UNIT-9

Communication for behaviour change

Learning objectives

- *Recognize the importance of integrating social and behaviour change communication (BCC) in immunization services to reduce vaccine hesitancy*
- *Identify the reasons for children missing vaccinations (dropouts or left outs) and possible interventions*
- *Learn about different communication tools, channels and opportunities to reduce vaccine hesitancy.*
- *Learn to develop a simple communication plan for the PHC/CHC using communication planning tools*

Key Contents

9 Communication for reducing vaccine hesitancy and increasing demand for immunization

Role of MOs in reducing vaccine hesitancy

MOs at the block and PHCs have a critical role to play in ensuring that all children in the population under their PHCs are fully vaccinated. MOs are already working very hard to ensure that the quality of health services for mothers and children in their PHCs and SCs and are well recognized by the communities living in their areas. This also means that their first responsibility will be to ensure that RI services are not only available but that these services are also of the best quality.

Vaccine hesitancy is the behaviour of parents, caregivers, or the community in hesitating to get their children vaccinated in spite of immunization services being available and accessible to them. Inadequate immunization services due to non-availability of vaccines, absenteeism of vaccinators and long distances to vaccination centres contribute to this hesitancy. Hesitation also comes from a number of other reasons (let's call them barriers), such as low perception of the benefits of vaccines, loss of wages, social beliefs, fear of AEFIs, demotivation owing to inadequate IPC skills of HW, to sometimes geographical barriers such as inaccessible terrain.

This section looks at **low immunization coverage from the behavioural perspective,** i.e. the reasons behind vaccine hesitancy and the interventions that can be initiated by MOs to achieve the communication objectives of increasing demand for vaccination services.

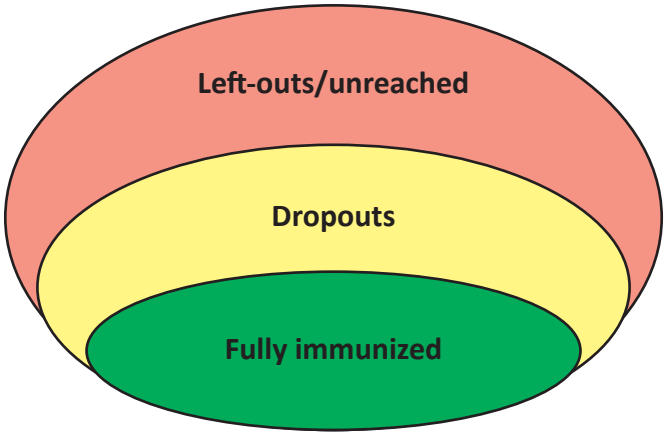
On the other hand, **vaccine confidence** is when parents, caregivers or the community understand the value of vaccination and voluntarily demand vaccination services as a right, whether these vaccinations are part of the RI schedule for their children or part of adult vaccinations such as TT for pregnant women. Vaccine confidence comes from adequate awareness about the benefits of vaccines, both to the individual and the community, and the trust in the immunization service delivery system to be able to provide quality vaccination.

Left-outs and dropouts

From a service delivery perspective:

- ***left-outs*** are those children who have never been vaccinated or reached (thus remaining unimmunized);
- ***dropouts*** are those children who started vaccination but did not complete the schedule (thus remaining partially immunized).

Fig. 9.1. Three types of behaviour groups

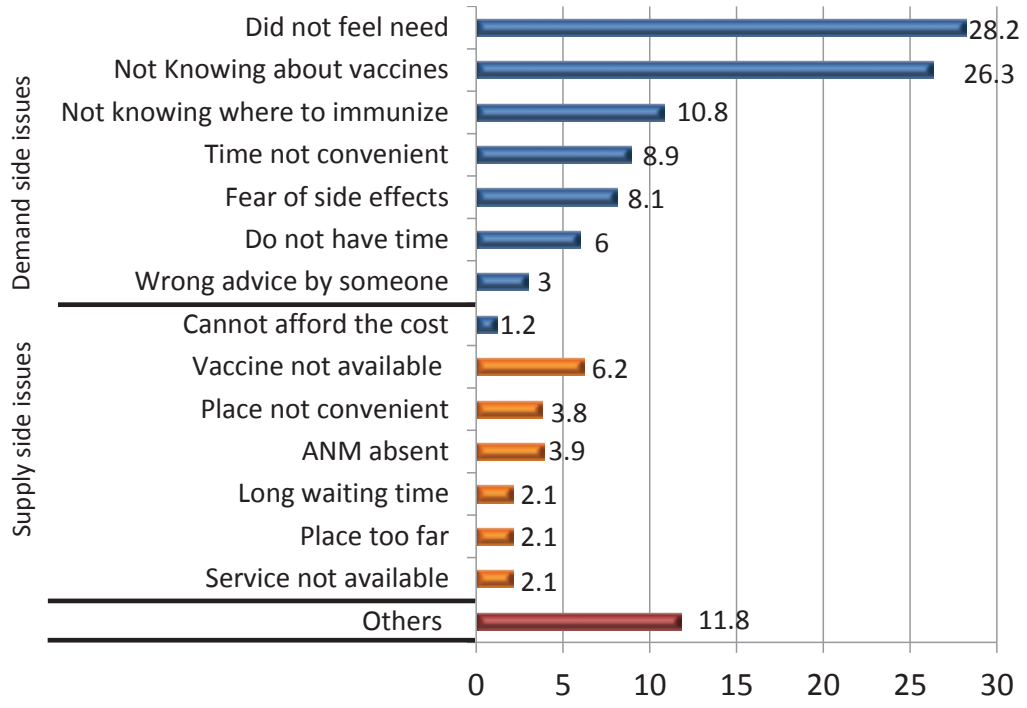


The immunization-targeted community can be divided into three groups as shown in Fig. 9.1. The aim of the health system (including MOs, HWs and mobilizers) should be to expand the inner circle to cover the entire universe of eligible children in its catchment area.

From a behavioural perspective, a large percentage of dropouts is a serious problem because it reflects the poor perception of parents/caregivers' about the benefits of vaccination or of the immunization service delivery system, or both, combined with other barriers that forces them to place immunization on a low priority.

People who "drop out" of the immunization system are the easiest to reach and be convinced to return for full immunization.

Fig. 9.2. Reasons for partial or no immunization (multiple responses) (n=10 542)

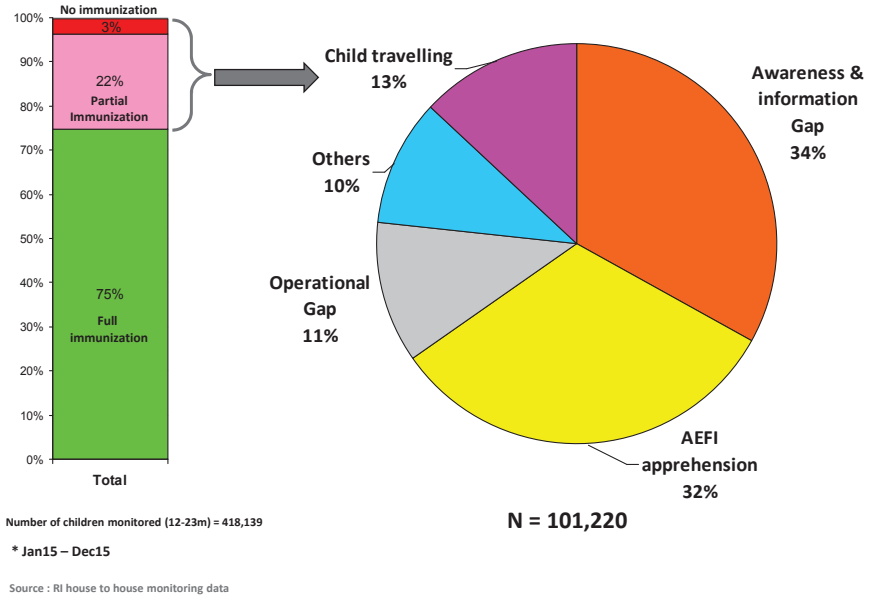


Why children do not get vaccinated: behavioural barriers

The Coverage Evaluation Survey (2009) identified the reasons for not accessing immunization services as cited by the community. A majority had demand-side issues, e.g. did not feel the need for vaccination; did not know about vaccines or where to go for vaccination; time not convenient; fear of side-effects; or did not have time.

Recent data from house-to-house RI monitoring in UP also highlighted lack of awareness and fear of AEFIs as major reasons for missed children as shown in Fig.9.3.

Fig.9.3. Reasons for missed children



The table below enlists reasons and possible interventions for tackling vaccine hesitancy. Medical officers are encouraged to review/discuss this table with staff during meetings.

Table 9.1: Reasons for missed children and possible interventions

Possible reasons	Possible interventions
Demand-side issues	
Parents not motivated to immunize children because of their poor understanding of its purpose and importance	• Engage with community leaders, school teachers, faith/religious leaders, youth networks, women's self-help groups (SHGs) and encourage them to talk to parents about the benefits of immunization. • Build capacities of HWs to counsel and effectively communicate with parents and the community on the importance of immunization. • Disseminate information on the benefits of immunization at health fairs and other events and make people aware of immunization services. • Use other communication channels such as local cable television, wall paintings and posters, mosque and temple announcements, traditional and folk media.
Cultural or religious reasons for refusal of vaccination (myths, rumours and misconceptions)	• Find out the reasons for reluctance by talking directly to communities/leaders. Try to address their misconceptions, doubts and fears by listening to them and offering support. • Involve community leaders (particularly the ones favourable to immunization) and other staff working within that particular community in order to encourage their fellow members to have their children immunized. • Arrange for an interaction between resistant groups and satisfied beneficiaries in the area to promote immunization.

Fear of side-effects or AEFI in the community discourages parents to immunize their children	• Involve religious leaders, village elders, school teachers and panchayati raj institution (PRI) members to accompany the field level workers (FLWs) during their house-to-house mobilization visits, organize folk shows to educate parents and communities on the importance of RI for children and dispel myths and misconceptions. • Remind HWs to always tell parents/caregivers about common side-effects that may occur and what to do should they occur. • Investigate any AEFI and apprise the community of the details of the case, possible causes and actions taken.
Financial or gender barriers to immunization, e.g. husbands disallowing wives to attend sessions because of time/lost labour, expense and/or fear of side-effects	• Counsel opinion leaders and influential persons about the dangers of VPDs and the benefits of immunization. • Encourage peer counselling by fathers of children who accept immunization. • Publicize that immunization services are entirely free.
Refugees/families that fear contact with government, e.g. those who lack documents/ scheduled castes or tribes/ nomadic groups/homeless families/urban slums/street children	• Determine where these populations reside. • Visit the communities and work with local mobilizers/educators/community groups/leaders to discuss reasons why they are not accessing immunization services. • Provide information on the importance of vaccination and date, time and place of the next nearest session. • Develop a list of children who have never accessed immunization services in the area and share it with HWs of the area for immunization and ensure follow-up.

Supply-side issues	
All newborns and infants not identified and listed	• Involve AWWs/ASHAs to identify and share lists of newborns and children with the HWs.
Sessions too infrequent or timings and days not convenient/not understood	• Plan sessions after consulting the community, e.g. early in the morning/late evening.
Session site too far away, e.g. border populations	• Include all the areas in the microplan. • Reorganize the catchment area so that remote sites are visited at least once every 2 or 3 months (plan at least 4 immunization sessions a year). • Work with neighbouring health facilities to coordinate services for border areas. • Improve outreach to communities through appropriate transport, additional staff and publicize outreach services.
Parents do not return because sessions are not held as planned or vaccines are unavailable	• In case of HW being on leave, deploy alternate vaccinators. • Ensure alternate delivery of vaccines to session sites. • Encourage community groups to report problems regarding HWs' attendance on session days to the PHC. • Conduct session monitoring and make real improvements; then publicize the improvements to communities. • Ensure adequate supplies of vaccines and logistics.
HWs do not clearly explain to parents what vaccines are due, when they are due and why they are needed	• Remind HWs/AWWs/ASHAs to always convey the 4 key messages to parents in a simple and understandable language. • Train HWs to provide filled-in MCP cards to all beneficiaries and to write the next due date on the card. • Ask caregivers to repeat the information given to them in order to increase the chances that they will remember when to return. Praise correct answers. • Thank the parents for bringing the child. • Publicize the immunization schedule.

HWs do not show respect towards parents or interest in the child's health, e.g. long waits, HWs shouting at mothers for forgetting the card or bringing the baby in late	• Sensitize and train HWs, ASHAs and AWWs to communicate with and treat parents with respect, warmth, friendliness and should empathize with the parents' situation. Encourage and praise the parents for bringing their children for immunization. Encourage parents to ask questions. • Guide HWs to visit dropouts before the next session to find out the reasons why they missed the session.
HWs do not know which children are due and what vaccines are due	• Organize tracking of children using RI Cards, immunization registers, counterfoils and tracking bags. • HWs can involve community teams (NGOs, community based organizations (CBOs), youth clubs, school teachers, volunteers, etc.) to identify children who are left-outs and dropouts • remind parents about the importance of full immunization; inform them about the date and time of the next session and mobilize parents for immunization sessions.
HWs do not understand/ explain to caregivers that immunization may be given to mildly ill children (false contraindication)	• Orient HWs that immunization can be safely provided to mildly ill children and that they should convince parents about this fact.
Children and mothers are not immunized when coming to the HWs for curative care (missed opportunities)	• When providing other services, always keep an eye on eligible children visiting the session with a parent or sibling. Enquire about their immunization status or refer to the list of due beneficiaries and provide services, as appropriate. • Put a reminder about immunization in the facility's waiting area.

MO as facilitator and enabler: 10 key roles

All medical officers must take a few simple steps for improving vaccine demand. The primary role of MO is to act as a facilitator and enabler for demand generation activities in order to be effective within their respective PHCs. Given below are some of the initiatives MOs must take:

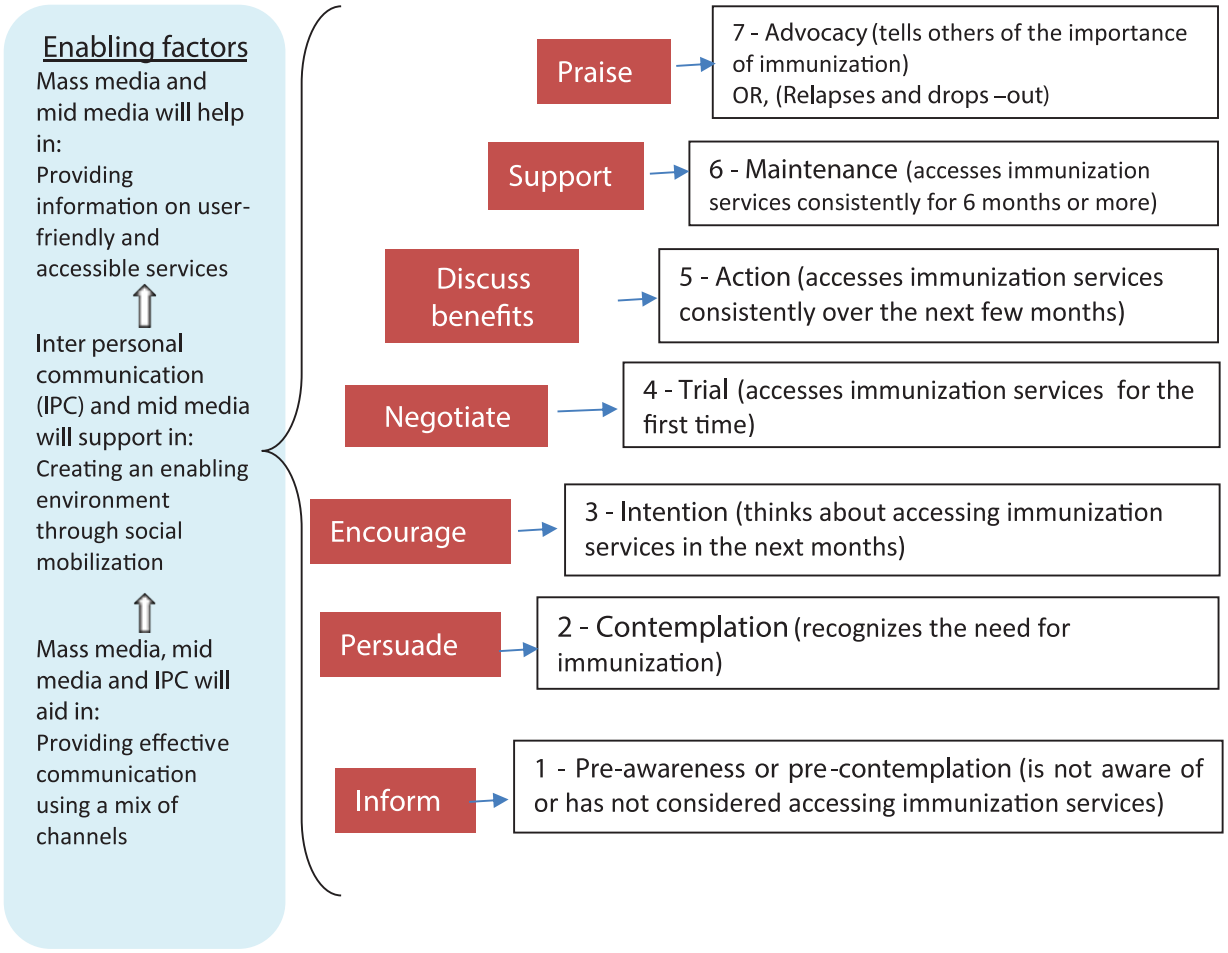
1. **Collect evidence for vaccine hesitancy/refusal**
2. **Undergo professionally-organized orientation in social and behavioural change communication (SBCC)**
3. **Ensure front-line workers and community mobilizers are well-trained in interpersonal communication skills**
4. **Strengthen or innovate supportive supervision for communication**
5. **Target populations through communication microplanning**
6. **Develop a communication plan using mapping and communication tools**
7. **Develop partnerships at local level**
8. **Generate resources for communication activities**
9. **Ensure the right communication tools (IEC) are available and used**
10. **Monitor communications interventions.**

Changing behaviour

Behaviour change is not a one-time effort but a continuous, well-planned endeavour. To mobilize parents and communities for immunization, we need to ensure that the community understands our message, taking care to keep our message simple and straight forward, avoiding too much information too fast. It is equally important that as health-care providers, we have complete information on the issue and take time to understand the community's perspective, establish and maintain credibility and also clarify misconceptions.

One of the most popular theories of behaviour change communication is called the "Stages of Change," proposed by F. Prochaska. It states that individuals are at various stages in the behaviour change cycle. Knowing at what stage of change an individual is – or a group of individuals are – will help create the appropriate change intervention (Fig. 9.4).

Fig. 9.4. Behaviour change cycle



For the RI programme to create an impact, behaviour change has to happen both at the parents/caregivers as well as service providers level. Behaviour change cannot be achieved in isolation; it is important to engage with key stakeholders in the community. This will help to create an enabling environment and motivate people to immunize their children.

For example, a mother who is aware of immunization but does not get her children routinely vaccinated could be in Step 4 of the stages of behaviour change (Trial). She might be aware of the benefits of immunization and also have accessed services, but needs to be encouraged further to continue getting her children vaccinated. The HW needs to discuss the benefits of immunization with the mother to motivate her further. Community networks and peer support groups can help in stimulating community dialogue to adopt immunization, thus helping the mother sustain this positive behaviour.

Involving the community to support immunization

Sharing responsibilities for increasing demand

Community participation is the key to increasing demand for services. An informed community has confidence in the immunization programme, ensures that provision of immunization services is tailored to the community's context (time, place and convenience) and therefore supports and demands immunization services.

You may not have much time to directly interact with the various community groups and leaders. However, encourage and support HWs and supervisors in establishing strong links with the community.

The community should be involved in the immunization programme from the planning phase.

Planning

HWs should:

- consult communities about service locations and timings to ensure a convenient service, e.g. shifting vaccination hours from mornings to afternoons in areas where mothers are busy in the fields in the morning;
- involve village elders, religious leaders and village youth to motivate the community to access the immunization sessions, dispel myths and misconceptions.

Implementation

Communities can assist with:

- arranging a clean outreach site such as a school, club, panchayat bhawan, community meeting room;
- informing families initially of scheduled outreach, and again when the HW has actually arrived;
- educating the community regarding free availability of these services;
- registering patients, controlling crowds, and making waiting areas more comfortable (by providing shade and organizing space and seating);
- disseminating appropriate messages and answering questions (health education);
- identifying and referring newborns and/or infants who have recently arrived in the community and sharing the list with the HW to include in the immunization register;

- facilitate transporting vaccines and HWs in some hard to reach areas ;
- motivating fellow community members to use immunization services and helping bridge cultural or educational gaps between HWs and caregivers;
- identifying dropouts and left-outs. Making home visits when children are behind schedule to explain the importance of adherence to the immunization schedule and to motivate caregivers;
- communicating with local people and informing HWs about suspected VPDs

Evaluation

Community leaders can contribute by responding to questions about the quality of services, including counselling provided by front-line workers.

Steps for involving the community

Step 1: Identify key stakeholders in the PHC area/community and also ways to engage with them

These could be:

- governmental departments and staff (Health, ICDS, Education, District/Block Administration, PRI);
- NGOs, local organizations and youth bodies such as Nehru Yuva Kendra, National Social Service (NSS), National Cadet Corps (NCC);
- professional associations (Indian Medical Association, Indian Association of Paediatrics);
- community (parents, village health and sanitation committee(VHSC), faith-based organizations, SHGs);
- private and traditional health practitioners.

Meet the key stakeholders on a regular basis, establish a rapport with them and seek their support for the immunization programme. Encourage them to talk to parents/caregivers about the benefits of immunization; give them some IEC material such as posters and handouts with messages on immunization which can be displayed at their offices/premises or during their meetings and also be disseminated in the community. Motivate religious leaders, particularly the ones favourable to immunization, to endorse and encourage their fellow members to have their children immunized; get temple/mosque/religious places announcements made giving out details about the next immunization session and calling on parents to get their children vaccinated.

Step 2: Conduct a situation analysis

- Hold community meetings, small group discussions or discussions with opinion leaders to assess the current extent of the community's involvement with immunization services, by finding out:
  - what the community already knows about VPDs and immunization;
  - community awareness and perceptions about immunization services;
  - perceived barriers to immunization (related to quality of immunization services and the community's knowledge, attitudes and practices);
  - issues affecting physical access to services (location, frequency, schedule);
  - issues on access to services by special groups (minorities, migrants etc.);
- Identify problems and reasons for left-outs and dropouts. Jointly seek possible solutions;
- Provide information, using basic language and non-scientific terminology, on the importance of immunization, and where and when services are available. Dispel misinformation and doubts that sometimes surround immunization;
- Encourage questions so that everyone can be better informed;
- Use stories, short plays, songs and visual aids to hold the group's attention and make meetings interesting;
- Discuss possible community support.

If required, re-align Health and ICDS sector boundaries for joint planning, implementation and monitoring of immunization activities.

Step 3: Establish mechanisms for coordination

Establish a consultative mechanism at the block/PHC level, or use existing forums such as the Rogi Kalyan Samitis to ensure regular coordination between departments and to enlist community support for immunization services.

- Establish alliances with programmes such as ICDS and organizations such as NGOs with community reach;
- Involve representatives of the key stakeholder groups listed in Step 1;

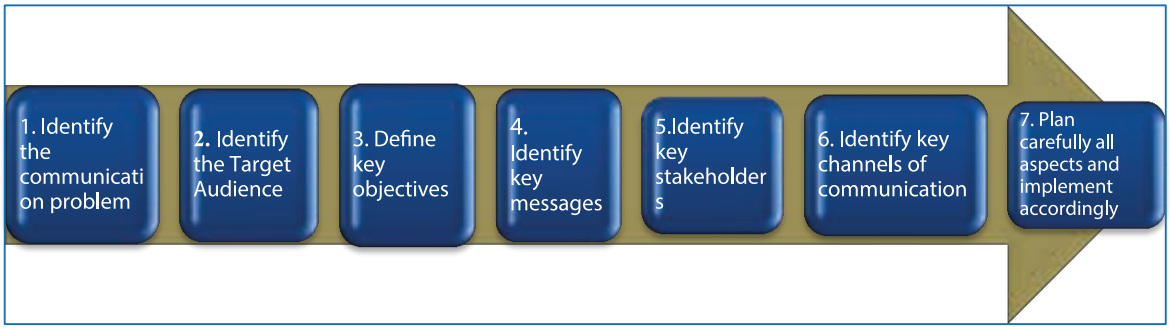
- Inform the members well in advance and prepare a clear agenda for the meeting including:
  - state and district immunization goals
  - current status of immunization in the district and block
  - key challenges and areas requiring support, with suggestions on possible interventions
  - possible roles of stakeholders
  - preparing and implementing a communication plan.

Step 4: Develop a comprehensive communication plan for community mobilization

A communication plan helps to organize actions to target our communication accurately, leading to the fulfilment of a goal. It gives a structure to determine whom we need to reach, and how. It can be longterm as well as short term, making our communication efforts more efficient, effective and lasting. This saves a great deal of time, as we know exactly what we should be doing at any point in the process. (See also Unit 3 - Forms 11 and 18)

The steps given in Fig 9.5 will help you and your team members to prepare a comprehensive communication plan for your area.

Fig. 9.5.Communication plan development



To develop a plan for communication, you need to consider some basic questions:

- Why do you want to communicate with the community? **(What is your purpose?)**
- Who do you want to communicate it to? **(Who is your target audience?)**
- What do you want to communicate? **(What is your message?)**
- How do you want to communicate it? **(What communication channels will you use?)**
- Whom should you contact and what should you do in order to use these channels? **(How are you going to disseminate your message?)**

Sample communication action plan

A sample communication action plan is outlined in Table 9.2.

Table 9.2. Developing a communication action plan

Communication objective: By…….(month and date), parents and caregivers of children under 2 years of age in village……., to be aware of the benefits of immunization and agree to get their children immunized as per schedule

Behaviour analysis	Primary target group (Individual/household level)	Secondary target group (community/service provider level)
Who is the target group?	Mothers/caregivers of children	HWs, community members
What is the current behaviour?	Parents not motivated to immunize children	ANMs may write the next due date in the immunization card, but few give mothers the four key messages or any other information, or invite questions
What is the recommended key behaviour?	Mothers/caregivers to access immunization services and get their children fully immunized	ANMs give mothers/caregivers four key messages, including when and where to go for next vaccination, what side-effects can occur and how to deal with them
What are the key barriers to the recommended behaviour?	▪ Lack of information on immunization ▪ Poor understanding of its purpose and importance ▪ Fear of AEFIs ▪ Cultural and religious reasons (myths and misconceptions) ▪ Long waiting time; days and time not convenient ▪ Time/lost labour, expense and/or fear of side-effects ▪ Lack of money	▪ ANM/AWW lack skills or focus on importance of communicating with mothers ▪ There are real or perceived social, economic, class and possibly ethnic differences between ANM/AWW and caregivers/community ▪ ANMs/AWWs lack time to give good counselling (because so many people are waiting for care)

Communication strategy	Primary target group	Secondary target group
Which barriers can be addressed through communication?	Demand side issues can be addressed through communication **(refer Table 9.1** on possible reasons for left-outs and dropouts)	
What is the key message for each target group?	Immunization is important and beneficial for your child. Get your child fully immunized	Communicate four key messages to mothers/caregivers
What are the suggested communication activities?	▪ Use posters, community meetings,radio, TV (where appropriate), and other channels to create awareness on the importance of immunization and inform parents/caregivers about the next immunization session. ▪ Orient community volunteers and school children on immunization and encourage them to discuss the benefits of immunization with parents/caregivers.	▪ Plan sessions after consulting the community (e.g. early in the morning/late evening) ▪ Visit the communities and work with local mobilizers/educators and community groups/leaders to discuss reasons for not accessing immunization services ▪ Provide information on the importance of vaccination and the date, time and place of the nearest session. ▪ Improve talks and counselling by reminding HW/AWW/ASHA to always communicate thefour key messages to the caregivers ▪ Train/orient HWs to provide filled-in immunization cards to all beneficiaries and to write the next due date on the card. Ask caregivers to repeat the information given to them in order to increase the chances of their remembering when to return ▪ Encourage ANMs/HWs to do more one-on-one counsellings.

Monitoring	Primary target group	Secondary target group
What are the monitoring indicators?	▪ Number of mothers caregivers who can tell the vaccine schedule ▪ Number of mothers who can recall the four key messages ▪ Number of ASHAs/AWWs/HWs with updated duelist	
How will you measure these?	RI monitoring data; rapid surveys; in-depth interviews Monthly HMIS reports	
Who will collect information/ data?	HWs and supervisors	

Communicating messages

The Immunization Programme uses different communication methods to reach parents and other target audiences with messages on RI such as radio, television, folk media, community meetings and interpersonal communication during sessions.

It is important to identify which communication methods or channels are the most appropriate for our target audiences, liked and used by them and can most effectively reach them with immunization messages. For example, while using mass media, it is important to know which radio stations and TV programmes are popular with the target population.

A mix of different communication channels is usually employed to reach different target groups, as each channel serves a specific purpose as outlined in **Table 9.3.**

Table 9.3: Benefits of communication channels

Mass media (radio, TV, etc.)	Mid media (reminder media)	Interpersonal Communication (IPC)
▪ Triggers thought and acts as a "hook" ▪ Reaches many people very quickly and repeatedly ▪ Reinforces messages delivered through other channels	▪ Reinforces and expands upon mass media messages ▪ Builds on messages delivered through IPC and serves as "reminders" or "message takeaways"	▪ Involves direct interaction with the audience ▪ Allows discussion and dispels myths and misconceptions ▪ Encourages, motivates and reinforces action

Thus, no single channel is the "best channel". Multiple, mutually reinforcing channels/ messages integrating all these channels together has a greater impact in stimulating behaviour change.

At the PHC level, you can effectively use the channels and tools for involving and informing the community about immunization services (Table 9.4).

Table 9.4. Channels and tools for communicating information on immunization

Communication channel or tool	Settings	Activities
Discussions between HWs and small groups of parents	Immunization sessions	Inform parents (using storyboards or flip charts) about importance of immunization, the immunization schedule and clarify individual concerns
Community mobilizers (ASHAs and AWWs)	Immunization sessions, home visits	Identify target beneficiaries and share lists with HWs. Make home visits to mobilize beneficiaries, inform about session dates and times and follow up dropouts
Local leaders such as PRI members, political/religious leaders, teachers, private medical practitioners	Work places or community events	Advocate for increasing immunization coverage and seek their support in mobilizing the community
Community groups, NGOs, CBOs, SHGs	Work places or community events	Advocate for increasing immunization coverage and seek their support in mobilizing the community
Public/street announcements	Town criers, community events	Provide basic information in support of immunization and publicize date and time of session
Drama and songs	As a precursor to discussion in community meetings	Counter rumours, misconceptions and other barriers to understanding. Provide basic information, e.g. on RI schedule
Poster, banner, tinplate and wall writing	Well-frequented places such as AWC, markets, bus stops, ration shops, schools, panchayat bhawan	Display information related to the session site, date and immunization schedule
AWW home visits with shared session due list	AWC, panchayat bhawan, school	Motivate and remind families to get their children immunized

RI form 11 for a SC communication plan is given at the end of this unit.

Increasing visibility and awareness of immunization services

Increasing the visibility and awareness of immunization and outreach health services to the general public, and particularly to beneficiaries, is the initial and perhaps the easiest step of communication. The designs for posters and hoardings on RI have been developed at the national level and the states/districts may use the prototypes to customize it according to their local needs. For example, banners and posters should preferably be in the local language. You should read the content and see the pictures of the material available to you before arranging for their placements. Make sure that what is written or shown is consistent with the guidelines of the programme. As programme managers, you will have to plan when and how to use these communication materials.

Fig. 9.6. Posters and banners used in RI

JeSaid are wellrecognized by the communities living in their areas. This also means that their first responsibility will be to ensure that RI services are not only available but that these services are also of the best quality.

Vaccine hesitancy is the behaviour of parents, caregivers, or the community in hesitating to get their children vaccinated or immunized in spite of immunization services being available and accessible to them. Inadequate immunization services such as non-availability of vaccines, absence of vaccinators and long distances between vaccination centre and home contribute to this hesitancy. Hesitation also comes from a number of other reasons (let's call them barriers), such as low perception of the benefits of vaccines, its affordability, social beliefs, fear of AEFIs, demotivation owing to HW

For example, if a poster stresses on birth dose vaccination following institutional deliveries, it should ideally be put up at institutional delivery points. If another poster encourages beneficiaries to ensure that their child completes the vaccine doses as per the immunization schedule, it could be put up at outreach sites as well as delivery points.

Strengthening interpersonal communication skills of front-line workers

ANMs/ASHAs/AWWs are a critical interpersonal link between health providers and community members. They carry out door-to-door visits and are actively involved with the community.For them to be able to effectively communicate with parents/ caregivers and mobilize them to get their children vaccinated, it is important that their interpersonal communication skills be strengthened. They also need to be equipped with appropriate knowledge about vaccines and their benefits, and how to counter prevailing myths and misconceptions on immunization with facts. Details on training of front-line workers are given in Unit 11 on training.

How and when to communicate key messages? Messages need to be appropriately timed: neither too early, lest they be forgotten nor too late for the behaviour to be practiced

Tips for effective IPC skills for communicating with caregivers

Speak clearly

- Use encouraging/helpful non-verbal communication.
- Posture – keep your head level.
- Spend enough time; do not be in a hurry.
- Use responses and gestures to show interest.
- Listen carefully and repeat what the mother says.

Greet

- Smile.Speak in a pleasant voice and tone.
- Maintain eye contact.
- Introduce yourself and your organization.

Ask

- Ask open-ended questions—What? When? Where? Why? How? Who?
    - How many children do you have?
    - Why did you not vaccinate your child?
    - How did you know about the immunization session?

Tell

- What diseases are prevented by vaccination.
- Where and when will the session be held.
- What minor side-effects can occur after vaccination and how these can be managed.

Help: Encourage the parents to come for vaccination by telling them about how to manage AEFIs.

Explain: Use **info-kits** to explain the importance of immunization and the immunization schedule.

Repeat: Use your visit to find out reasons for left-outs and dropouts.

Four key messages to be given to caregivers

- What vaccine was given and what disease it prevents
- What minor adverse events could occur and how to deal with them
- When and where to come for the next visit
- To keep the immunization card safe and to bring it along for the next visit

Holding an effective community meeting

- Identify local community representatives who would participate in the meeting;
- Hold the meeting at a convenient time and place, e.g. on market days, close to places of worship;
- Be prepared with data on the coverage and dropout rates and a map of the health areas with low coverage;
- Provide a comfortable and welcoming environment for the discussion;
- Listen to the community; find out what the community already knows about VPDs and immunization;
- Provide information, using basic language and non-scientific terminology, on the importance of immunization, the status of the immunization programme and where and when services are available. Dispel misinformation and doubts that sometimes surround immunization;
- Encourage the participants to ask questions so that everyone can be better informed;
- Use stories, short plays, songs and visual aids to hold the group's attention and make meetings interesting;
- Involve as many group members as possible in the discussion and ask them to suggest solutions to problems;
- Help mobilize resources for immunization.

Exploring new media and digital communication

The reach of digital media is expanding exponentially and you should exploit every potential communication media. The digital media, either mobile or internet-based, is inexpensive and requires minimal effort. During planning for communication, whether it is for strengthening routine RI programmes or for campaigns, remember to identify media behaviour of the population in your block/under your PHC. As MOs, you have the potential and opportunity to be innovative. There are a number of ways to achieve impactful communication using new digital technologies, as follows:

1. Social media such as Facebook, Twitter, and YouTube are becoming highly popular as preferred modes of communication among the new millennia (young, educated generation).
2. Mobile phones have not only reached every village but also almost every villager, including into women's hands. The potential of reaching the targeted stakeholders is thus enormous. SMS messaging, voiceover messages using celebrities and reminder calls are some simple, direct and affordable ways of reaching the stakeholders with messages.

3. iPads and Notebooks: Digital tools such as iPads or digital Notebooks have now become very powerful tools for IPC sessions to be conducted by front-line workers with the communities. RI counselling using multimedia formats during household visits can be made not only educative but also entertaining.
4. Digitized PHCs: Visitors to PHCs, whether they are patients or their families, can be effectively counselled and exposed to key messages on RI using these digital tools innovatively. A MO who is innovative can make their PHC a model on the use of new media and digital technologies.
5. Data collection and analysis: These digital tools can also be used for purposes of data collection and monitoring and evaluation of different communication interventions for instant results.
6. Training before using: Innovative require capacity building of health service providers to enable effective use.

Appendix: RI form 11: Communication plan for a SC (See Unit 3 for details)

Sub centre communication plan for RI Quarter- 1 / 2 / 3 / 4 **RI Form 11**

Name of Block:_____ Name of ANM:_____ Name of Subcentre:_____

Name of Village						
Nane of Session site	1-	2-	3-	4-	5-	6-
Activities						
Miking / drum beating- Name and contact number						
Mosque announcement - Contact person and number - announcement time						
Meetings (Mothers meeting,AWW meeting,etc -Contact person and number - Monthly / weekly)						
VHSC meeting - contact person and number - location - attended by ANM Monthly / weekly - enter date						
School Rallies - school name and contact person with number (once a month in villages on rotation)						
Celebrations / Special Days (eg Mothers day, health day etc) - contact person and number						
Wall paintings - locations						
Banners - identify 4 key locations - Ensure display at least one day before RI day						
Painting competition / Exihibition - (once a quarter -school name and contact person with number						
Posters - identify 5 key locations (other than Panchayat ghar, Ration store, AWWcentre, Sub centre, Bus stand) - ensure display at least 2 days before RI day						
Pamphlets / Leaflets - available with - contact person name and number - distribute before RI session day						
Counselling aids / job aids (flip books etc.,) - available with - contact person name and number						
Other						
Manpower involvement - with contact number						
Name of ASHA						
Name of AWW						
Name of Mobilizer / CMC						
Name of community influencer						
Name of PRI member						

Date:_____ Sign of ANM:_____ Sign of MO:_____

Notes: