in this case, polio); a process for harnessing the capacities of the partners in a coordinated manner; and the basis for serving as intermediaries between the government and communities. The secretariat model also serves as a useful mechanism for mobilization and cooperation of networks of international and national civil society organizations.

Conclusion

Expenditure on communications and community engagement has been a small share of the polio program budget;[28] and the approved GPEI budget for these activities in 2017 and 2018 is approximately 8% of the entire polio program budget.[29] Although this is a comparatively small percentage, these efforts are vitally important to the overall polio strategy. Based on the polio program achievements, a strong case can be made for 8% to be minimum expenditure level for all health and development programs.

Derived from the analysis above, it is suggested that the core elements we have outlined—social mobilization, norms and culture, community-based surveillance, data-driven strategies, and operational oversight—are key for effective communication programs, regardless of whether the funding and management are internal or external to a country.

More specific to communication and community engagement action, the polio communication experience suggests that adopting the following seven practices is important for effective strategies and action:

1. Incorporate communication and community engagement strategies early—this is paramount.
2. From the beginning, link epidemiology, communications/community engagement, and program monitoring—it is not expensive and has a major payoff.
3. Encourage and support communities to speak up (and be willing to listen to them)—this will ensure relevance, resonance, trust, and engagement, which are crucially important.
4. Facilitate "listening" among health and development programs, governments, and the United Nations—this is more of an issue of organizational culture than it is of funding levels.
5. Ensure that communication strategies and products (be they print, media, social media, or interpersonal) are driven by data—this will increase effectiveness and reduce costs.
6. Have knowledgeable and empowered communication and community engagement focal points, whose job is to work with their medical, epidemiology, and monitoring equivalents to ensure collaborative and integrated strategies and actions.

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