"When people are determined, they can overcome anything."

— Nelson Mandela
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Acronyms

ACSM  Advocacy, communication and social mobilization
AEFI  Adverse event following immunization
AFRO  WHO Regional Office for Africa
CBO  Community-based organization
CSO  Civil society organization
EPI  Expanded Programme on Immunization
HW  Health worker
ICC  Interagency coordinating committee
IEC  Information, education and communication
IPC  Interpersonal communication
IPCC  Interpersonal communication and counselling
KAP  Knowledge, attitude and practice
MCV1  First dose of measles vaccine
MCV2  Second dose of measles vaccine
MR  Measles and rubella vaccine
NGO  non-governmental organization
RI  Routine immunization
SIA  Supplementary immunization activities
SMART  Specific, measurable, achievable, realistic and time-bound
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
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Introduction
About the guideline

The ‘Communication Guideline for Measles Elimination in the African Region’ is designed to equip immunization programme managers and health promotion/communication planners and implementers to carry out their work at various levels (national to community levels). It serves as a reference document – which users can adapt and customize to suit their national contexts – with tools and resources for planning measles/measles-rubella vaccine communication activities.

The Guideline is based on standard Communication for Development strategies and tools aimed at the elimination of measles in Africa by 2020 and incorporates good practices and lessons from past communication initiatives for measles-rubella immunization, as well as the Expanded Programme on Immunization (EPI) in Africa.

Structure of the guideline

The Guideline is divided into two major parts:

**Part 1** presents operational guidelines for a management and coordination system for communication initiatives for routine immunization (RI) and supplementary immunization activities (SIA) for measles-rubella. It includes tips for programme staff and volunteers on how to strengthen interpersonal communication (IPC), counselling skills and other approaches that build trust among caregivers and families and increase demand for measles-rubella vaccinations.

**Part 2** presents important steps and resources for developing a communications strategy. Steps include communications analysis and formative research, evidence-based planning and budgeting, design and development of communications materials and monitoring and evaluation.
In 2012, the Measles and Rubella Initiative launched the Global Measles and Rubella Strategic Plan 2012–2020,\(^2\) including the following five-pronged strategy for the elimination of measles, rubella and congenital rubella syndrome by 2020:

1. Achieve and maintain high levels of population immunity by providing high vaccination coverage;
2. Monitor disease using effective surveillance;
3. Develop and maintain outbreak preparedness, respond rapidly to outbreaks and manage cases;
4. **Communicate and engage to build public confidence and demand for immunization,**\(^3\) and
5. Perform research and development.

WHO AFRO has also set out a Regional Strategic Plan for Immunization 2014–2020.\(^4\) Consistent with the Measles and Rubella Initiative global goal, the Strategic Plan objective is to eliminate measles by 2020. It has the following three regional targets for measles elimination:

1. All countries to achieve an incidence of confirmed measles of less than 1 case per million population by 2020.
2. Measles-containing vaccine (MCV) coverage to be at least 95 per cent at the national and district levels and SIA coverage for both MCV1 and MCV2 to be 95 per cent in all districts.
3. At least 25 countries to introduce rubella-containing vaccine by 2020.

WHO and UNICEF recommend the following strategies for achieving and maintaining the three measles elimination targets:\(^5\)

- **Strengthen RI** with a two dose-schedule to protect every child.
- **Conduct SIAs** to provide an opportunity for unvaccinated children and those who missed the second dose (MCV2), prioritizing hard-to-reach, dropout and resistant populations.

**The importance of communication**

Advocacy and communication is one of the five key components of immunization programmes (**see Figure 1**).

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3. Countries use data to identify and understand reasons for under vaccinations.
Part 1
Communication operational guidelines
This section lists key steps for planning and managing communication activities for measles-rubella campaigns and RI, **with a special focus to hard-to-reach and resistant populations.** The nine key steps are:

1. **Coordination, oversight and management:** Establish a communication coordination group under the inter-agency coordinating committee (ICC) at the national and district levels.

2. **Human resources:** Assign relevant staff at all levels to help manage and implement activities in the communication plan.

3. **Capacity building/strengthening:** Train health workers, community health volunteers and vaccinators in interpersonal communication and counselling (IPCC) and community engagement around key measles-rubella vaccine messages.

4. **Funding and resources:** Prepare a budget to implement the measles-rubella vaccine communication plan and initiate negotiations for funding with donors and national ICCs.

5. **Contracting:** Identify components that will require special skills and select qualified consultants and contractors from your roster to work on them.

6. **Communication analysis/formative research:** Review data to identify good practices and lessons learned from past measles/measles-rubella vaccine, child health days/weeks, Periodic Intensification of routine immunization or polio campaigns and RI (Part 2).

7. **Implementation planning and budgeting:** Prepare costed communication implementation plans at the national level and micro plans at sub-national levels (Part 2).

8. **Evaluation of communication outcomes:** Measure impact against programme outcomes and goal (Part 2). Work with planning, monitoring and evaluation staff to integrate vital communication indicators into the post-measles/measles-rubella vaccination campaign.

9. **Documentation and reporting:** Document all of the stages of RI and SIAs to capture the good practices and lessons learned from the processes (take photos and videos) (Part 2).
1.1 Establish management and coordination mechanisms

Assign a full-time communication manager at the national and sub-national levels who reports to and is a member of the ICC.

**Activate National and Subnational Communication Coordination Groups**

Form or activate a communications coordination group at the national and sub-national levels (provincial, district or county) under the national EPI ICC. In some countries, this may be a standing subcommittee in the ministry of health known as advocacy, communication and social mobilization (ACSM) (see Box 1 for an example of a good practice).

The chairperson/convener should be a full-time communications professional from the convener agency. The group membership should include at least one representative and one alternate from the relevant communication/information, education and communication (IEC) departments of partner government ministries, leading non-governmental organizations (NGOs)/civil society organizations (CSOs), professional networks, the private sector, academia and media and development partners. All members should be conversant in the objectives of the communication initiative and understand their respective roles.

**Box 1 — Good practice from the Democratic Republic of the Congo: Partner coordination for immunization and child health communication**

In the Democratic Republic of the Congo, the Ministry of Health leads the ICC for immunization. Formed in 1996 to harmonize approaches and support to polio eradication, the ICC quickly expanded to address EPI. It has encouraged national consensus among donors and key health colleagues on supporting RI and SIAs. The immunization ICC facilitates partnership among the Ministry of Health EPI and Epidemiological Unit, WHO, UNICEF, the United States Agency for International Development, the Government of Japan, the European Union and their technical sub-contractors, Basic Support for Institutionalizing Child Survival, Santé Rurale; Rotary International, Doctors Without Borders, Catholic Relief Services, Catholic Medical Bureau and the Protestant Church of Christ in the Congo.

The functions of the ICC are divided into two subcommittees that: 1) address technical and logistical issues; and 2) plan and implement communication, social mobilization, advocacy and resource mobilization. This latter subcommittee, the Social Mobilization and Resource Mobilization Subcommittee has worked with the ICC to ensure that communications strategies and activities are included in immunization planning at all levels in the country.

Results of the collaboration:

- National, provincial, and health zone immunization and health staff receiving standardized training and support in communication techniques;
- Application of evidence-based and strategy-specific annual immunization plans and documents that include communication;
- Development and use of available communications guidelines and materials for community mobilizers and health workers, including radio spots, briefing materials, cards and theatre sketches; and
- Since 1999, this model and has been applied to other child health areas, notably with measles-rubella vaccine/EPI and malaria task forces.

Meetings of national and district ACSM subcommittees

1. In preparation for the SIA, the national communication/ACSM subcommittee should begin meeting eight months in advance, in conjunction with ICC meetings. These meetings can be monthly or bi-weekly until the communication strategy and district micro plans are developed and funded. As the campaign period approaches, meetings can become weekly.

2. When the national communication strategy is approved, the district ACSM should be activated to develop a detailed district communication micro plan.

3. Prepare PowerPoint presentations for preparatory meetings, to cover the following:
   3.1. The process of developing the communication plan
   3.2. Implementation plans and projected costs
   3.3. Adaptation, translation and dissemination of media products and IEC tools
   3.4. Team and individual responsibilities
   3.5. A plan to review progress on assigned tasks
   3.6. Timelines for submission of individual and team tasks
   3.7. Monitoring and evaluation plans, methods and tools in coordination with planning, monitoring and evaluation team
   3.8. Documentation assignments and dissemination plan

4. Always maintain a record of discussion and agreements or meeting minutes.
   4.1. Prepare a record of discussion and agreements template
   4.2. Assign a regular recorder and an alternate to ensure consistent record of discussion and agreements
   4.3. Use a smartphone voice recorder to record the discussion
   4.4. Circulate the record of discussion and agreements to all stakeholders to ensure fulfilment and follow-up of assigned agreed actions and strengthen internal communication with national and district ICCs.

1.2 Develop SIA communication plan

Planning communication activities for SIA

Box 2 lists 11 recommended good practices from Ethiopia’s 2011 Measles SIA (see also Annex 1.2).

Box 2 — Good Practices from Ethiopia: Managing, planning and implementing advocacy, social mobilization and communication for measles SIAs

1. Develop specific national level plans for ACSM to complement the other EPI components in SIA macro plans.
2. Make funds available for intensified social mobilization activities at least one month prior to the first day of SIA implementation.
3. Start social mobilization activities, including contacts with opinion leaders and community dialogue sessions, at least one month prior to the SIAs. Town criers/local announcers should be deployed at least three days prior to the SIA.
4. Conduct house-to-house social mobilization activities by health extension workers and community health volunteers, model families, and Development Army Patriots, in areas where they have been deployed.
5. Use clear and crisp messaging through multiple channels that are available to and preferred by audience groups, in the appropriate languages.
6. Allocate adequate funding to ACSM activities.
7. Formulate process, output and outcome indicators for monitoring communication interventions at all levels.
8. Design evidence-based communication messaging (i.e., based on an understanding of the knowledge, attitudes and practices (KAP), as well as the values and norms of the community).
9. Prepare a literature review and conduct focus group discussions and KAP studies prior to planning communication activities and designing messages.
SIAs: Addressing equity by reaching every child in every community

The primary goal of SIAs is to vaccinate every eligible child, focusing on children from hard-to-reach and underserved populations who may have limited access to regular health services and/or are missed by RI. These include:

- Children from urban and suburban areas;
- Undocumented urban settlers/squatters;
- Migrant workers and politically and/or socially marginalized populations or minority groups;
- Nomadic and floating populations and communities inhabiting difficult (e.g. mountainous) terrain;
- Populations in areas near international and internal borders;
- Refugees, internally displaced persons and other transient populations;
- Persons living in areas of civil unrest;
- Affluent communities in which opposition to vaccination is prevalent;
- Religious and fundamentalist groups who oppose vaccination;
- Populations known to shoulder a heavy disease burden, such as HIV infection;
- Other groups marginalized along lines of gender, age, disability, ethnicity or socio-economic status; and
- Socially distant populations.

Communication actions to increase demand among hard-to-reach populations

- Participatory community mapping of hard-to-reach groups: Districts can employ these mapping techniques through their respective health centres or local health committees. Community mapping must be carried out with groups of community stakeholders rather than with individuals. These groups should be identified at least eight weeks before SIA implementation.

- Engaging community leaders/influential persons: In many African countries, community leaders and elders occupy a central role in and are consulted on a wide range of subjects. As custodians of culture, they play a significant role in either changing or adhering to cultural beliefs, and reaching out to caregivers/families from high-risk communities.

- Small group discussions: Health workers or district health practitioners or mother support groups can lead small groups of hard-to-reach parents to address concerns about immunizations; identify and fill information gaps and correct misinformation; respond to questions; and reinforce positive attitudes and enabling behaviours.

- House-to-house visits: House-to-house visits depend on IPC, which is effective in creating awareness and convincing decision makers in the household and community to present eligible children for vaccination (see Box 3).

- Street announcements: In many African countries, town criers use bullhorns, megaphones or public address systems on mobile audiovisual vans to announce the vaccination schedule.

- Recognizing completion role models: In some countries, a rubber stamp on the vaccination card to mark completion is used to recognize a fully immunized child. Parents recognized for their children’s completion can be tapped as role models for social mobilization and community engagement activities.
Elements of an SIA communication plan

1. A working coordination mechanism and communication structure
2. An evidence-based communication plan for the SIA (see Annex 1.2)
3. Approaches to engaging hard-to-reach, resistant and dropout families
4. District/community level communication micro plans with weekly plans/daily activities integrated within SIA district micro plans
5. Key messages and positioning of messages for different participant groups
6. Advocacy with local leaders and influencers
7. Social mobilization of partners and allies
8. Community engagement activities carried out before, during and after SIA by community leaders and groups, and community volunteers (e.g., house-to-house visits, street announcements using megaphones and mobile vans, etc.)
9. IPCC tools, IEC/visibility materials and media products
10. Media plan
11. Plan for the SIA launch (see Annex 1.5)
12. Training modules and session plans on IPCC with training tools for health workers and vaccinators
13. Training of spokespersons
14. Orientation session plans and materials for implementers, supervisors and stakeholders on the SIA communication strategy, monitoring and reporting
15. Communication plan for risk communication and to respond to a crisis/adverse event following immunization (AEFI)
16. Monitoring and evaluation methods and tools as component of SIA monitoring
17. Documenting and reporting good practices and lessons learned

Box 3 — Good Practice from Kenya: House-to-house visits and use of mobile phones for promoting and monitoring the 2012 measles SIA campaign

To support 2012 SIAs in Kenya, American Red Cross volunteers conducted house-to-house canvassing in 11 urban districts, focusing on dropout and vaccine-hesitant communities.

Three days before the SIA campaign launch, volunteers conducted house visits that were documented using a web-enabled mobile phone application that relayed information collected to all campaign management levels in real time. During the campaign, volunteers reported daily immunizations to their coordinators. Post-campaign house-to-house visits were conducted within four days to verify the immunization of eligible children, assess information sources and detect adverse events following immunization.

Of the 164,643 households visited, 56 per cent said that they had heard about the planned 2012 measles vaccination campaign 1–3 days before the start dates. Twenty-five per cent of households reported that they would have missed the measles supplemental dose had they not been reassured by the house-to-house visit. Pre-and post-campaign reasons for refusal showed that house-to-house communication reduced misconceptions, fear of injections and reliance on herbal remedies. Daily reporting of immunizations using mobile phones informed changes in service delivery plans, facilitating better immunization coverage. House-to-house visits were more often remembered as sources of information (70 per cent) than traditional mass awareness channels such as megaphones (41 per cent) and radio (37 per cent).

Effective Communication for Measles and Rubella Elimination in the African Region

Key messages for measles-rubella RI and SIAs

1. Explain what vaccine is to be given and the disease that the vaccine will prevent
2. Explain what side effects may occur, how to treat them and when they should be reported
3. Tell the mother/caregiver the place and time of the text immunization session
4. Tell the mother/caregiver to bring the child back for the scheduled immunization even if he/she is sick
5. Tell the mother/caregiver to a) take good care of the child health record/immunization card; keep it in a safe place as they would a birth certificate and b) bring the card in every time the mother and/or child comes to a health facility

Figure 2 — Five essential messages that health workers need to give mothers/caregivers during measles-rubella RI

Note: Each of the five messages should be given more than once

Box 4 — Key messages health workers need to give to mothers/caregivers during measles-rubella SIAs

Measles
- Measles is a dangerous disease that can kill children.
- It is so contagious that any child exposed who is not immune is likely to get the disease.
- The signs include a red rash over the entire body, fever, runny nose, red eyes and cough.
- Children with measles must be taken to a health centre immediately. A child with measles can develop ear and eye infections, diarrhoea, pneumonia, blindness, deafness or swelling of the brain.
- Give at least two doses of the measles vaccine to prevent measles. The first dose is given at 9 months of age or soon afterwards. The second dose is given at 15-18 months of age.
- The measles vaccine is safe. Sometimes mild swelling and redness can occur at the site of the vaccine injection. This will go away with warm compresses and paracetamol.
- An extra dose of measles vaccine is given during measles SIAs to all children aged 9 months to 15 years even if they were previously vaccinated and regardless of whether they already had measles.
- Take your child (insert target age range) to the nearest health centre or vaccination post during the measles immunization days taking place on (insert dates).
- Bring your child’s immunization card, so the health workers can tell you if other vaccines are needed.
- If you do not have the vaccination card/child health record, you still need to bring your child in for vaccination. Other important health services, such as (insert integrated interventions) will also be available during the campaign.

Rubella/congenital rubella syndrome
- Rubella is a highly contagious disease that can cause crippling birth defects or the death of the unborn child of an infected pregnant woman.
- Irreversible birth defects caused by congenital rubella include deafness, cataracts, heart defects, encephalitis, liver and spleen damage.
- All infants/children should be protected with rubella vaccination, using a measles-rubella vaccine. This protection lasts for life.
- If enough people are vaccinated with rubella vaccine, injuries to unborn babies caused by rubella infection in the mother can be avoided.
**Part 1: Communication operational guidelines**

**Effective Communication for Measles and Rubella Elimination in the African Region**

**Prepare, localize and distribute communication materials**

Communication materials and tools should be distributed to the health centres 4-6 weeks before the SIA, with a proposed deadline of two weeks prior to SIA implementation. Steps for preparing and distributing communication materials are as follows:

- Communication materials should be carefully designed and pre-tested in a participatory manner with stakeholders, and backed by evidence/data to support specific communication objectives for different participant audience groups.

- Depending on purpose, user and audience, communication materials can be designed for:
  - **Caregivers**: child health record book and vaccination cards and printed materials such as flipcharts, brochures, leaflets, Q&As, frequently asked questions and field guides.
  - **Health workers**: job aids such as flip charts, audio-visual materials, video and audio packages, tally sheets, report forms, AEFI and other forms and checklists.
  - **Community health volunteers and mobilizers**: visibility materials such as aprons, vests, visors, arm bands and t-shirts.
  - **Trainers and trainees**: training materials, PowerPoint presentations and audio and video packages.
  - **The general public**: posters, vinyl or tarpaulin sheets, banners and billboards/hoardings.

- One to two months before the SIA, each health centre and district should receive the necessary localized communication materials and job aids, ready for distribution to intended users.

- Brief each intended user on how to effectively use the material to support their communication.

**Prepare an AEFI communication plan**

A good AEFI media plan should include:

- A database with contact details of print and broadcast journalists covering health issues.
- A media kit or information package with frequently asked questions on measles and rubella and immunization in general; an AEFI fact sheet; and a measles-rubella vaccine-preventable disease technical brief.

In the event of an AEFI it is important to:

- **Keep the media informed** by sending regular updates on plans and programmes. Sensitize the media on the benefits of immunization and its impact nationally and globally.
- **Organize regular media orientation workshops and field visits**: Help journalists better understand the measles campaign and the advantages of immunization. Always note all proceedings and discussions with journalists.
- **Identify and train spokespersons in advance**: Place one spokesperson at the central level and one in each district if possible. Share the contact details of the spokesperson(s) before the immunization campaign starts with all concerned focal points at the district and national levels to ensure the coordination of messages.

**Box 5 — Key messages health workers need to give to mothers/caregivers during measles-rubella SIAs**

1. **What and why**: The rationale of the measles-rubella immunization campaign.
2. **For whom**: The targeted age group.
3. **When and where**: Dates and location of the nearest vaccination point.
4. **What interventions**: The interventions that targeted children will receive.
5. **Expected reactions** after the vaccination.

*Vitamin A drops*

- Vitamin A provides defence against measles and diarrhoea and prevents blindness.
- To prevent vitamin A deficiency in *insert area*, vitamin A drops will be given to all children age 6 months to 5 years during measles SIA days on *insert dates*.
- Vitamin A contributes to your child’s healthy growth and development.
- Prevent vitamin A deficiency by giving vitamin A supplements to children age 6–59 months.
- Lack of vitamin A can cause night blindness and other eye problems.

Crisis communication in the event of an AEFI

Include all stakeholders involved in running the campaign. The communication subcommittee and the spokesperson should prepare a written media release (with status updates at frequent intervals) before any media contact.

The spokesperson should always speak with prepared talking points and a media release note and observe the following:

- Have answers for likely and difficult questions
- Avoid speculation on the cause or blaming an individual
- Assure that an investigation is ongoing and action is being taken
- Use simple words and short sentences

Key messages should cover the following facts:

- Immunization prevents disease
- Non-immunization puts the child at risk of disease and complications
- Vaccines may cause reactions, but these are rarely serious without any long-term problems
- The national immunization programme places the utmost importance on immunization safety. Any suspected issue is investigated.
- The current AEFI is being investigated and the RI/SIA must continue to protect the population from disease.

During dialogues with parents/caregivers in the event of an AEFI:

- Listen patiently and sympathetically to their concerns. Reassure and support them but do not make false promises.
- Assist the caregiver in taking the patient to a health facility
- Keep the caregiver/parents informed of the condition of the patients

Risk Communication when a Measles Outbreak Occurs

When a measles outbreak is confirmed, be prepared with a risk communication plan, using elements from the crisis communication plan. Implementing a risk communication plan facilitates effective community involvement and media engagement for wide public awareness. The risk communication plan be designed to:

Keep the public informed to quell fear and encourage cooperation.

- Transmit clear and concise messages that convey the following:
  - that an outbreak exists;
  - the benefits of measles-rubella vaccination; and
  - the signs and symptoms of the disease.
- Encourage parents whose children have had a recent rash and fever to consult a health care facility as soon as possible.
- Instruct parents to bring their children to a health facility/vaccine post for vaccination.
- Provide information on locations and opening hours of health facility/vaccine posts.
- Mobilize community leaders and health staff to organize emergency meetings to alert caregivers of the urgency of vaccination and importance of acting when symptoms occur.
- Maximize message dissemination by engaging media partners, including national and local radio and television stations and newspapers, as well as online and social media.

As soon as the outbreak is recognized:

- Activate the selected spokesperson to serve as the media focal person.
- Brief and provide key messages to the selected spokesperson.
- Tell the media that all information about the outbreak will be provided by the spokesperson.
- Only release information to the media through the spokesperson to ensure that the community receives clear and consistent information.
- Meet with the spokesperson on a regular basis to give frequent, up-to-date information on the outbreak and response and clear and simple health messages for the media to use.

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1.3 Empower health care workers: Build self-confidence and IPCC

Studies have shown that the quality of interaction between health care providers and parents/guardians greatly influences the completion or non-completion of a child’s immunization schedule. Key aspects of this interaction include:

- **IPCC skills**, including listening, interviewing, giving clear instructions and having the ability to empathize, motivate and be supportive and respectful
- **Supportive supervision**, including actively identifying successes, modelling positive behaviour, and giving constructive feedback and correction
- **Recognizing good performance** of health workers and community health volunteers
- **Providing IEC materials** such as job aids, IPCC tools and other communications materials (see Part 2, Step 3).

4. Select training facilitators/consultants experienced in IPCC skills, social mobilization and community engagement activities.
5. Begin the training at least 4–6 weeks before the start of the SIA launch.
6. Access and customize available examples of training modules and session facilitator guides on IPCC and social/community mobilization, including *Training Manual on IPC*. Adapt these to the training needs of the specific participants and programme context (see Annex 2.2 for an example of a three-hour session on strengthening health workers’ IPCC skills in measles-rubella vaccination/EPI).
7. Plan to conduct training as close to SIA implementation as possible to ensure that skills, concepts and key messages are still fresh in participants’ minds.

**Guidelines for organizing training sessions on IPCC and social mobilization**

1. Integrate IPCC into the ongoing training program for health workers and service providers in preparation for measles-rubella activities. Plan the training as a cascade with the national level, with the first level as a training of trainers for district level trainers, who will in turn train community health workers, vaccinators, mobilizers and youth volunteers.
2. Conduct training need assessments that inform the training modules and interactive session plans, presentation materials and group dynamics tools (role playing, group exercises, relevant ice breakers).
3. Design half-day/full-day modules on IPCC and social mobilization. These should be integrated into the practical component of the training of trainers and training rollout for health workers, vaccinators and other immunization service providers for measles RI and SIA.

**Box 6. Good practice from Ethiopia: Training health workers and vaccinators for measles SIA**

List of lessons learned on building communication capacity among health workers in Ethiopia:

**Assess training needs and outcomes**

- Include pre- and post-tests to assess participants’ knowledge, attitudes and skills. The pre-test helps tailor the training agenda and the post-test evaluates the effectiveness of training sessions (content and process). Supervisors must demonstrate adequate knowledge during the post-test to ensure that they can provide adequate support in the field during the SIAs.

**Design training based on needs**

- Design training sessions based on training needs assessments using a generic/standard list of topics and training materials. Translate training materials into local languages and separate the agenda from micro-planning activities to allow enough time for the micro plans to be developed, while giving participants time to role play and practice needed IPC skills. In all
1.4 Mount advocacy activities

Advocacy is form of communication that aims to inform and motivate influential persons to take actions supportive of measles-rubella vaccination programme objectives and goals.

**Participant audiences for advocacy**

The national and district ICC will oversee advocacy at their respective levels.

- Health and fiscal policy-makers/parliamentarians
- Ministry of health
- Other ministries and departments (e.g. education, finance, communications, social welfare, etc.)
- Donors and development partners
- Religious leaders
- Immunization champions and popular personalities in sports, film, theatre, radio and television
- Media and telecommunications executives
- Medical institutions and professional associations of physicians, paediatricians, etc.
- Directors of NGOs/CSOs/community-based organizations (CBOs)
- Practicing doctors, pharmacists
- Academic institutions
- Other health-focused organizations

**Guidelines for planning advocacy**

In planning your advocacy with policy-makers, parliamentarians and other influencers, take the following steps:

1. Gather evidence about measles-rubella immunization status in your country/district;
2. Prepare easily understood charts and graphs from available data and information;
3. Analyse existing policies on the measles-rubella immunization programme versus the outlook of the group;
4. Prepare a plan that includes advocacy objectives and expected outcome; design key messages; decide on advocacy activities and procedures; and determine advocacy tools;
5. Assess available resources (funds, materials, time, staff and partner support);
6. Develop a timeline for various advocacy events/activities;
7. Develop advocacy tools with compelling evidence and messages (10 minute PowerPoint presentation, advocacy pack with data in infographics, Q&A, frequently asked questions, fact-sheets, booklet or leaflet, banner, standee, etc.);

**Implementing participatory training methods**

- Allow a minimum interval time of two weeks between training and SIA implementation.
- Skilled personnel and a team of resource persons should conduct training of trainers.
- In all training sessions, apply adult learning principles and include role play, demonstrations and exercises to impart practical skills, ensure participation and make learning fun.
- Conduct training for micro-planning well before training vaccinators, as the timing of these activities is different.
- Involve facilitators and supervisors in the training of vaccinators and maintain a reasonable ratio of trainer to trainee (proposed ratio of no more than 25 trainees per facilitator/trainer).


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8. Tap existing or new partners and networks to support your advocacy effort (e.g. youth groups, media, religious/community leaders);
9. Conduct advocacy; and
10. Document the proceedings, showcasing good practices and lessons.

**Box 7 — Good Practice from the Democratic Republic of the Congo: Hands-on advocacy with national immunization leaders – fostering ownership of childhood immunization data**

The Democratic Republic of the Congo is among the 10 countries with largest number of unimmunized children. Civil strife has weakened immunization programmes and improvements in the quality of data are needed to make the programme more effective and cost efficient.

To improve the data, WHO, UNICEF and the United States Centers for Disease Control and Prevention created a group of national immunization leaders and taught them a systematic way to monitor their programme data. Beginning in August 2012, the Strengthening the Quality and Use of Immunization Data Team, travelled to the Democratic Republic of the Congo to establish a national expert group on data quality. The group learned a technique for assessing how immunization data is collected, recorded, reported and analysed at each level of the health system. A coordination committee with representatives from the Ministry of Health, WHO and UNICEF helped plan and facilitate all activities related to this initiative.

After the training, the national expert group used the technique to conduct assessments in Kasai Occidental Province. After completing the assessment, the team returned to the Democratic Republic of Congo for a debriefing workshop with the national expert group to discuss their experiences.

Several members of the group told the Centers for Disease Control and Prevention that the project provided a truly eye-opening experience. They reported that they had experienced the real challenges in recording and reporting of quality immunization data at the frontline of health care.

This project offered a much-needed opportunity for the country’s national leaders to systematically assess field situations and use the findings to make good decisions.


**Advocacy activities and key messages**

**Advocacy with local authorities and religious leaders**
- Keep local authorities and religious leaders informed and oriented about any upcoming measles-rubella SIAs and other major EPI events.
- Be ready with an advocacy kit, including briefing notes and scripted key messages.
- When a crisis occurs, early communication is essential.

**Advocacy with other government ministries (e.g. education, finance and social welfare)**
- **Key message**: “Measles elimination is dependent on cooperation, collaboration and partnership. Achieving this goal also directly contributes to the goals of your ministry.”
- Develop a small but attractive booklet on measles-rubella and other vaccine-preventable diseases.
- Make a 10-minute PowerPoint presentation on the linkages between measles-rubella immunization, EPI, education and sanitation, justifying the kind of support needed and how it will help the programme. Prepare an infographic using the information in the PowerPoint presentation.
- Provide an attractive flyer or leaflet highlighting initiatives taken or planned toward measles elimination by 2020 in your country.
- Hold face-to-face meetings with the minister of health or EPI chief to sensitize on key issues.
- Invite stakeholders to presentations and workshops, especially when cross-sectoral linkages and resource complementation are being discussed.
- Invite stakeholders to SIA launch events.
- Facilitate advocacy meetings between the ministry of health and other departments.
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• Acknowledge their partnership and support in publications, public forums, online media, other media and IEC materials, as appropriate.

Advocacy with medical institutions/associations/health practitioners
• Key message: “Immunization is the most cost-effective child survival strategy that the medical community can help promote and sustain, and thereby gain personal and institutional credits.”
• Keep members informed about measles-rubella elimination initiatives through email correspondence, sending links from the ministry of health website and special groups through social media (Facebook, Google groups, etc.).
• Prepare a proposal using a PowerPoint presentation with infographics on how members can support measles-rubella elimination.
• Support members to conduct studies and research and provide advice on improving RI and the implementation of SIA campaigns.
• Identify and prepare a list of members in the districts and create networks.
• Invite members to training workshops as resource persons.
• Offer members incentives for providing support, such as recognition certificates and awards.
• Induct selected senior members into district immunization advisory committees.
• For selected senior members from districts, create opportunities for interviews with media and talk shows on television and FM radio stations.
• Develop mass media/IEC promotional materials showcasing the participation of private health practitioners.

Advocacy with traditional healers and traditional birth attendants
• Key message: “Immunization is a safe and free intervention that builds defences against life-threatening diseases in children, eradicated diseases such as smallpox (with polio on the verge of eradication) and saves the lives of millions of children and adults globally.”
• Make pictorial presentations through flipcharts and infographics in the local language on the disease risk of measles and rubella and the benefits of measles-rubella immunization. Request that they pass measles-rubella vaccine key messages along using IEC materials during patient visits.
• Provide examples of how vaccination prevents childhood diseases and deaths and eradicates diseases such as smallpox and polio.
• Invite to group meetings and seek their counsel on health issues.
• Provide with IEC materials for display and distribution to clients.
• Engage and offer small incentives such as certificates of recognition.

1.5 Engage Communities

Guidelines for planning community engagement

1. Meet with identified community leaders and other respected figures to explain the purpose of community engagement and seek their advice before meeting other community members.
2. Establish alliances with local government institutions that are already working with the community and conduct joint visits and information exchange.

3. Work through existing community organizations/structures whenever possible and build upon established collaborative relationships. Provide training to charismatic and opinion leaders as a means of strengthening their leadership skills for participatory development.
4. Arrange visits and walk-throughs to observe residents and the terrain and engage residents on an informal basis (individually, in the household, etc.). Visit areas where community residents may congregate.
5. **Periodically arrange formal community meetings**, working through local leaders/influencers/contacts in different locations, during times that are most convenient for most people (keep in mind caregivers’ availability). Make a special effort to meet with women’s groups and young people.

6. **Focus discussions on people’s concerns and interests**. Try to identify an issue or action related to immunization that interests the majority and get feedback with facts and figures. Identify basic common goals and become aware of the gaps vis-a-vis the reality of the situation.

7. **Work with small groups**. Even if community-wide meetings are held, working with small groups facilitates role modelling and allows peer influence to serve as a conduit for change.

8. **Look for different mechanisms to involve hard-to-reach groups**. Ensure an equitable representation of hard-to-reach groups, particularly women and eligible children. If these groups do not actively participate, determine why and consult the community on how to remedy the situation and whom should do so.

9. **Provide periodic data/information updates and feedback** to community members and encourage the exchange of ideas and strategies with other communities (and/or their representatives) who have already had successful participatory experiences.

10. **Establish strong connections with local channels** such as radio, social media and community media (e.g. public address system, village crier/street announcers, community theatre, etc.) that will allow constant information sharing and feedback that bolsters community participation in achieving RI and SIA targets.

### 1.6 Engage partners in social mobilization

**Guidelines for planning social mobilization**

1. **Develop national and district level social mobilization plans** involving all feasible partners and allies down to the community level, specifying communication actions they will take to support SIA before, during and after the campaign. Develop a community engagement micro plan as a key part of the district communication action plan.

2. **Identify community mobilizers** (i.e. health workers, vaccinators, community health volunteers, mothers’ groups, neighbourhood associations, community health committees, youth groups, theatre groups, etc.) that could implement community engagement activities.

3. **Ensure that community mobilizers are aware of and sensitive to community values**, social norms and practices and understand the barriers to the recommended behaviours.

4. **Train mobilizers on delivering key messages** and IPC skills and facilitating meetings using lively, interactive and participatory techniques. The mobilizer can then conduct cascade training on participatory techniques for community groups.

5. **Ensure that RI strengthening efforts and SIAs use plenty of motivational visibility materials and methods**. Be creative and work locally in developing, pre-testing and using creative techniques, IPCC tools, IEC and media products, audiovisual materials and group media such as local storytelling, role playing, songs, etc.

6. **Enlist champions and role models or positive deviants**. Set your criteria for role models and invite their testimonials (i.e. groups of mothers/parents/guardians who have completed their children’s measles-rubella vaccinations and health workers consistently cited by parents/guardians as having given them satisfactory health services, IPCC and knowledge sharing on immunization).

7. **Establish mechanisms to get daily feedback on social mobilization activities** with partners and implementers and community engagement with community leaders and members, focusing on challenges. Make immediate adjustments based on feedback.

8. **Ensure that visits to RI facilities and SIA vaccination sites are positive and memorable**. Health workers and vaccinators should see to it that parents/guardians and vaccine recipients are satisfied and happy with their experience. Bad experiences can prevent revisits and generate a negative impression of immunization.
9. **Document good practices and lessons.** Take plenty of action photos and videos and record quotes using smartphones or cameras. Enlist the support of journalists and commission case study writers to capture good practices and lessons (see Annex 2.9).

**Mobilize key stakeholders**

**Frontline health workers**

- Convene post-SIA and occasional RI meetings with health workers, vaccinators, community health volunteers and mobilizers to share their knowledge, views and work experience, challenges and successes.
- Offer training in IPC and counselling skills at mutually convenient times. Remember to address logistics and offer small incentives and rewards for good performance.
- Ensure that health workers, vaccinators and community mobilizers are equipped in advance with the necessary resources such as IPC tools, IEC materials and techniques, presentation equipment, etc.

**Faith-based organizations, religious leaders and other community influencers**

- Identify and approach highly esteemed people from the area – community leaders, religious leaders, opinion leaders and other charismatic and well-regarded members of the community. Be aware of any opposition to vaccination and find out the reasons.
- Engage and educate these stakeholders on the benefits and any minor side effects of measles-rubella immunization, as well as other key messages.
- Motivate stakeholders to help with community engagement (i.e. reaching out to the community during regular events that incorporate dialogues and inspire actions that promote measles-rubella vaccination/EPI).
- Provide communication tools to enable them to organize interactive meetings in comfortable venues.

**Community groups**

- Mobilize community leaders, CBOs such as schools, faith-based organizations, mothers’ support groups, children’s clubs, youth groups and other community-based networks to help increase demand for measles-rubella immunization, particularly in hard-to-reach and resistant groups.
- Support annual commemorative events (e.g. World/ National Immunization Week, World/National Health Day, Day of the African Child, Global/ National Handwashing Day, Child Rights Day, etc.) by organizing community activities that engage all family members in fun social but health-informative activities.
- Support dialogues and meetings led by community groups and influencers.
- Define and roll out a local media strategy that gives community members voice and visibility (e.g. community radio programmes, radio dramas, theatre troupes, banners, local media outreach). Engage national and local celebrities and local “heroes” and role models.

**NGOs, CSOs and CBO networks**

- Map out all NGOs, civic groups, CBOs and relevant interest groups such as women’s groups, mother support groups, water users’ associations, school clubs, children’s clubs, youth groups and self-help groups.
- Prepare interactive presentations and group dynamics tools for training and orientations.
- Involve partner NGOs, CSOs and CBOs in developing training assessments, agendas, interactive session plans and materials, or customize existing modules to suit their needs, and conduct participatory training.
- Monitor social mobilization and community engagement efforts and involve and train community volunteers using participatory monitoring methods such as participatory community mapping; text messages through mobile phones; storytelling, and other methods. Document all activities with audiovisual aids and written report.
1.7 Engage mass media and social media

**Guidelines for preparing a media plan and engaging the media**

1. **Maintain a database** of media organizations and practicing media staff covering health issues, as well as key immunization experts and health authorities at national and district levels. Establish rapport and maintain two-way communication.

2. **Develop an updated media kit** containing key messages in the form of Q&As or frequently asked questions on measles-rubella immunization, including fact sheets, progress reports, case studies with photos, graphs and relevant illustrations and other audience-appropriate materials.

3. **Conduct orientations, training workshops and field visits** for media staff and journalists to improve their understanding of immunization advantages as well as the complexities of an immunization programme. This involves building alliances and forming a media consultative group, and preparing monthly or quarterly updates on measles-rubella/EPI RI and SIA plans or developments relating to new vaccines and vaccine safety issues.

4. **Set up a spokesperson system.** Select and train spokespersons at the national and administrative levels for SIA media blitzes and in the event of an AEFI or rumour. Organize a media skills orientation for spokespersons and ensure continuous training and updating of key messages and their communication skills. Equip them with prepared key message sheets and other related information on vaccine and immunization safety.

5. **Organize media briefings** with national, provincial/district level journalists on updates, the latest data and EPI challenges and successes to keep media informed periodically about the progress of RI and SIA plans. Maximize online platforms such as email and social media to keep media contacts regularly informed of all RI and SIA campaign events.

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**Box 8 — Good practice from Uganda: U-Report – citizen feedback on health services via SMS**

In Uganda, UNICEF is using mobile phones and broadcast media to get direct information and feedback from Ugandans on everything from medication access to water and sanitation. The project, entitled U-Report, allows users to sign up for regular SMS-based polls and messages via a toll-free short code. Citizen responses are used both in weekly radio talk shows to create discussion on community issues, and are shared among UNICEF and other aid organizations to provide a better picture of how services work across Uganda.

U-Report may have potential for use in district health offices and among health workers for tracking hard-to-reach populations for future measles/measles-rubella SIAs.

1.8
Hard to reach and disadvantaged communities

Who:
- Ethno-linguistic minorities and slum dwellers
- Marginalized and ‘floating’ populations, both urban, peri-urban, and rural
- Migrant workers, nomads, travelers
- Socially, politically, culturally marginalized groups
- Religious / political groups who oppose vaccination

Their characteristics: to be considered while planning to reach them.

Demographic:
The quantity and characteristics of the group
- Where are, these groups found?
- How many are there in the group?
- What do members of the group have in common?
- (Where) do they get together?
- Who else contacts them and how?

Cultural:
The way of life of a group of people
- Which organizations could we work with to develop an information network?
- What established information networks do people already use and how could we tap into them?
- Are there individuals we could work through? How?

Behavioural and Attitudinal:
The way the group’s attitude to council influences their behaviour
- Who do they trust?
- What methods of outreach can we use?
- How can we establish new relationships?
- What or who can influence them?
Part 1
Annexes
Annex 1.1
Recommended tasks/terms of reference for national and district communication committees

1. **Recommended tasks/terms of reference for national health promotion/ACSM subcommittee**

   1.1 Play the facilitating and supporting role for effective development and implementation of the measles-rubella/EPI national communication strategy for RI and SIA.
   1.2 Map human resources available for communication – names, designations, capacities and any additional staff from other ministries and divisions, partners; NGOs, CSOs and CBOs.
   1.3 Develop reporting structures and protocols, focal points, assign responsibilities and accountability.
   1.4 Facilitate communication analysis and KAP research (secondary and primary data).
   1.5 Participate in the review of national/district coverage of hard-to-reach populations.
   1.6 Mobilize and allocate financial and other resources at national and district levels.
   1.7 Conduct advocacy for inter-sectoral support, partnerships and collaborations.
   1.8 Facilitate the development of the national and district communication plans.
   1.9 Develop and implement capacity building activities for national and district members.
   1.10 Support capacity building of frontline workers in districts and orientations for partners.
   1.11 Oversee management and implementation of communication activities.
   1.12 Strengthen media relations at the national level through appropriate media advocacy.
   1.13 Oversee national level mass media and information and communication technology activities as in communication strategy.
   1.14 Use/customize Measles and Rubella Initiative brand images9 and provide customized Measles and Rubella Initiative branding tools in local languages and images to the district ACSM group.
   1.15 Ensure funds are allocated for monitoring and evaluation of communication outcomes; documentation of good practices and lessons; and utilization of monitoring and evaluation data for future SIA planning.
   1.16 Make policy decisions to offer incentives and recognition for specific communication activities, measles-rubella/EPI champions and role models.
   1.17 Oversee planning for crisis communication in the event of AEFI, rumours and noise.

2. **Recommended tasks/terms of reference for district health promotion/ACSM subcommittee**

   2.1 Map human resources for data gathering and developing and implementing the communication micro plan.
   2.2 Create focal points, set up reporting mechanism, assign tasks and ensure accountability.
   2.3 Assess learning needs and develop and implement capacity building activities.
   2.4 Contract out: review available baseline data on KAP and demand-side barrier analysis and communication situation analysis (see Section 2.1).
   2.5 Develop the district communication action plan for measles-rubella RI and the SIA.
   2.6 Advocate to mobilize resources from the national level and within districts.
   2.7 Develop district-specific, language- and culture-appropriate channels and materials.
   2.8 Implement communication activities as per the district communication action plan: advocacy, social mobilization, community engagement and behaviour change communication.
   2.9 Establish media relations at the district level and engage the media and social media in promoting measles-rubella RI and SIA.
   2.10 Monitor, evaluate and document good practices and lessons.
   2.11 Hold regular district communication committee meetings to analyse progress and do mid-term adjustments.
   2.12 Promote inter-sectoral partnerships and collaborations at the district level.
   2.13 Update progress to national communication committee communication strategy, implementation and current outcomes.

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## Annex 1.2
### Checklist of inputs for SIA communication micro-planning

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Yes</th>
<th>No</th>
<th>Observation / comments</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communication subcommittee meeting regularly</td>
<td></td>
<td></td>
<td></td>
<td>Existence of RODA/Minutes of meetings</td>
</tr>
<tr>
<td>2. Social and community mobilization micro plans developed at district level</td>
<td></td>
<td></td>
<td></td>
<td>Existence of plan</td>
</tr>
<tr>
<td>3. Existence of sketch maps of villages identifying resistors, hard-to-reach groups and dropouts</td>
<td></td>
<td></td>
<td></td>
<td>Existence of maps</td>
</tr>
<tr>
<td>4. Advocacy, communication and social mobilization plans integrated into micro plans</td>
<td></td>
<td></td>
<td></td>
<td>Existence of district ACSM plan</td>
</tr>
<tr>
<td>5. List and map of hard-to-reach and resistant groups</td>
<td></td>
<td></td>
<td></td>
<td>Existence of lists and mapped locations of hard-to-reach groups</td>
</tr>
<tr>
<td>6. Dedicated IPC/media plans to reach hard-to-reach/dropout/resistant groups</td>
<td></td>
<td></td>
<td></td>
<td>Existence of plans for hard-to-reach groups, meetings, village criers, media</td>
</tr>
<tr>
<td>7. List of SIA posts/facilities</td>
<td></td>
<td></td>
<td></td>
<td>Existence of lists</td>
</tr>
<tr>
<td>8. List of households with eligible children per post</td>
<td></td>
<td></td>
<td></td>
<td>Existence of list</td>
</tr>
<tr>
<td>9. Communication/social mobilization funds made available</td>
<td></td>
<td></td>
<td></td>
<td>Funds received by districts</td>
</tr>
</tbody>
</table>
Annex 1.3
Guidelines for preparing the SIA launch

1. Organize joint planning meetings with the district immunization coordinating committee and the communication subcommittee that are:
   1.1 Led by district health/EPI officer
   1.2 Inter-sectoral, with representation from all partners and stakeholders

2. One month before the SIA launch, meet frequently, plan and organize the launch.
   2.1 Set the date and venue for the launch and agree on guest of honour.
   2.2 Invite guest of honour with ample lead time to ensure his/her commitment for that day.
   2.3 Prepare agenda for the launch.

3. Assign responsible persons from the communication subcommittee or contract an events manager for the following tasks:
   3.1 Prepare advocacy/orientation materials for district officials.
   3.2 Organize advocacy/orientation meetings with inter-sectoral district authorities and the media.
   3.3 Finalize the agenda/programme for the launch. Prepare an invitation list and send to guest of honour, members of national and district ICCs, health and EPI officers, key immunization experts, professional health associations, donors and development partners, religious leaders, educators, private sector notables, youth groups, and other key influencers, popular personalities, media partners, etc.
   3.4 Prepare visibility materials: backdrop, standees, welcome banners, giveaways.
   3.5 Prepare media and advocacy kits.
   3.6 Plan for the production of a video documentary from past SIAs, testimonials and activities of role model parents, health workers, community health volunteers, institutions, etc., to be shown during the SIA Launch.

4. Determine the message position for announcements, branded visibility and IEC materials with measles-rubella/EPI logo.

5. Prepare talking points or speech for guest of honour.

6. Prepare public service announcement, script for a dramatized spot and a press release to announce SIA for dissemination through village criers, public address systems, community radio, local newspapers, digital media, SMS, email and social media platforms, etc.

7. Customize the standard media kit for the launch in the local language and context.

8. Prepare a press release using EPI and measles-rubella vaccine brand/logo along with district logo on letterhead for branding.

9. Seek support of the Measles and Rubella Initiative and other development partners in resource complementation, media engagement, preparation of visibility materials and facilitating invitations.

10. Contract an agency to design, pre-test and produce measles-rubella vaccine visibility materials (banners, posters, etc.).

11. Plan to document the event via videos and photos for post-SIA launch media releases and reports.

12. Monitor media coverage and file press clippings, website hits, comments and likes from social media.
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Annex 1.4
Template for planning your advocacy – 10 questions

Q1. What is our advocacy goal?
To create broad-based political will among decision makers that would lead to the creation and implementation of policies, structures programmes, ICC and allocation of adequate resources.

Q2. What are our specific objectives for measles-rubella vaccine (MR)/EPI advocacy? (desired actions from decision makers)
- Make a commitment/exhibit political will for MR/EPI
- Know the impact of MR/EPI on the health of children and the economic benefits of investing in MR/EPI
- Improve MR/EPI policies, programmes, structures and coordination
- Increase budget allocation for MR/EPI, including communication
- Include MR/EPI issues in their speeches and pronouncements

Q3. What results do we want to achieve from our advocacy? (interim outputs and outcomes)
- Improved MR/EPI policies
- Funds allocated for the comprehensive multi-year MR/EPI strategy, including communication strategy
- National and district coordinating groups formed, terms of reference agreed and meeting regularly
- Partnerships established with government, NGOs, professionals, internationals and bilateral partners, etc.
- Monitoring and reporting system for the comprehensive multi-year plan, including communication strategy, established
- National measles and rubella immunization comprehensive multi-year plan strategy implemented

Q4. Who can make it happen? (which audience groups)
- Decision makers (prime minister, ministers, parliamentarians, administrators, district chief, etc.)
- Donors (foundations, philanthropic bodies, bilateral agencies, multilateral agencies)
- Development partners: United Nations agencies, international NGOs, academic institutions, professional associations
- Media/print, television and radio journalists, creative agencies, production houses
- Civil society organizations, NGOs, CSOs, CBOs
- Eminent personalities, bishops, priests, champions for children and the general public

Q5. What do they need to hear? (primary and secondary messages for each audience group)
- Status and trends; determinants of MR/EPI
- Impact on child health and development, on economic and national development
- Ongoing interventions and programmatic gaps to be addressed
- Actionable recommendations for multi-sectors and for each sector
- Areas requiring MR/EPI policy change/development and suggested ways forward

Q6. Who can make it happen? Who do they need to hear it from?

<table>
<thead>
<tr>
<th>Messenger</th>
<th>Audience level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health MR/EPI</td>
<td>National, district</td>
</tr>
<tr>
<td>District health chief</td>
<td>Sub-district administrative levels</td>
</tr>
</tbody>
</table>

Q7. How can we get them to hear our advocacy appeal? What events? Approaches and opportunities? Who is responsible? Timeline? Budget?

- Small meetings with partners, donors, development partners
- Big meeting: prime minister, ministries of health, finance, education, social welfare/women and children, social communication, industry and environment, agriculture, donors, development partners, media etc.
- Media briefing: radio, television, newspapers, telecommunications companies
- Special events: SIA launches, African Vaccination Week, World Immunization Week, etc.

Q8. What tools and materials do we need to develop?

Advocacy materials and tools: kit containing policy briefs, infographics, MR/EPI profiles
- PowerPoint presentation on MR situation, national and district level
- Summary of results and recommendations from national surveys, communication analysis, etc.

Q9. How much will it cost? Where will it come from?

Funds needed for MR/EPI communication/ACSM activities

A. National MR SIAs for [YEAR]

Example, if total budget is: $10,000,000.00

B. MR/EPI communication component– 20% of national budget for SIA

Then: $2,000,000.00 allocated for communication

Q10. How do we tell if it is working?

Expected results | Indicators | Data collection method | Responsibility
--- | --- | --- | ---

Annex 1.5
How to prepare a press release

Write a press release that will provide a newspaper editor with pertinent information about the issue. Mark it as “URGENT” or “EMBARGOED” as the case may be or if necessary. Place the name of the city where the event is happening and the dateline.

Headline:
Write a short but interesting and clear headline that would arouse interest and attention.

Content:
Using a strong lead sentence include the 5 W’s: who, what, when, where, why

• Apply the inverted pyramid style, where the main points are in the lead sentence, and present all other relevant facts in a logical sequence, with the least important at the end of the story.
• Use quotes within the first three paragraphs. A quote from a person of authority adds interest and lends credibility to your story (e.g. from the minister of health, national immunization programme/EPI manager).
• At the bottom left of the page, write the name, title, organization and phone number of the contact person.
• Attach a fact sheet, Q&A or briefing material, including photographs with captions.
• Expect editors to cut out what seems non-essential given the limits of print space and air time.

Style:
• Use short, simple sentences, no more than 25 words, up to three sentences per paragraph.
• Keep the press release to 1-2 pages.
• Avoid technical jargon, adjectives and adverbs.
• Use active sentences to create a sense of importance or urgency in the story.
• Check your facts for accuracy and proofread carefully before dispatching the story.
Annex 1.6
How to prepare for a media interview

**Before the interview:**
- Review the information you communicate – is the data correct? Are the sources reliable?
- Prepare key messages. You can include messages from press releases in the interviews.
- Find out who is conducting the interview and what media outlet they work for.

**During the interview:**
- Maintain eye contact with the interviewer.
- Dress in a professional manner.
- Think before you speak, take time to frame your answers and speak clearly and audibly in simple conversational language. Stick to facts and avoid speculation or personal opinions.
- Make sure you get your key message into the dialogue, more than once if possible.
- Be warm and friendly but determined to get the right message across.
- Be enthusiastic and engaged – try not to look nervous, even if you feel uncomfortable.
- Never say “no comment”.
- Remember that there is no such thing as an ‘off the record’ statement that you can be certain the interviewer will keep confidential.
- Try to imagine how the interview will appear to members of the audience. Will they be persuaded by your message?

**Dealing with difficult questions:**
- If you get stuck on a question, move on to your key messages.
- Be assertive but calm, not aggressive, take your time and don’t let the interviewer interrupt you when giving your key message. Make sure you know all the facts.
Annex 1.7
Guideline to develop communication monitoring and evaluation plan

1. Identify what will be monitored and evaluated

Overall communication programme inputs, process, and outputs will need to be monitored and evaluated to determine if it is meeting its objectives. This comes from having a clear idea about what you are trying to achieve and how you plan to achieve it.

Consult your Log Frame to determine what activities and indicators to measure and determine how you will monitor each indicator and evaluate. It is particularly important to track outputs, but often the emphasis is put on tracking processes only, two need to be balanced.

2. Defining and refining indicators

Indicators are the mechanism that evaluates the progress of each objective, and can be for inputs, processes, outputs, outcomes, or impacts. Define indicators for each activity required to meet an objective using the Log Frame Worksheet.

3. Develop data collection tools

Determine how data for each indicator will be collected and evaluated, keeping in mind that most data will come from programme records. Create a checklist of all reports and records that can be used in monitoring and evaluation. Data collection tools should be developed in conjunction with the staff that will be utilizing them to ensure they are user friendly.

You should select your data collection tools based on determining:
- The purpose of your monitoring activities
- The resources you have available
- The accessibility of study participants
- The relative advantages and disadvantages of each method as it relates to your work specifically
- The end users of your evaluation report

4. Identify the required resources

Now that all of the elements for your monitoring and evaluation plan are in place, the next step is identifying the human and financial resources that will be necessary for carrying out your M&E plan.

5. Develop a monitoring and evaluation training protocol

Based on the human and financial resources identified, determine how applicable staff will be trained to carry out M&E activities. Training of staff will vary for every data collection tool, but constructing a manual is recommended. Allow one to four weeks for trainings.

6. Develop a reporting framework

The results of your M&E work will likely need to be shared as a report, so keeping the structure of your work conducive to that format is helpful. Summary statistics should make up the majority of the report.

Remember to tailor your communications M&E indicators and tools to the specific communications practices at your national, sub-national, or district level.
Part 2: Communication technical guidelines
The first step to operationalizing communication is to have a carefully drafted evidence-based communication strategy that answers the following questions:

1. What is the behavioural change objective for that communication?
2. Who is engaged on both the supply and demand sides?
3. What will be the core message(s), and will the messages be communicated using channels and vehicles?
4. What tasks and products will be needed (i.e. activities and tools)?
5. How will the appropriateness of the messaging and channels be pre-tested?
6. How the communication effort outcomes be monitored and evaluated?
2.1 Guiding principles when preparing the communication strategy:

1. **Align** the communication strategy with the existing comprehensive multi-year plan for immunization and maternal, newborn and child health and nutrition.

2. **Equity**: Ensure the inclusion of people who are more vulnerable, marginalized and face discrimination.

3. **Trust, credibility and transparency**: Provide accurate, unbiased and evidence-based messages and disclose information about immunization and vaccine safety.

4. **Mix communications channels and localize materials**: Use a combination of interpersonal channels, community-based media and mass media. Make sure that messages and materials are culturally sensitive, in local languages and supported by service availability.

5. **Public-private partnerships**: Work with faith-based organizations, NGOs, CBOs, business groups, media and civil society to leverage resources for measles-rubella vaccine/EPI communication programmes.

6. **Evidence-based programming**: Strengthen formative research, monitoring and evaluation to establish an evidence-base for communication programming.

7. **Community participation for immunization**: Involve and mobilize communities as much as possible and feasible in all stages of communication programming.

2.2 Five steps for developing the communications strategy\textsuperscript{11}

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**Figure 3** — Five essential messages that health workers need to give mothers/caregivers during measles-rubella RI


\textsuperscript{11} Government of Zambia Ministry of Community Development, ‘Comprehensive communication strategy for EPI 2012-15’.
STEP 1. Collect and analyse data for a communications analysis

A communications situation analysis will reveal factors that contribute to people’s behaviours and predispositions in regard to RI/measles-rubella SIAs. The analysis involves five components: 1) problem and programme analysis; 2) communication environment analysis; 3) participant audience analysis; 4) behaviour analysis; and 5) channel analysis.12

1. Problem and programme analysis

A problem analysis answers/includes the following:
- What is the problem?
- Who is affected by the problem?
- What immediate, short and long-term measures are being taken to address the problem?
- A causality analysis drawing on data from KAP studies, demographic and health surveys, multiple indicator cluster surveys and any other current surveys or databases.

A programme analysis answers the following:
- What has been the programme’s response to the problem? Is there a proactive communication plan for the response?
- Does the national immunization programme integrate communication? Are there dedicated communications staff?
- Does the programme budget include communication? If so, what structures and coordination mechanisms are in place for communication?
- What other structures and partnerships are needed to make communication interventions effective?

2. Communication environment analysis

A communication environment analysis describes the broader communication landscape and the socio-cultural, economic, political and geo-physical context, including:
- Current policies and plans related to demand for/uptake of RI/measles-rubella SIAs
- Anti-vaccination groups and their influence, with data if available
- Communication structures and funding at all levels
- Capacity of existing staff in communication planning, management and implementation
- Availability of communication and social mobilization expertise and institutions providing research, monitoring, evaluation and materials development
- Major supply and demand side barriers

3. Participant audience analysis

The participant audience analysis identifies and maps relevant participant groups, their characteristics, and their influences on each other to overcome barriers to the demand and uptake of measles-rubella vaccine/EPI.

Participant audiences include:
- Primary participant audiences: Mothers, fathers, caregivers and guardians of children who have not received the two doses or who received only one dose.
- Secondary participant audiences: Those who provide a supportive environment for primary audience groups to accept measles-rubella vaccinations during RI and SIAs (e.g. fathers/spouses, grandparents and other relatives, neighbours, health workers, traditional healers, community leaders, CBOs, etc.)
- Tertiary participant audiences: Government officials, health managers, donors and development partners, whose actions provide the enabling environment in national and sub-national institutions to achieve desired behaviour and social change and programme outcomes.

4. Behavioural barrier analysis

A barrier analysis should identify the following:
- The behavioural (KAP) and socio-cultural beliefs and practices that prevent the primary participant from demanding measles-rubella vaccines and completing two doses of measles-rubella vaccinations; and
- The factors at the individual, family, community and national levels that would motivate parents/guardians to demand and complete two doses of measles-rubella vaccines for their children.

Table 1 provides a list of barriers to measles-rubella immunization classified by participant audience group. Table 2 provides a barrier analysis based on behavioural barriers and other obstacles across different participant groups.

5. Channel analysis

The communication channel analysis examines the extent to which communication channels and social networks are available to the intended participant audience group, and how these are accessed and used. It also establishes channels and methods that have been used in the past, their failures and successes.

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Table 1 — Barriers to demand and uptake of measles-rubella immunization in Africa, by participant audience group / Communication for Development approach

<table>
<thead>
<tr>
<th>Individual and household – caregivers / behaviour change communication</th>
<th>Community leaders and members / community engagement / change</th>
<th>Health service delivery / IPC and counselling skills</th>
<th>Institutional and health system / capacity building</th>
<th>Partners - social mobilization</th>
<th>Policy and decision makers - advocacy</th>
<th>Communication channels - partnership and capacity building</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mistrust of vaccines</td>
<td>• Low level of understanding of value of immunization</td>
<td>• Not informing on the importance of immunization and when to return for second dose</td>
<td>• Weak health promotion and communication structure</td>
<td>• Weak coordination of social mobilization among partners</td>
<td>• Lack of health/EPI communication policy and guidelines</td>
<td>• Insufficient communication infrastructure (radio, transport, equipment, media and mobile phone ownership by mobilizers and people)</td>
</tr>
<tr>
<td>• Low level of understanding of value of immunization</td>
<td>• Poor communication skills</td>
<td>• Not well versed in measles, rubella and RI key messages</td>
<td>• Inadequate communication budget, staff and tools</td>
<td>• Weak partner commitment and participation</td>
<td>• Poor understanding and integration of communication in measles-rubella efforts</td>
<td>• Mass media, mobile technology, IEC and visibility materials not fully harnessed</td>
</tr>
<tr>
<td>• Low importance of child immunization</td>
<td>• Lack of orientation on community engagement approaches</td>
<td>• Poor IPC and counselling skills</td>
<td>• Inadequate communication capacity among partners</td>
<td>• Lack of appropriate IEC materials</td>
<td>• Communication not regarded as a priority</td>
<td>• Media practitioners lack orientation on measles and rubella issues and key messages</td>
</tr>
<tr>
<td>• Men not supportive of immunization</td>
<td>• Lack of awareness that vaccine is safe for sick child</td>
<td>• Disrespectful of clients</td>
<td>• Lack of orientation on key social mobilization approaches and messages</td>
<td>• Lack of communication capacity and training for health workers and mobilizers</td>
<td>• Communication plan not integrated into comprehensive multi-year plan, training, supervision and monitoring</td>
<td>• Inadequate IEC materials designed in local languages and appropriate to socio-cultural realities</td>
</tr>
<tr>
<td>• Low level of understanding of value of vaccination</td>
<td>• Little interest and support by community leaders</td>
<td>• Competing programmes, and oversubscribed health workers</td>
<td>• Lack of evidence-based communication strategy and costed plan</td>
<td>• Lack of communication capacity and training for health workers and mobilizers</td>
<td>• Lack of political will to allocate staff, funding and material for communications interventions</td>
<td></td>
</tr>
<tr>
<td>• Competing priorities</td>
<td>• No involvement in communication analysis, planning, implementation and monitoring</td>
<td>• Lack of IPCC and communication training</td>
<td>• Lack of appropriate IEC materials</td>
<td>• Lack of guidelines for trainings of trainers, IPCC and social mobilization</td>
<td>• Lack of evidence-based communication strategy and costed plan</td>
<td></td>
</tr>
<tr>
<td>• Wrong timing of SIA</td>
<td>• Absence of community events promoting vaccination</td>
<td>• Lack of communication capacity and training for health workers and mobilizers</td>
<td>• Communication training not integrated into health worker training</td>
<td>• Weak supervision</td>
<td>• Lack of political will to allocate staff, funding and material for communications interventions</td>
<td></td>
</tr>
<tr>
<td>• Distance to facility</td>
<td>• Lack of community ownership EPI</td>
<td>• Lack of guidelines for trainings of trainers, IPCC and social mobilization</td>
<td>• Weak supervision</td>
<td>• Weak information network and feedback at all levels</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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13 Based on a document review of barriers to communication from countries: Eritrea (2015); Lesotho (2015); Madagascar (2014); Somalia (2011); Tanzania (2013); Uganda (2011); Zambia (2013); Zimbabwe (2015).
### Table 2 — Example of a behaviour analysis on measles-rubella immunization

<table>
<thead>
<tr>
<th>Participant audience</th>
<th>Existing behaviour</th>
<th>Desired action/behaviour change</th>
<th>Barriers</th>
<th>Enablers/facilitators</th>
</tr>
</thead>
</table>
| Mothers, caretakers, guardians | • Not aware of immunization schedules  
• Do not appreciate importance of immunization | • Knows full immunization schedule  
• Takes children according to schedule | • Demand side:  
• Poor knowledge  
• Mothers too busy  
• Lack family support  
• Service side:  
• Vaccination posts - not accessible, too far, working hours  
• Supply side:  
• Vaccines not always available | • Presence of community health volunteers, health committees, mothers' support groups, role models  
• Caretakers trust vaccines; confident in programme |
| Fathers | • Inadequate knowledge of immunization schedules  
• Hesitate to take child for vaccination | • Can state vaccination schedule  
• Help take children for vaccination | • Perception that vaccination is woman's responsibility | • Men attend community meetings  
• Men have access to mass media |
| Health workers | • Too busy to educate people.  
• Mother's perception that health workers do not treat poor people with respect | • Explain to mothers and guardians about importance of vaccination  
• Health workers treat people with respect | • Poor communication skills  
• Heavy workload | • Have knowledge about EPI and vaccine schedule  
• Can explain importance of immunization |
| Community health volunteers | • Not always available to mobilize communities for vaccination  
• Community health volunteers go house-to-house;  
• Mobilize/organize activities with communities  
• Practice good IPC | • Supply side:  
• Community health volunteers expect to be paid  
• Conflicting priorities  
• Lack of transportation for house-to-house visits | | • Community health volunteers can convene community meetings  
• Perceived as credible and trustworthy  
• Skills in community mobilization  
• Budget for meals and transport |
**STEP 2. Design the strategic communication plan**

**Formulate goals and objectives**
To achieve your communication goal, define objectives for advocacy, communication and institutional capacity building. The communications objectives and desired behavioural outcomes form the basis of the indicators used to monitor programme progress from the KAP baseline. The same indicators will be used to evaluate the outcome.

**Establish SMART communication objectives**
Communication objectives should be SMART: specific, measurable, attainable, relevant/realistic and time bound. After formulating SMART objectives based on the country context, determine strategic communications approaches and activities based on the desired actions/behavioural objectives (see Table 3). Involve stakeholders in deciding on the most culturally appropriate, relevant and preferred communication activities.

### Table 3 — Behaviour objectives for measles-rubella RI and SIA, by audience group and communication approach

<table>
<thead>
<tr>
<th>Participant audience group</th>
<th>Desired actions</th>
<th>Communication approach and activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers, fathers, caregivers, guardians, extended family members</td>
<td>• Complete their children's two-dose measles-rubella immunization schedule</td>
<td>Behaviour change Communication</td>
</tr>
<tr>
<td></td>
<td>• Bring children for measles-rubella immunization during RI and SIAs</td>
<td>• Using interpersonal /all relevant channels,</td>
</tr>
<tr>
<td></td>
<td>• All other supportive behaviour</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Community leaders, CBOs, mother support groups, village health management committees</strong></td>
<td><strong>Community engagement/ social change communication</strong></td>
</tr>
<tr>
<td></td>
<td>• Explain during community events and gatherings the importance of measles-rubella vaccines and EPI – that these are safe and provide effective protection against diseases</td>
<td>• Community dialogues, traditional celebrations and special national and local events</td>
</tr>
<tr>
<td></td>
<td>• All other desired actions as informed by the formative study</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Health workers, vaccinators, community health volunteers, supervisors, health practitioners</strong></td>
<td><strong>Community engagement</strong></td>
</tr>
<tr>
<td></td>
<td>• Demonstrate good IPC, counselling and social mobilization skills in their delivery of immunization and other health delivery tasks</td>
<td>• Using IPC supported by IPC tools/IEC materials (e.g. flip charts, leaflets, posters, wall charts handbooks, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Explain benefits of measles-rubella vaccine and immunization to parents/ guardians and families</td>
<td>• Other channels as informed by the channel analysis</td>
</tr>
<tr>
<td></td>
<td><strong>Religious leaders, faith-based organizations, CSOs, NGOs, local government authorities, business sector, school officials, partners in EPI</strong></td>
<td><strong>Social mobilization</strong></td>
</tr>
<tr>
<td></td>
<td>• Promote measles-rubella vaccine/EPI during constituent assemblies and informal discussions</td>
<td>• Using IPCC, assemblies, media interviews, supported by IEC materials (e.g. fact sheets, leaflets, posters, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Counter community resistance and any loss of confidence due to AEFI</td>
<td></td>
</tr>
</tbody>
</table>
**Implementation modalities**

Using evidence from the formative research, prepare the communication plan using six implementation modalities. Determine specific milestones and activities under each of the modalities and include these in the detailed implementation plan and timeline (see Figure 4 and Annex 2.4).

| Planning and coordination | • Form inter-agency and partner coordination mechanism  
• Establish communication management and oversight  
• Establish measles and rubella brand image and recognition scheme  
• Launch SIA at national and district levels  
• Establish task forces for communication modalities |
| --- | --- |
| Advocacy and partnership | • Generate high level national political commitment  
• Develop laws, policies and allocate resources  
• Generate multi-sectoral partnerships  
• Generate commitment at district and community levels |
| Capacity strengthening | • Train district health workers on IPCC (training of trainers and cascade training to community health volunteers)  
• Cascade train community health workers and health volunteers/mobilizers on IPCC  
• Orient partners and leaders on social mobilization  
• Brief media on child-friendly and gender-sensitive reporting |
| Media engagement | • Carry out media blitz pre-SIA and at SIA launch  
• Sustain coverage during SIA, post-SIA and during RI  
• Develop PSAs, spots, plugs, jingles and entertainment education for radio, TV, social media and SMS  
• Engage and utilize IPC, traditional, mass and social media  
• Develop, pre-test and use IEC messages and materials |
| Planning and coordination | • Conduct house-to-house visits by community health volunteers to promote SIA demand and uptake of MCV1, MCV2 and RCV and monitor obstacles  
• Community leaders and groups organize community events  
• Mother support groups, schools, other community networks and local media participate in SIA promotion and launch |
| Social mobilization | • Mobilize religious leaders and influencers  
• Mobilize educational institutions  
• Mobilize partners to reach hard-to-reach groups  
• Engage girl and boy scouts, and schoolchildren to promote measles-rubella vaccination  
• Mobilize the private sector |

**Figure 4** — Communication implementation modalities and examples of activity for measles-rubella SIA campaign
STEP 3. Develop campaign theme, messages and materials

Creative approaches, channels and media

Entertainment education involves incorporating educational messages into popular entertainment content – such as radio, television, cartoons, popular music, street theatre, puppetry, storytelling, poetry, comic books and other formats – to raise awareness, create favourable attitudes and encourage responsible action. In Africa, entertainment education formats, notably the ‘Soul City’ television soap opera series, have encouraged people to live healthier lives. Some of the episodes in this series showcased immunization issues.

Box 9. Good practice from Madagascar: Tapping local talents for entertainment education and social mobilization

In Madagascar, community health workers trained in IPC by UNICEF conduct essential and effective outreach to families. The health system in Madagascar relies on community health workers their social mobilization activities to lay the groundwork for immunization and hygiene campaigns. These campaigns are also supported by local artists, who use their fame to disseminate key health messages.

The community health worker programme is an essential pillar of a wider social mobilization programme that UNICEF and partners are running in Madagascar. Other components of the programme include carnivals, discussions on local radio stations and concerts.

Guidelines for selecting, designing and producing IEC materials

Design communication materials to reinforce IPC, social mobilization, community engagement and mass communication efforts. Use IEC materials as part of a mix of channels to support awareness raising, understanding, acceptance and completion of two doses of measles-rubella vaccines.

1. Select the most appropriate type of IEC material for the audience

Types of IEC materials:

- Print, graphics and audiovisual materials: flyers, handbills, leaflets, brochures, handbooks, Q&As, frequently asked questions, charts and graphs, flipcharts, posters, infographics, display boards, vinyl displays, banners, billboards and hoardings, PowerPoint presentations, video and audio products and various training tools.
- Digital media and information and communication technology products: audio and video recordings of public service announcements, dramatized spots and plugs, and documentary features for dissemination via radio, television and the Internet via email, websites, YouTube, social media platforms and mobile phones.

Select the most appropriate IEC materials for the specific participant audience group based on evidence generated during formative research. Pre-test the material with a sample of the intended audience to answer the following questions and adapt message positioning, format and style accordingly:

- Are the materials appropriate to the audience’s written literacy and educational level (in the case of leaflets and handbooks) and visual literacy level (in the case of flipcharts, display boards, posters and banners)?
- Are there any culturally-specific values, beliefs and norms that may influence the acceptance of the design and the way the message is framed?
- What are the audience’s impressions or experiences of past EPI/health promotion materials and processes?


14 Singhal, Arvind and Everett Rogers, Entertainment Education: A communication strategy for social change, Routledge, 6 December 2012.
2. Determine production costs and logistical requirements
Materials can be costly and/or time consuming to design and produce. Some materials may require creative designers and other professional expertise or production equipment. Materials also have varying logistical demands, with some requiring more time and effort to distribute, deliver or disseminate.

3. Develop a creative brief
The creative brief serves as a link between the formative research and the development of audience-appropriate IEC materials. The creative brief should cover the following elements: participant audience, communication objective, barriers, key message/advice, supporting statement, tone and creative considerations.

4. Design the draft or prototype
When designing new IEC materials or customizing existing materials, answer the following questions:
• Does it fit the audience’s learning style?
• Is the content presented in a short, simple and organized manner?
• Are culturally relevant values represented?
• Are visuals, images and photographs culturally relevant and realistically represented?
• Is text written at an appropriate comprehension level?
• Is the text believable/credible to the audience?
• Is the format inviting, visually appealing and easy to follow for low literacy audiences?

5. Pre-test the prototype or the customized IEC material
Pre-test the draft material, concepts, messages and design with a representative sample of the intended audience before finalization and production. The pre-test measures five characteristics of the IEC materials: comprehension, attractiveness, acceptance, involvement and inducement to action (see Annex 2.10).

STEP 4. Implement and monitor

Prepare a costed implementation plan
When the communication strategy is finalized, prepare an implementation plan, with a schedule of activities and benchmarks to monitor progress. Include a description of the programme management tasks with partner roles and responsibilities. Prepare a line-item budget estimate that includes consultant and institutional contract costs (see Table 4).

Table 4 — Communication functions and costs to consider for budget planning

<table>
<thead>
<tr>
<th>Function</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Formative research</td>
<td>Staff time, consultants and/or subcontractors, other direct costs (per diem, lodging, travel expenses, fuel and other misc. travel expenses), administrative costs (office supplies, renting or purchasing computers and other misc. equipment, communications and office space).</td>
</tr>
<tr>
<td>2. Strategy formulation</td>
<td>Staff time, consultants, per diem, lodging and other related travel expenses, meeting room rental, supplies (e.g. paper, rental or purchase of computers, projectors and other equipment).</td>
</tr>
<tr>
<td>3. Development of IEC materials</td>
<td>Staff time and consultant time (e.g. for writing, creative design, photography, word processing/editing), distribution costs (postage, fuel, staff time).</td>
</tr>
<tr>
<td>(for all participant audience groups)</td>
<td></td>
</tr>
<tr>
<td>4. Development and airing of mass media/broadcast materials</td>
<td>Staff time and consultant time (managerial, creative and technical input), subcontractors (advertising and marketing firms) and airtime and other technologies (SMS).</td>
</tr>
</tbody>
</table>

**Prepare a monitoring plan**

Monitoring is carried out during implementation to determine whether planned communication activities are on track and are effectively engaging audiences toward desired behavioural responses. Monitoring efforts should:

- Track the proper and timely use of resources;
- Measure and document what has been accomplished at different stages of the programme;
- Determine whether the activities have been effective so far;
- Determine to what extent mothers/caregivers are increasing demand/uptake of measles-rubella vaccines for their eligible children; and
- Determine whether adjustments need to be made during implementation.

The indicators for monitoring and evaluating communication outcomes should be integrated into the SIA monitoring and evaluation plan (see Table 5).

<table>
<thead>
<tr>
<th>Function</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Development of local creative treatments and channels (e.g. drama groups, mosque announcements, etc.)</td>
<td>Staff time and consultant time (managerial, creative and technical input), cost of subcontractors and/or of ongoing expenses (per diem, travel, etc.), equipment purchase or rental.</td>
</tr>
<tr>
<td>6. Pre-testing of materials</td>
<td>Staff and consultant time and expenses (per diem, lodging, travel) and/or subcontractors, supplies (e.g. paper, video equipment, tape recorders or other required technologies).</td>
</tr>
<tr>
<td>7. Production and distribution of materials, hoardings</td>
<td>Printing, audio and video recording and production and distribution/posting of billboards, panels and banners.</td>
</tr>
<tr>
<td>8. Training in IPCC, communication, social mobilization or advocacy</td>
<td>Staff and consultant time and/or subcontractors for planning, implementing and evaluation, meeting with and training of health staff, local leaders, journalists, etc., per diem and expenses of participants, training facilities and equipment rental, development and production of training tools.</td>
</tr>
<tr>
<td>9. Implementation of advocacy, social mobilization, community engagement</td>
<td>Incentives, allowances for volunteers for meals and transportation, meeting costs, fuel, supplies and materials.</td>
</tr>
<tr>
<td>10. Monitoring and evaluation; (routine monitoring and special studies) of advocacy, social mobilization, community engagement and behaviour change communication efforts; preparing reports and presentation materials</td>
<td>Staff and consultant time (e.g. for planning, implementing, data processing and development of presentation materials and reports), per diem, lodging, and travel expenses, fuel and admin/communications costs, supplies (documents).</td>
</tr>
<tr>
<td>11. Documenting good practices and lessons learned</td>
<td>Staff and consultant time (e.g. for planning, field research, writing and audio and visual documentation), per diem, lodging and travel expenses, fuel and admin/communications costs, supplies (documents).</td>
</tr>
</tbody>
</table>
Use a participatory approach to monitoring and evaluation to strengthen the ownership and capacity of communities and stakeholders in all stages of the measles-rubella vaccination/EPI programme. Participatory behaviour monitoring tools include: transect walks and community mapping, social networking, oral histories and storytelling, health facility surveys and direct observation.

**Communication Indicators**
*Possible data sources:* Work plans, financial documents, program reports, program reviews, and assessments:

1. **% of caregivers aware** of MR campaign prior to arrival of vaccinators
   - at least 90% nationally & 80% in high risk areas

2. **Sources of information about SIA** in high-risk areas and nationally
   - % reached through mass media (TV, radio, newspapers, etc.)
   - % reached through loudspeaker announcements or local media
   - % reached through health service workers
   - % reached through community / interpersonal sources (local leader, neighbor, family member, etc.)
   - % reached through social media

---

**Table 5 — Planning template for monitoring and evaluation of measles-rubella vaccine/EPI communication**

<table>
<thead>
<tr>
<th>Desired behaviour outcome (based on SMART objective)</th>
<th>One year after participating in measles-rubella vaccination/EPI by (target date), mothers/caregivers/guardians in hard-to-reach district A report completing their children’s two-dose measles-rubella immunization schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target (%)</td>
<td>100</td>
</tr>
<tr>
<td><strong>Indicator</strong></td>
<td><strong>Monitoring</strong></td>
</tr>
<tr>
<td></td>
<td>- Proportion of mothers who state completion of two doses of measles-rubella vaccine</td>
</tr>
<tr>
<td></td>
<td>- Proportion of mothers who state they trust measles-rubella vaccines to protect their children</td>
</tr>
<tr>
<td></td>
<td><strong>Evaluation</strong></td>
</tr>
<tr>
<td></td>
<td>- Proportion of children under 5 who completed two doses of MCV</td>
</tr>
<tr>
<td></td>
<td>- Caregivers’ sources of information about measles-rubella SIA/RI</td>
</tr>
<tr>
<td>Data source</td>
<td>Caregivers</td>
</tr>
<tr>
<td>Data gathering method</td>
<td>Survey, key informant interviews, community health volunteer text messages to community health workers, district health officer</td>
</tr>
<tr>
<td>Person in charge</td>
<td>Community health volunteers, health workers, district health officer</td>
</tr>
<tr>
<td>Budget</td>
<td>$ per district</td>
</tr>
</tbody>
</table>
**Document good practices and lessons learned**

Document good practices in writing, photographs, video and audio recordings for review, sharing and adaptation or replication. These documents will prove useful to mobilizing resources from donors, fostering stronger collaboration with partners and media, and strengthening cooperation with primary stakeholders during community gatherings.

- **Good/best practices** are documented and assessed programming practices that provide evidence of success/impact in using a combination of programme elements (supply side) and participatory communication elements (demand side) in planning, implementing and monitoring measles-rubella vaccination/EPI.

- **Lessons learned** are detailed reflections of positive or negative lessons from implementing community level strategies and media engagement when communicating about a given health intervention such as measles-rubella vaccination/EPI over a given period of time. Lessons can form the basis of future planning and be shared with other groups who intend to undertake similar programming.

**STEP 5. Assessment**

An assessment is a lighter form of evaluation and tries to answer the questions: what happened, were the objectives achieved, and why? Assessment helps to determine whether the communication plan is achieving the intended results, increasing demand for measles-rubella vaccination, and reaching over 95 per cent coverage. In so doing, it facilitates decisions on which aspects of the communication strategy can be improved or adjusted and helps to identify any emerging areas for future communications strategies to address.

The impact and outcome of communication efforts are tied to other measles-rubella programme indicators. Communication outcome indicators must therefore be included in the programme evaluation. Table 5 provides a template for monitoring and evaluation of measles-rubella EPI communication and sample evaluation indicators. Figure 5 gives a sample of Nigeria’s post-SIA campaign evaluation of caregivers’ information sources about the campaign.


---

**Figure 5** — Post-SIA evaluation: sources of information on Measles Vaccination Campaign among caregivers in Nigeria, 2015 (%) (N=14,064)
Part 2
Annexes
Annex 2.1
Checklist for communication management

☐ Do you have a communication coordination group in place to support measles-rubella SIA and RI at the national and subnational levels?

☐ Are the terms of reference spelled out at the national and subnational levels?

☐ Is there a structure, designated staff and budget for EPI communication in partner agencies?

☐ Is there a full-time communication professional assigned to manage and oversee communication?

☐ Are there dedicated staff assigned for day-to-day demands related to communication situation analysis, planning, implementation, documentation, monitoring, evaluation and media relations?

☐ Is funding secured for management, coordination and implementation of the measles-rubella Communication for Development strategy?

☐ Are funds allocated for contracting out the following (assuming low internal capacity):
  ☐ Development of communication strategy and costed implementation plan
  ☐ Design of communication training and orientation modules/materials
  ☐ Development, pre-testing and dissemination of materials and media products
  ☐ Formative research, monitoring and evaluation and report writing
  ☐ Case study writing of good practices and lessons learned
  ☐ Others __________________________

☐ Has training needs assessment been conducted among frontline health workers, communication staff and partners?

☐ As a result of the training needs assessment, have session plans and training materials been prepared?

☐ Are training/orientation modules available elsewhere for customization?

☐ Have potential consultants/contractors or resource persons been identified for the design and execution of specific phases of the communication strategy:
  ☐ Communication situation analysis/formative research
  ☐ Creative materials development, pre-testing and production
  ☐ Effective communication/IPC training and media orientations
  ☐ Monitoring process, outputs and behaviour outcomes and evaluating results
  ☐ Documenting good/best practices and lessons

☐ In case of an outbreak, are you prepared with a risk communication plan?

☐ In case of AEFI, are you prepared for crisis communication?

☐ Have you identified and trained spokespersons for measles and rubella at national and subnational levels?

☐ Are talking points and scripts prepared for them?

☐ Do you have a communication management plan with assigned tasks on the above?
Annex 2.2
Checklist for communication planning

A. Communication situation analysis/formative research (Part 2)

☐ 1. Has a communication situation analysis been conducted? Do you have secondary data? What baseline data do you need for communication planning?
☐ 2. What are the main supply-side programme outcome issues and demand-side problems that communication seeks to address?
☐ 3. Have you mapped the key participant audience groups for measles-rubella RI?
☐ 4. From formative research, have you done a behaviour analysis for each participant group?
☐ 5. Have you done an analysis of interpersonal, traditional, mass media and information and communication technology channels, including entertainment education and IEC materials (channel analysis)?

B. Communication strategy development (Part 2)

☐ 1. Have you prepared matrices for strategy development? Macro and micro implementation planning? List of items for budget planning?
☐ 2. Have you defined behaviour outcome objectives or desired actions (know, feel and do) for each participant audience group as primary, secondary and tertiary target?
☐ 3. What are the communication objectives in terms of specific communication actions?
☐ 4. What are the key messages for specific participant groups?
☐ 5. Based on formative research, what are appropriate communication channels and IEC materials to support advocacy, social mobilization, community engagement and desired behaviour and social change?

☐ 6. Is there plan to pre-test IEC materials? What pre-testing tools and protocols are in place?
☐ 7. Have you prepared a dissemination/distribution plan for the communication/IEC materials?
☐ 8. Have you prepared a media and information and communication technology plan? Does the plan include social media mobile phones?

C. Planning implementation and monitoring

☐ 1. Do you have a worksheet/template for implementation planning?
☐ 2. Based on evidence, what milestones and activities have been determined for advocacy; social mobilization and community engagement; social and behaviour change; media engagement; creative development of key messages, channels and media; and the use and dissemination IEC materials?
☐ 3. Who will take responsibility for each activity? Which partners have committed?
☐ 4. Does the plan include indicative costs, indicators and means of verification for each activity?
☐ 5. Is there a behaviour monitoring plan to track behaviour outcomes by participant audience group?
☐ 6. Is there an implementation monitoring plan to track process indicators and means of verification?
Annex 2.3
Key elements/outline of communication strategy document

1. Situation analysis

Purpose: What is the health situation that the programme is addressing and why?

Key health issue/programme and problem analysis: What are the behaviour and social changes at different participant levels that need to occur in order for the health and measles-rubella/EPI situation to improve?

Context/communication environment: How does the programme context – social, cultural, religious and political – affect the health and measles-rubella/EPI situation?

Barrier analysis: What does the analysis show in terms of demand side barriers/obstacles and supply bottlenecks, and communication opportunities to achieve intended behaviour and social change outcomes? How can these be addressed through communication?

Communication analysis/formative research: What direction does your formative research and baseline KAP point to for addressing the health behaviour and social change issues in communities?

Participant audience analysis

Behaviour analysis

Channel analysis: What information is missing that may limit your ability to develop an evidence-based, inclusive and participatory strategic communication plan? How will gaps be addressed prior to implementing the strategy?

2. Communication strategy for addressing multiple Social Ecological Model levels

A. Intended populations/participant audience groups

B. SMART objectives

C. Strategic communication approach and entry points based on barriers and opportunities

D. Key messages for each participant audience group

E. Creative strategy: channels, media, entertainment education and IEC tools

3. Programme implementation, management and monitoring

A. Coordination mechanisms and partner roles and responsibilities

B. Implementation plan, including timeline, responsibilities and estimated costs

C. Monitoring plan and tools, including timeline and responsibilities

D. Budget

4. Evaluation

A. Evaluation plan, including timeline and responsibilities

B. Reporting and documenting good practices and lessons, including dissemination plan
## Annex 2.4

**Sample template for developing costed communication implementation plan**

### Annex 2.6 — Sample template for developing a costed communication implementation plan for MR elimination programme 2016-2020

<table>
<thead>
<tr>
<th>Activity / Level</th>
<th>Activities</th>
<th>Expected outcome</th>
<th>Timeline</th>
<th>Responsible</th>
<th>Estimated Budget</th>
<th>Source of funds</th>
<th>Process indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Communication situation analysis and formative research</strong></td>
<td>Desk review of data —</td>
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<tr>
<td></td>
<td>KAP study (if no baseline data)</td>
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<td></td>
<td>Formative research — mapping HTR, barriers, channels</td>
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<td>Budget Sub-Total — A</td>
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<tr>
<td><strong>B. Communication Strategy Development — RI; SIA</strong></td>
<td>National</td>
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<td>Provincial / District</td>
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<td>Budget Sub-Total — B</td>
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<tr>
<td><strong>C. Planning for Advocacy for RI; SIA</strong></td>
<td>National</td>
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<td>Budget Sub-Total — C</td>
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<tr>
<td><strong>D. Social Mobilization for RI; SIA</strong></td>
<td>National</td>
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<td>Provincial / District</td>
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<td>Community</td>
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<tr>
<td></td>
<td>Mass media</td>
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<td>Budget Sub-Total — D</td>
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</table>
### Part 2: Communication technical guidelines

**Effective Communication for Measles and Rubella Elimination in the African Region**

<table>
<thead>
<tr>
<th>Activity / Level</th>
<th>Activities</th>
<th>Expected outcome</th>
<th>Timeline</th>
<th>Responsible</th>
<th>Estimated Budget</th>
<th>Source of funds</th>
<th>Process indicators</th>
</tr>
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<tbody>
<tr>
<td><strong>E. Community Engagement for Behaviour and Social Change Communication</strong></td>
<td>District</td>
<td></td>
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<tr>
<td>Community</td>
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<td>Family</td>
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<td></td>
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</tr>
<tr>
<td>Interpersonal / group communication</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mass media: national / subnational</td>
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<tr>
<td>Use of mobile technology, production, printing and distribution of IEC materials</td>
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<td></td>
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<tr>
<td>Creative media design, pretesting, production, printing and distribution of IEC materials</td>
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</table>

**Budget Sub-Total — E**

<table>
<thead>
<tr>
<th><strong>F. Capacity building</strong></th>
<th>Activities</th>
<th>Expected outcome</th>
<th>Timeline</th>
<th>Responsible</th>
<th>Estimated Budget</th>
<th>Source of funds</th>
<th>Process indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Supervisors, HW and CHV in key messages on IPC and counseling, CE</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Orientations: Spokespersons, champions, media and implementers</td>
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<td></td>
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</tbody>
</table>

**Budget Sub-Total — F**

<table>
<thead>
<tr>
<th><strong>G. Monitoring and evaluation</strong></th>
<th>Activities</th>
<th>Expected outcome</th>
<th>Timeline</th>
<th>Responsible</th>
<th>Estimated Budget</th>
<th>Source of funds</th>
<th>Process indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior (Outcomes) Monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Implementation (Activities) Monitoring</td>
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</tr>
<tr>
<td>Evaluation / PIE</td>
<td></td>
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<tr>
<td>Writing good practices and lessons</td>
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</tr>
</tbody>
</table>

**Budget Sub-Total — G**

**Total (estimated budget)**
### Annex 2.5

**Sample specifications for some IEC materials**

<table>
<thead>
<tr>
<th>IEC material</th>
<th>Printing specifications</th>
<th>Description/suggested use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Poster</strong></td>
<td>Colour: four colours throughout</td>
<td>• For best visibility and impact in public places, poster size 29x38 inches</td>
</tr>
<tr>
<td></td>
<td>Size: 19x29 inches</td>
<td>• Display in places of maximum visibility. For good readability, keep the lowest edge of</td>
</tr>
<tr>
<td></td>
<td>Paper: chromo art paper 170 gsm for indoor long-term display and in areas protected from</td>
<td>not lower level about 3 ft. from the ground.</td>
</tr>
<tr>
<td></td>
<td>sun and rain. For bulk printing of posters for outdoor display, use 95-100 gsm</td>
<td>• Ensure that large posters are displayed at covered places where many people gather</td>
</tr>
<tr>
<td></td>
<td>For superior quality indoor displays for longer period, use 170 gsm with matte finish.</td>
<td>such as at waiting rooms of hospitals, bus and train stations, etc.</td>
</tr>
<tr>
<td></td>
<td>Fabrication: Cut to size</td>
<td>• Distribution: Determine number of health facilities, community centres, schools, etc.</td>
</tr>
<tr>
<td></td>
<td>Quantity: [XX] pieces</td>
<td>and specify mode of distribution (who, how, where, by when, etc.)</td>
</tr>
<tr>
<td></td>
<td>Approximate Cost: [XX]</td>
<td></td>
</tr>
<tr>
<td><strong>FAQ brochure</strong></td>
<td>Colour: 2-4 colours throughout</td>
<td>• Distribution: Determine advocacy, social mobilization and training events – where,</td>
</tr>
<tr>
<td></td>
<td>Open size: 8.25 inches x 11.7 inches (A4)</td>
<td>when, per district [X] number of districts + national events, [X] number of users.</td>
</tr>
<tr>
<td></td>
<td>Closed size: 8.25 inches x 5.7 inches</td>
<td>Specify mode of distribution (who, how, where, by when, etc.)</td>
</tr>
<tr>
<td></td>
<td>Pages: 4-6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paper: 170 gsm - matte finish;</td>
<td>• Determine strategic placement locations where visibility is highest (e.g. national</td>
</tr>
<tr>
<td></td>
<td>Fabrication: cut to size, centre, stapled, coated</td>
<td>highway, district intersection). Determine monthly placement cost. Contract company to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>do placement services to mount and dismount.</td>
</tr>
<tr>
<td><strong>Hoarding/billboard</strong></td>
<td>Colour: four colours throughout</td>
<td>• Distribution: Determine number of health facilities, community centres, schools, etc.</td>
</tr>
<tr>
<td></td>
<td>Size: use 1 x 2 ratio - 8x16 ft.,10x20 ft. or 12x24 ft., etc.</td>
<td>+ national centres. Specify mode of distribution (who, how, where, by when, etc.)</td>
</tr>
<tr>
<td></td>
<td>Medium: can be painted on tin sheets or digitally printed on vinyl and mounted on wooden</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or metal frames</td>
<td></td>
</tr>
<tr>
<td><strong>Cloth or vinyl banners</strong></td>
<td>Material: Soft sheeting fabric without starch, 100% cotton or vinyl</td>
<td>• Distribution: Determine number of health facilities, community centres, schools, etc.</td>
</tr>
<tr>
<td></td>
<td>Ready: 17 inches x 72 inches with 3 ft. border on each side to be sewed on 17 inch side</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fabric weight: 110 gms per sq. m</td>
<td>+ national centres. Specify mode of distribution (who, how, where, by when, etc.)</td>
</tr>
<tr>
<td></td>
<td>Colour: fastness to water</td>
<td>Specify responsible health worker who will mount them, where and by when.</td>
</tr>
<tr>
<td></td>
<td>Cloth tensile strength: 120 N, Tear strength: 6N</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Printing: two columns, single side text and visuals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amount: [XX] banners</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approximate cost: [XX]</td>
<td></td>
</tr>
<tr>
<td><strong>Press/print advertisement</strong></td>
<td>Two different size options for press ads:</td>
<td>• Useful in urban areas with low vaccination coverage, high literacy and subscription</td>
</tr>
<tr>
<td></td>
<td>1. Horizontal (half page, 200 column – 25x33 cm)</td>
<td>• May be released in both national level and district level, may be repeated a number of</td>
</tr>
<tr>
<td></td>
<td>2. Vertical (quarter page, 100 column – 25x16 cm)</td>
<td>times. Use both colour and black and white ads.</td>
</tr>
</tbody>
</table>

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Annex 2.6
Example of three-hour session on strengthening IPCC in measles-rubella SIA training

Objectives of the session:
At the end of the session, participants should be able to:
• Explain the principles and importance of IPCC in the measles-rubella/EPI programme
• Describe the desired communication interaction between a health worker and a caregiver (card exercise)
• Apply the exercise and role plays that illustrate good and bad IPCC in their future training
• Demonstrate the qualities of a health worker with good IPCC skills (see Annex 2.10).

Exercise 1. Roles that health workers play as communicators in the measles-rubella/EPI programme

Time: 20 minutes

Materials: Flipboard paper, different coloured marker pens, blank coloured 3x6 inch cards, tape, board pins

Facilitation technique:
Task 1. Divide participants into small groups of three or in pairs depending on the size of the plenary. Ask them to identify the role of IPCC in the measles-rubella/EPI programme. Give participants three coloured blank cards each and ask them to write three responses to the following questions with the word "to" on individual cards, to be collected and read by the training facilitator in a plenary session. Cluster the cards on the board. They will be used later in the session.
1. As a health worker, what communication actions to you take at the community level to help the measles-rubella/EPI programme achieve its objectives?
2. What communication efforts do you undertake to increase demand among mothers and caregivers for two doses of measles-rubella and other vaccines for children?
3. What communication activities can you use to mobilize husbands, village opinion leaders and religious leaders to promote immunization and help improve the health and well-being of their constituents?

Task 2. In plenary, break IPC down into the two types: one-on-one communication and group communication. Write the words (one-on-one and group discussion) on blank coloured cards and post with masking tape or pins on a clean board. Help participants reach consensus on a definition for each type:
• One-on-one: communication or exchange of information, ideas and feelings between two people
• Group discussion: interaction among three or more people

Facilitator’s notes:
Task 3. Ask the participants how they would use these two types of communication to fulfil the roles generated during Task 1. Take each ‘role of communication’ card and have participants agree whether it is best done through one-on-one communication, group discussion or both. Place the card under the appropriate heading. If some roles can use both methods, place a third heading entitled ‘both’ and place it between the two headings ‘one-on-one’ and ‘group’. At the end of the session, the cards should be in three clusters.

Past session answers to the role of health worker as communicator: (facilitator may prepare flash cards and add to appropriate headings)
• Provide correct information for mothers about vaccines during home visit
• Undertake rumour control about vaccines and AEFI in mother groups
• Convince local authorities to influence communities to demand RI services
• Raise awareness about good hygiene and sanitation practices with mothers
• Promote the adoption of a new vaccine as part of RI
• Bring the views of the community to district health offices so that they are integrated into the objectives and activities of RI and SIAs
• Encourage mothers to breastfeed their babies exclusively until six months
• Demonstrate to mothers how to prepare nutritious complementary food
• Engage community leadership so that they support EPI objectives

• Help improve the relationship between the vaccinators and community members
• Find out what motivates mothers to bring their children to health centres
• Serve as a link between communities and service delivery
• Identify who and where are the hard-to-reach and underserved members
• Facilitate the identification of poor, underserved and marginalized members who do not take advantage of RI services
• Play supportive and problem solving roles
• Link with community and religious activities to invite and remind mothers of RI schedules and health practices through announcements
• Facilitate a process whereby the community to assesses and analyses the situation and prepares an action plan
• Monitor the implementation of the community action plan/annual plan for EPI
• Identify gaps and reasons behind them
• Work with district and community health authorities to adjust health education priorities and activities

Exercise 2. Role play: Good and bad IPC
The following role play demonstrates an exchange between a health worker and a mother/caregiver and highlight some common communication challenges. After participants play both scenarios, ask them to consider the quality of the communication and then review the communication checklist of effective health worker IPC skills.

Scene 1: The health worker (HW) and Mom Alma
— HW: Baby Jonas! (shouts towards the row of seated women) ...Baby Jonas!!
— Alma: Yes Nurse? (she stands up and moves towards the procedure table with her baby)
— HW: Don’t you listen? Why do you come here then? Show me your card!
— Alma: (Becomes uncertain of what to do and stands in front of the procedure table)
— HW: Just sit down! Don’t waste my time; I have many children for immunization today.
— Alma: (Sits down and gets her baby ready for injection)
— HW: (Writes on the card and then gives the baby an injection without any regard for the baby or the mother. Writes on papers on his desk, ignoring the mother) 
— HW: Look, are you stupid? Give me your card. See? Everything is in this card. You have to be reading this card properly and make it your Bible or Qur’an. You see I have already marked the injection I gave your baby on the card and the day and date you should return for the next vaccination. The card contains the immunization schedule as follows (head down, he reads the information from the card as rapidly as possible).
— Alma: Please Nurse...
— HW: Madam! No questions. You are wasting my precious time. I have told you that I am always very busy in this clinic. Who’s next? Baby James!

Interpersonal communication and counselling checklist for measles-rubella/EPI sessions
→ Greet the mother/caregiver and congratulate her for bringing her child. Make her feel welcome and maintain a pleasant disposition.
→ Ask the mother for the child’s vaccination card:
  If the mother has a card:
  → Thank the mother for bringing the card and remind her that it is valuable and to bring at each visit.
  → Check the child’s health card to see which immunizations he or she should receive during the visit.
  If the mother has no card:
  → Do not scold a mother for not having a card.
  → Issue the mother a new card and tick off the immunizations that she reports the child already has.
→ Explain that the card is valuable, should be kept safe, and brought to each visit.
→ Always explain to the mother what disease(s) the vaccine will prevent. Encourage them to ask questions.
→ Address concerns about immunization immediately by correcting any misconceptions (e.g. if a woman believes false rumours that a vaccine is a contraceptive). Talk to her about this first.
→ Explain possible side effects and how to manage them. If the mother knows to expect side effects – for example a slight fever from a particular vaccine – she will not be frightened by the child’s discomfort and will more likely return for the next immunization.
→ Inquire whether and when the mother has received the tetanus toxoid vaccine to protect herself and her future newborn babies from tetanus.
→ Encourage the mother to bring her child to complete the full series of scheduled vaccinations before her child’s first birthday so that her child will be protected against the seven dangerous diseases and receive a vaccination diploma.
→ Remind her to keep herself healthy, breastfeed exclusively and practice good sanitation for herself and her family.
→ Write down and remind the caregiver the place, day and date for the next immunization and vitamin A supplementation.
→ Check for recall of next visit. Ask the mother when she will return for the next immunization session and thank her.
Annex 2.7
WHO format for writing a best practice case study

1. **Title of the best practice**: This should be concise and reflect the practice being documented.

2. **Introduction**: This should provide the context and justification for the practice and address the following issues:
   - What is the problem being addressed?
   - Which population is being affected?
   - How is the problem impacting the population?
   - What were the objectives being achieved?

3. **Implementation of the practice**
   - What are the main activities that were carried out?
   - When and where were the activities carried out?
   - Who were the key implementers and collaborators?
   - What were the resource implications?

4. **Results of the practice – outputs and outcomes**
   - What were the concrete results achieved in terms of outputs and outcomes?
   - Was an assessment of the practice carried out? If yes, what were the results?

5. **Lessons learned**:
   - What worked really well?
   - What facilitated this?
   - What did not work and why?

6. **Conclusion**
   - How have the results benefited the population?
   - Why is that intervention considered a best practice?
   - What are the recommendations for those intending to adopt the documented best practice? How can it help people working on the same issue(s)?

7. **Further reading**

**Notes**: The write-up should not exceed 1,500 words, double spaced, 12 point font.

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### Annex 2.8

**Generic pre-testing questions for various prototypes of IEC materials**

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<td>1. Please tell me in your own words what the spot said.</td>
<td>Depending on the nature of the content ask one or both of these first two questions: 1a. What do you think the message of the film/video is? (what do you think the film was trying to tell you?) 1b. What do you think was the main reason this film was made? - To entertain people? - To inform them about something? - To persuade them to do something?</td>
<td>1. First, I would like to show you this (picture, photograph) that may be used in one of our posters. Please tell me what you see in this picture (PROBE: Please tell me what this looks like to you.)</td>
<td>If you are developing a pamphlet, these are some of the procedures you should follow:</td>
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<td>2. Did you feel that the spot was asking you to do something in particular? Yes – No – Don’t Know; if yes, what?</td>
<td>2. In general, do you think it is a good idea that __ (whatever the topic of the film is)? What is good or bad about ____________</td>
<td>2. Now look at the whole poster. In your own words, what is the message of this poster? (PROBE: What do you think it says?)</td>
<td>Our organization is making a pamphlet/handbook for people in your community. We would like your advice on the cover. Here are three designs, which one do you like best? A – B – C; why do you like that one?</td>
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<td>3. Did the spot say anything you don’t believe to be true? Y – N – DK; if yes, what was not true?</td>
<td>3. Did the spot say anything that might bother or offend people? Y – N – DK; if yes, what?</td>
<td>3. Do you feel that the poster is asking you to do something in particular? Y – N – DK; if yes, what?</td>
<td>If you are developing a pamphlet, these are some of the procedures you should follow:</td>
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<td>4. Did the spot say anything that might bother or offend people who live in ____? Y – N – DK; if yes, what?</td>
<td>4. Do you think this film/video, etc. is intended for someone like yourself or is it for other people? a) like yourself; b) for others; c) DK; if others, why?</td>
<td>4. Did the poster say anything you don’t believe to be true? Y – N – DK; if yes, what was not true?</td>
<td>This material is about __________ but we have not decided on a title yet: Which do you like the best among the three options? A – B – C</td>
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21 Adapted from Bertrand, Jane T., *Communication Pretesting: Media Monograph 6*, Communication Laboratory,
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<td>5. Do you think this spot is intended for people like yourself or for other people? a) like yourself; b) for others; c) DK; if others, why?</td>
<td>5. Was there anything you liked very much about the film? Y – N – DK; if yes, what?</td>
<td>5. Is there anything in this poster that might bother or offend people who live in _______? Y – N – DK; if yes, what?</td>
<td>If you are testing a completed pamphlet, use the following series of questions: I would like to show you an unfinished copy of a pamphlet we have created. As you can see, it contains some pictures and phrases underlined in red. Please read the text underlined in red. Take your time and we’ll talk about them when you have finished.</td>
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<td>6. Was there anything you liked very much about the spot? Y – N – DK; if yes, what?</td>
<td>6. Was there anything you didn’t like? Y – N – DK; if yes, what?</td>
<td>6. If there are people in the pictures, do the people you see remind you of your friends or are they different from your friends? Like my friends – Different from my friends – DK; if different, in what way?</td>
<td>I’ll review all of the phrases underlined in red and ask you to tell me in your own words what the idea is (go over each sentence)</td>
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<td>7. Was there anything you didn’t like? Y – N – DK; if yes, what?</td>
<td>7. In general, do you think this film should be shown to other groups around here like yourselves, or would it be better to find other films instead?</td>
<td>7. Is here anything in particular you like very much about this poster? Y – N – DK; if yes, what?</td>
<td>What do you think the entire pamphlet is saying or asking people to do? Do you find anything in the pamphlet that you think is not true? Y – N – DK; if yes, what? Is there anything in the pamphlet that might bother or offend people who live here? Y – N – DK; if yes, what?</td>
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<td>8. In comparison with other spots on the radio these days, how would you rate this spot: Excellent – Good – Fair – Poor – DK</td>
<td>8. Is there anything you don’t like? Y – N – DK; if yes, what?</td>
<td>Do the people you see in the pictures remind you of your friends or the others in the community? • Like people here • Different from people here • DK • If different, in what way?</td>
<td></td>
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<td>9. What do you feel could be done to make this a better spot?</td>
<td>9. What do you feel could be done to make this a better poster?</td>
<td>Is there anything you particularly liked? Y – N – DK; if yes, what? Is there anything you particularly didn’t like? Y – N – DK; if yes, what? In your opinion, what could be done to make this better?</td>
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Resources

Communication materials

1. Fact sheets: http://www.who.int/mediacentre/factsheets/fs286/en/
2. Infographics: www.cdc.gov/globalhealth/immunization/infographics.htm

Eastern and Southern Africa country documents


West and Central Africa country documents

Notes
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