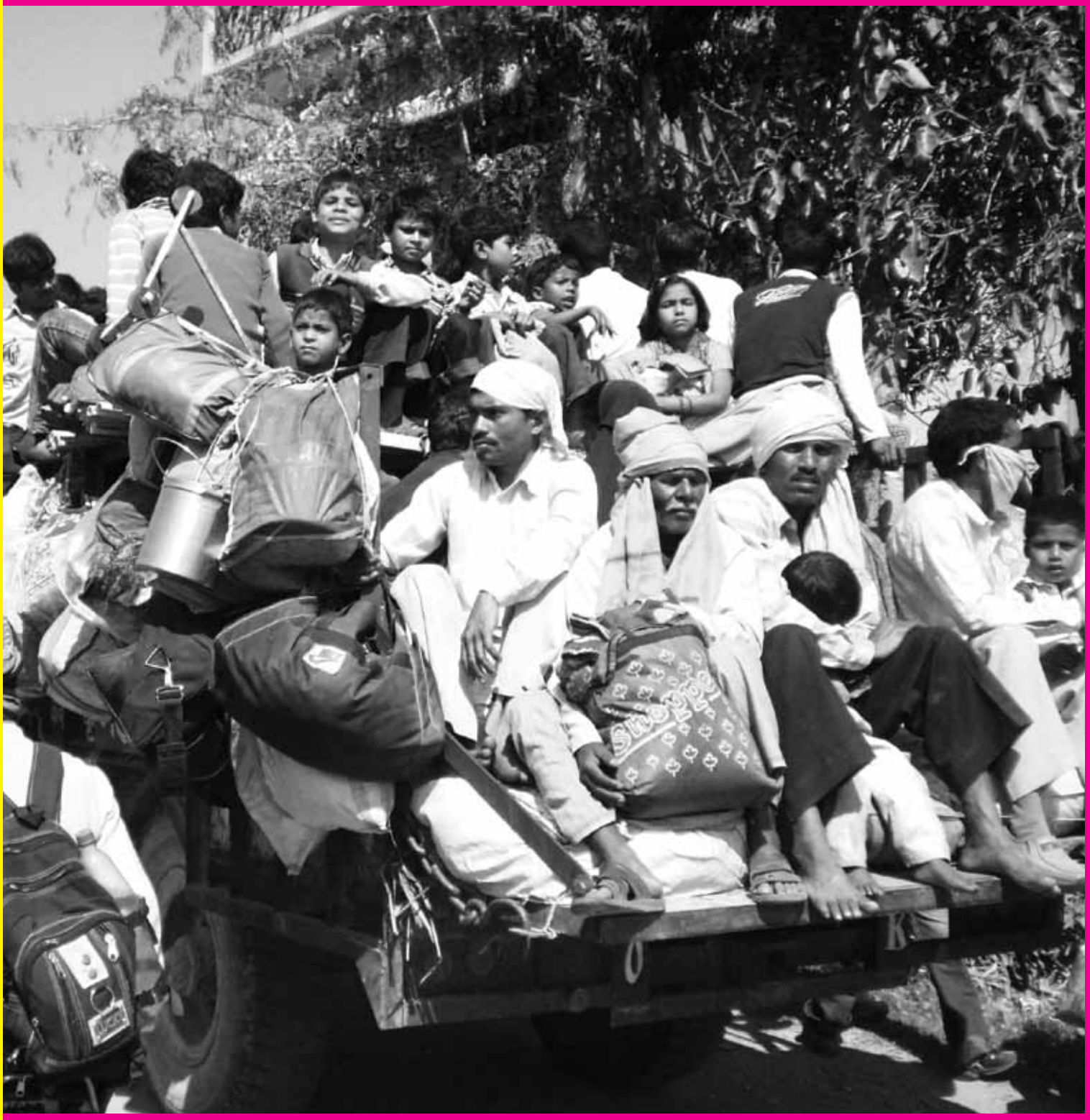

# ERADICATING POLIO

**Reaching out to moving populations**

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unite for children

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# ERADICATING POLIO

## Reaching out to moving populations

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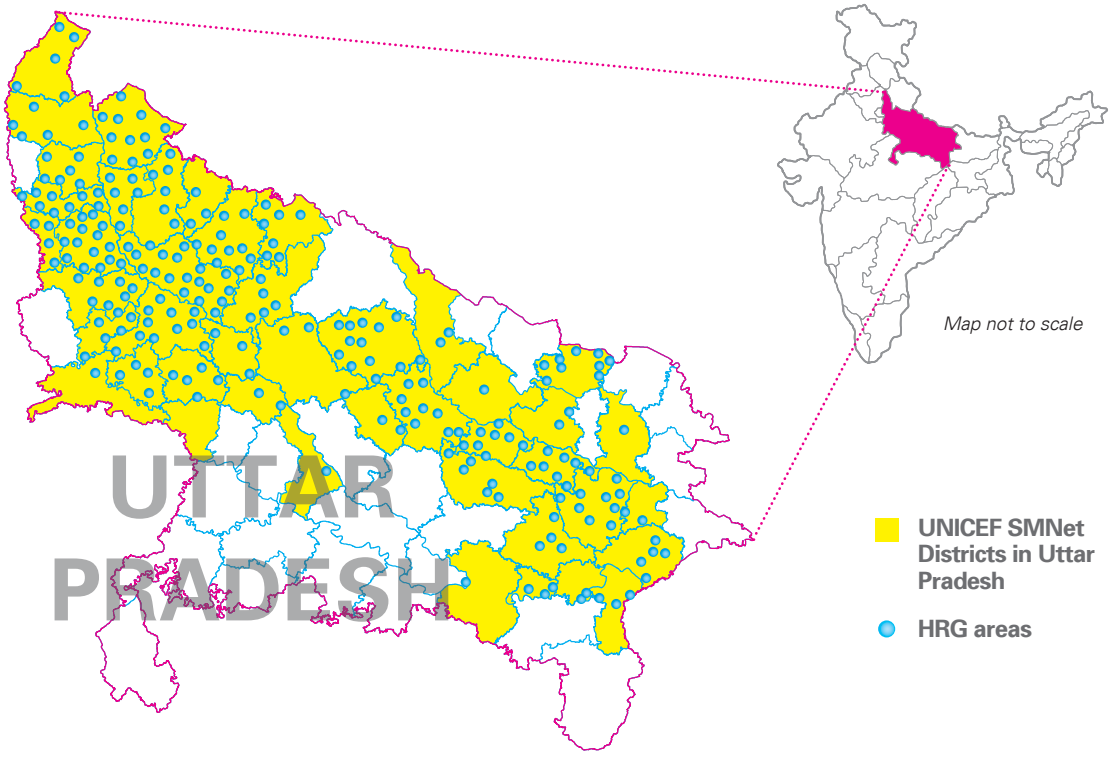



# ABOUT THE DOCUMENT

Lack of access to basic health facilities, unpredictable mobility and a dismal state of sanitation and hygiene make migratory groups vulnerable to infectious diseases like Polio. They are also considered the primary cause behind transmission of the poliovirus beyond endemic regions to the rest of the country. It is therefore necessary to include the migratory population in immunization activities to make the Polio eradication programme a complete success.

Through its Social Mobilization Network (SMNet), UNICEF has been systematically tracking and identifying migrant populations in the high risk areas of Uttar Pradesh (UP). The task of including these unreachable but susceptible sections of population was challenging but not insurmountable.

Through special purpose Block Mobilization Coordinators (BMCs) for High Risk Groups (HRG) and District Underserved Coordinators (DUCs), more sites and children have been identified and included in vaccination micro plans. This has led to these historically excluded groups getting access to basic health services. Most importantly, the novel strategy has initiated a process of representation for this overlooked section of the population.

# ACRONYMS

| | |
|---|---|
| **ASHA** | Accredited Social Health Activist |
| **ANM** | Auxiliary Nurse Midwife |
| **AWW** | Anganwadi Worker |
| **BMC** | Block Mobilization Coordinator |
| **CMC** | Community Mobilization Coordinator |
| **CMO** | Chief Medical Officer |
| **DIO** | District Immunization Officer |
| **DUC** | District Underserved Coordinator |
| **GB Nagar** | Gautam Budh Nagar |
| **GPEI** | Global Polio Eradication Initiative |
| **HRA** | High Risk Area |
| **HRG** | High Risk Group |
| **IEAG** | India Expert Advisory Group for Polio Eradication |
| **NCR** | National Capital Region |
| **WHO-NPSP** | World Health Organisation - National Polio Surveillance Project |
| **OPV** | Oral Polio Vaccine |
| **ORS** | Oral Rehydration Salt |
| **PHC** | Primary Health Centre |
| **RI** | Routine Immunization |
| **SIA** | Supplementary Immunization Activity |
| **SMNet** | Social Mobilization Network |
| **UNICEF** | United Nations Children's Fund |
| **UP** | Uttar Pradesh |
| **USS** | Underserved Strategy |
| **WHO** | World Health Organization |
| **WPV** | Wild Polio Virus |

पोलियो से सुरक्षा

मेरे बच्चे को दो बूँद हर बार

# CONTENTS

# one

# BACKGROUND

The Polio Eradication Programme is driven by the philosophy that every unimmunized child is a potential carrier of the virus. Polio eradication interventions are constantly revisited and revamped with a sense of urgency to match the epidemiological patterns of the virus.

Before the launch of the Global Polio Eradication Initiative (GPEI) in 1988, the wild poliovirus was endemic in as many as 125 countries. It affected an estimated 350,000 globally[1]. The coordinated efforts of stakeholders made GPEI the largest public health initiative in the world. This brought down the number of affected to 650, with just three countries in the endemic category – Pakistan, Afghanistan and Nigeria – in 2012[2].

Preceding the formation of GPEI, India accounted for an estimated 200,000 cases[3] of polio, 50 per cent of the total number of cases worldwide. India's last case was reported in West Bengal on January 13, 2011. The polio survivor, an 18-month-old girl named Rukhsar from Howrah district, was infected with type-1 poliovirus. India achieved a major milestone in February 2012, when the World Health Organization (WHO), removed India from the

1 Communication Handbook for Polio Eradication and Routine EPI, UNICEF

2 Polio Eradication Fact-file, Volume 1, March 2012, UNICEF

3 From 200,000 to Zero, The journey to a polio-free India, UNICEF


*Living conditions in slum areas in Ghaziabad, Haryana, India*

list of Polio endemic countries. However, the journey has been highly challenging particularly in the state of Uttar Pradesh (UP).

Between1993 and 2001, UP consistently reported more cases of paralytic polio than any other state in India. In 2002, 1,271 (80 per cent) of India's 1,599[4] polio cases occurred in UP. The majority of polio cases in the state were reported from 13 districts of western UP. The state has remained highly vulnerable to polio due to several factors such as poor sanitation, low nutritional status of children, and high resistance among certain communities. UNICEF and the WHO mapped the areas with high number of polio cases in UP and categorized them as High Risk Areas (HRAs).

One of the most critical barriers for the polio eradication programme was intense resistance to the Oral Polio Vaccine (OPV), particularly among minority communities. There were several myths and misconceptions commonly echoed by people to justify their resistance. The magnitude of the resistance was very high and deeply rooted, creating enormous difficulties for polio eradication teams.

4 Critical Leap in Polio eradication, 2003

# two

# FOCUS ON HIGH RISK GROUPS (HRGs)

Additionally, there were communities that were constantly migrating, which made outreach activities difficult for the vaccination teams.

UNICEF and partners designed strategic interventions to address underserved and migrating communities. The clear mandate was to reach every child in every round, despite underserved conditions.

Even until 2009, India's share in the total number of polio cases worldwide was quite high, registering almost 45 per cent of the total 1,604 cases[5]. The reasons for this persistent level were extensively deliberated at the 21st Meeting of the India Expert Advisory Group for Polio Eradication (IEAG) in November 2009. IEAG made recommendations for scheduling Supplementary Immunization Activities (SIAs) and Routine Immunization Activities (RIAs), so that coverage could be improved. It emphasized that focused concentration on high risk blocks should be accompanied by identification of transit areas and mobile groups for inclusion in operational plans. It was also recommended that specific monitoring of coverage in mobile communities should be expanded[6].

5 From 200,000 to Zero, The journey to a polio-free India, UNICEF

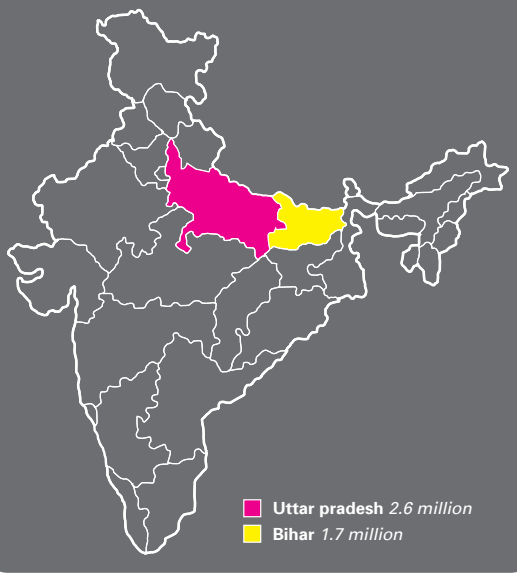
6 21st Meeting of the India Expert Advisory Group for Polio Eradication Delhi, India, 5-6 November 2009, Conclusions and Recommendations

*Group of mothers with their childern at a construction site in Ghaziabad, Uttar Pradesh, India*

The highly mobile and hard to reach segments of the population are part of the millions of Indians who are constantly on the move throughout the country. As per census 2001, there were two states with the largest number of net migrants, 2.6 million from UP and 1.7 million from Bihar, migrating out of the state. The mobility of these populations was a key barrier to polio eradication and a source for spreading the virus throughout the country.

The scope of the underserved strategy included a special focus on the HRGs, with the objective of mapping and vaccinating all children less than five years of age.

**Figure 1: Largest number of net migrants**



# three

# HIGH RISK GROUPS IN UTTAR PRADESH: DEFINING THE UNDEFINED

The success of the underserved strategy in Uttar Pradesh was driven by the focused approach of all stakeholders involved in the eradication programme. The tracking and mapping of migratory groups was, however, marked by a lack of knowledge on different kinds of groups, their socio-economic characteristics and the reasons for low participation.

Based on existing research, evidence and monitoring data, nomads, slum dwellers and brick kiln and construction workers were categorized under HRGs. The unanimous acceptance of these groups as HRGs by all the stakeholders was critical for better tracking and ultimate full coverage of the programme.

Nomads are groups of communities who travel from place to place for livelihoods, putting up deras (settlements) wherever they stop. They squat on the village ground and use resources such as water or pasture lands for grazing their cattle[7]. Nomads make up approximately 0.7 per cent of the population of Uttar Pradesh and can be clustered within five major nomadic groups[8]. The major nomadic groups prominent in UP are Kanjars, Gadia Lohars, Nats, Gandhiley and Banjara. Traditional and faith healers have also been categorized as nomads due to their high mobility and other similar nomadic characteristics. Regularly on the move, with unpredictable migration patterns, these groups survive beyond the reach of even the most basic health services making them highly vulnerable.

7 Underserved Strategy document, *T*racking and mobilization of high risk groups, UNICEF, Lucknow

8 The underserved strategy update, Volume 6, November 2009, New Delhi

*Slums in outskirts of Ghaziabad district, Uttar Pradesh, India*

Other than nomads, temporary and permanent slum dwellers are also susceptible to polio and considered part of high-risk groups. Rapid industrialization and growing urbanization have led to the emergence of slums in most urban areas. As per census 2001, nearly 752 lakh people lived in slums in India and UP had an 11 per cent share of this population. As per the same census, 25 per cent of the urban population in the state lives in slums. "*A slum is a compact settlement of at least 20 households with a collection of poorly built tenements, mostly of temporary nature, crowded together usually with inadequate sanitary and drinking water facilities in unhygienic conditions*" - Report of Committee on Slum Statistics/Census. The lack of basic amenities in slums makes the residents vulnerable to infections.

Brick kiln and construction workers are also considered as high risk groups. Western UP has a large number of brick kilns with constant labour movement especially during the monsoon, when kilns are not operational and labourers return home or move around for other opportunities. Moreover, the real estate boom in the urban areas of UP, especially in the National Capital Region (NCR) has resulted in a large concentration of construction workers residing near the sites in temporary settlements. They tend to move from one site to another, depending on the demand for labour. Most of these workers are from the states of Madhya Pradesh, Bihar, West Bengal and different districts of UP. Due to their low socio-economic status and constant mobility in search for work, these labourers are not covered under any health programmes and consequently remain highly vulnerable.

# four

## WHY TARGET THESE GROUPS?

The high degree of mobility puts these groups at a relatively higher risk of missing the immunization rounds. There are many factors that make them highly susceptible to various diseases including polio. Some of the key factors are[9]:

**Poor nutrition and sanitation levels:** Due to poor nutrition, sanitation and hygiene practices, the overall immunity of children in high risk groups is compromised. This makes them vulnerable to polio.

**High mobility:** Due to the mobile nature of the high risk groups, children are susceptible to be missed during polio vaccination rounds. Consequently, they continue to be carriers of the WPV and transmit the virus as they move to neighboring districts or states. This can lead to a resurgence of polio in other regions.

**Low socio-economic status:** The underlying causes of migration are mostly associated with poverty and lack of employment in the native areas. For most migrant workers, the income from odd jobs and manual labour is not enough to lift them out of poverty. This impacts their health, nutrition and sanitation, thereby increasing their susceptibility to communicable diseases.

**Limited access to civic amenities:** As these groups are constantly moving and are not part of the native population, they are unable to access facilities provided by government and municipal corporations including water supply, electricity, garbage disposal, sewage, or social services like primary health and education. Moreover, most of them do not possess any identification document, which impedes their integration into the local population.

**Poor state of sanitation:** Migrants live in overcrowded settlements with poor sanitation facilities. They usually defecate in the open and

9 Factors identified based on the observations and series of discussions of SMNet group members and other stakeholders with HRGs.

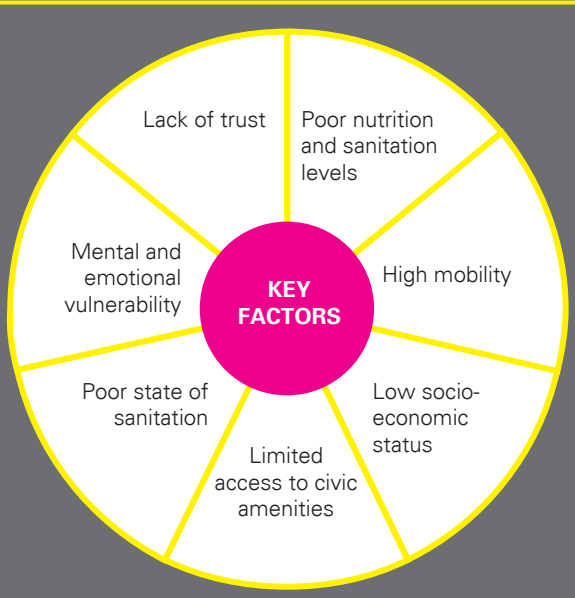
*Children in the slums in Ghaziabad, Uttar Pradesh, India*

live in squalid conditions. These places are feeding grounds for infectious diseases like polio.

**Mental and emotional vulnerability:** Due to their low socio-economic status, migratory groups are also mentally and emotionally vulnerable. The workers risk being exploited and earn far less than mandatory wage or what is initially promised to them. They tend to have a despondent approach to life and remain ignorant about accessing available government services for a healthy life.

**Lack of trust:** Low literacy, poverty, and in some cases, a history of exploitation, have resulted in a sense of distrust towards outside interventions or government services. Their low participation is as much a result of lack of awareness as resistance to a government public health programme.

**Figure 2: Reasons for high vulnerability of HRGs**



# five

# THE MODEL OF CHANGE: STRATEGY TO ENGAGE HRGs

Targeting the highly vulnerable and mobile social groups was not an easy task. Extensive research and deliberations among the partners led to introduction of the **'migrant and underserved strategy'**. It focused on increasing the vaccination coverage among mobile populations. The broad objectives of the strategy were:

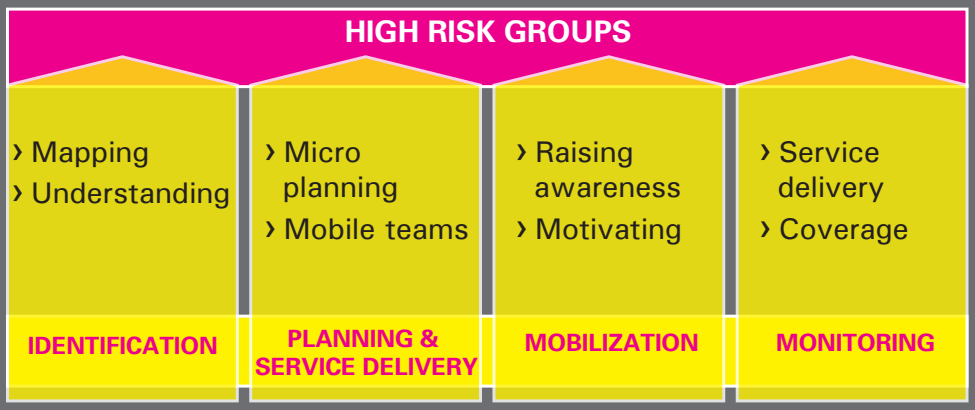
- Better tracking and effective micro planning through rigorous mapping and walkthrough;
- Improved service delivery through effective mobile teams; and
- Thorough monitoring of the polio programme within these social groups.

UNICEF focused on facilitating the implementation of migrant and underserved strategy in the state. It identified barriers and used innovative ways to overcome the challenges and enhance coverage of HRGs.

As presented in the Figure 3, UNICEF's support has been on four critical processes of the Underserved Strategy. The details are discussed below:

- **Identification** of HRGs and develop understanding about their demography, social and economic characteristics. Developing deeper understanding of the

**Figure 3: Approach to high risk groups**




HRGs was important in order to evolve an effective service delivery mechanism with a communication strategy best suited to them.

- **Effective service delivery mechanism** was deployed by sharing information about the HRGs with the health department for effective mobile vaccination micro plans. Subsequently, mobile teams were formed to reach out to the HRGs at their door step at a time most suitable to them. The identification and mapping of HRGs enabled better micro planning and evolving effective service delivery mechanism.
- **Mobilization** of HRGs and motivating them to participate in the polio rounds was critical for success of the strategy. UNICEF emphasized on a range of activities that aimed at reinforcing key messages at the right place and time. Employers and other prominent stakeholders were involved in the process to facilitate community mobilization.
- **Monitoring** of service delivery and coverage of OPV among the HRGs efforts in partnership with the health department. Data collected was used for better planning and community mobilization efforts.

# six

## KEY ACTIVITIES

Shortage of manpower was one of the stumbling blocks for better coverage of OPV among the HRGs. To support the health department and World Health Organisation - National Polio Surveillance Project (WHO-NPSP), UNICEF involved SMNet in mapping, identification, survey and mobilization of HRGs.

In the high risk areas[10] where the SMNet was already active, the Community Mobilization Coordinators (CMCs) were made responsible for identification, mapping and mobilization of the activities.

In 2009, one of the deliberations of IEAG (Indian Expert Advisory Group) focused on migrants, especially in the National Capital Region (NCR). Incoming migration in the NCR is fast rising due to rapid urbanization and the resultant real estate boom. The migratory population is mainly the laborers who work in the construction sites. Covering such a huge migratory population was difficult for the existing service delivery mechanism. UNICEF

The SMNet was formed in UP in 2001 to support polio eradication efforts by identifying high-risk areas and working with underserved communities in planning, implementing and monitoring social mobilization and other immunization activities in high-risk areas. The three-tier network of community mobilizers (community level, block level, and district level) performs the main work of the SMNet. UNICEF supported SMNet currently consists of about 5,500 members in 46 districts in UP.

10 An area is classified as High Risk Area, depending on standardized criteria which consisted of the case load in the area over a period of time and certain specific risk factors.

has been asked to provide support to the Government to track the migrants in these areas. For areas not covered by SMNet in specific districts, 40 special-purpose BMCs[11] were recruited by UNICEF on the request of Government of Uttar Pradesh. Further, UNICEF engaged DUCs[12] in the HRG sites. These DUCs were supporting the government system in the HRG sites that were being missed or under-covered in the existing micro plans. They were also responsible for providing overall guidance, and sharing and consolidating the data at the district level.

According to Dr. R.K Garg, CMO, Gautam Budh Nagar special BMCs were enlisted to cover each and every child at HRG sites. This helped in developing proper micro plans and supervision during the polio rounds, which made the social mobilization efforts of BMCs very effective.

## Plotting the geographical spread

Efforts were geared towards plotting HRG sites, since approaching the sites required elaborate and specific maps. Under the Under Served Strategy (USS), all the sites were coded on the basis of type: nomadic sites, brick kilns, construction sites and temporary and permanent slums. These maps are regularly updated through pre-round enlisting, validation and street monitoring activities. The plotting and mapping provides critical information for planning, developing effective micro plans and deploying sufficient mobile teams.

11 Block Mobilization Coordinator: BMC is block-level functionary in the SMNet

12 District Underserved Coordinator: DUC is the district-level funtionary of the SMNet as a part of underserved strategy

## Understanding the HRGs

The SMNet functionaries started their work by enlisting these HRGs. Within their chosen sites/groups, the functionaries familiarized themselves with the ways of their target communities by learning their language, regular interactions, striking rapport and positioning themselves as a link between the underserved communities and the existing government systems. Emphasis was given on developing an understanding about the socio-economic characteristics of the HRG and the supply-demand barriers that impede coverage. The purpose was to understand the reasons for non –participation of HRGs in polio vaccination drives.

After the enlisting process, the functionaries mobilized these groups using various strategies such as mothers meetings, IPC, etc. The process was challenging and SMNet members faced resistance from the communities and their employers. In case of the mobile population, tracking the target communities itself was a difficult task. In the HRAs, where the SMNet has been active over a long period of time, the process of interacting with the native population was a relatively easier task. The CMCs were from the community itself, which made it easier to start a conversation with the target groups. In the case of HRGs, BMCs/DUCs faced a range of barriers in large HRG sites.

The BMCs were unable to meet the target beneficiaries during normal working hours, since they would leave early for work and return only late in the evening. In order to meet them, the BMCs worked according to the workers' schedule and met them early in the morning or late in the evening. There were many communication hurdles. As a

*Use of IEC material for mobilization, Ghaziabad, Uttar Pradesh, India*

confidence building measure, the DUCs had to familiarize themselves with the languages and dialects spoken by the groups in order to improve their impact. With regular interaction, the DUCs made themselves a part of the set-up and became familiar with the issues. The information gathered in this process was used in developing better micro plans.

Dr Shirish Jain, DIO, Ghaziabad has noted that earlier, limited information was available about the numbers and social characteristics of the HRGs. As a result, in some areas, the HRGs were sometimes missed out in the planning process. In the last few years, with the efforts of SMNet, there is clear information and better coordination for a comprehensive micro plan to ensure maximum coverage.

## Separate micro plans for HRGs – mobile team plans

Post USS and with the active support of SMNet functionaries in the HRG areas, a separate planning exercise to vaccinate HRGs was formulated. The crucial information collected by SMNet about the numbers, location, socio-economic status, and employers, etc. played an important role in developing effective micro plans.

The WHO-NPSP officials continue the street monitoring activity till two days before the polio rounds to ensure all sites are incorporated in the micro plans. The impact of the rigorous pre-round mapping and identification activities is evident from the gradual decrease in the number of children who were being missed out.

To encourage the health workers and vaccination teams to reach the sites at the

right time, special vehicles are arranged by the health department and Rotary International. Mobile teams are formed for vaccinating children in HRGs, in order to ensure that remote locations are also covered.

According to a HRG BMC in Sadiq Nagar, a comprehensive survey of eligible children is conducted a week before SIA. The list is shared with the health department and other partners for better micro planning. As a result, the vaccination team is able to cover more number of children. They may miss a few kids or families but not huge numbers, unless there is a large scale migration.

## Social mobilization - pre round communication activities

The main reasons for low participation among migrant groups were low levels of awareness than ill-informed resistance. Accordingly, there has been an emphasis on raising awareness among HRG communities about polio and OPV. The awareness efforts were linked to an effective service delivery mechanism to ensure behavioural change in terms of enhanced coverage among children.

Besides regular communication efforts of the health department, the SMNet carry out elaborate communication and outreach activities in their respective HRG areas. They conduct regular community meetings and engage with contractors and employers. The aim is to apprise the community about the benefits of the polio vaccine and the importance of regular dosage to remain protected from polio. Community mobilization activities are undertaken at the time and location convenient to the community. For example, the mother meetings and community meetings are organized in the evening at brick kiln and construction sites, to ensure maximum participation.

Other innovative approaches have been used to track and mobilize the communities. A pool of local informers has been established to reinforce messages and track the movement of community members. The informers also play an important role in notifying newly emerging settlements. Similarly, employers and important stakeholders have been involved to facilitate participation during the polio rounds.

## Tracking HRGs through a pool of informers

It was important to develop rapport and reinforce key messages in the migrant community. Since a large number of sites were being identified, it was increasingly difficult for the health department, WHO-NPSP and SMNet members to visit each and every site on a regular basis. To overcome this situation, the ‘informers’ were identified from within the communities or among the ones residing in the vicinity of the HRG site. As of January 2012, there are 5,837 informers throughout UP, who provide information on HRG locations and help connect social mobilizers and health workers to HRGs. This network has proven invaluable to mobilizers and vaccinators, not just as information providers but also as facilitators during the polio rounds.

*BMC interacting with a nomadic family in Gautam Buddh nagar, Uttar Pradesh, India*

Mr. Mohammad Akbar Ali, who recently became an informer, has been living in Kathaira Road Slum at Dadri for the past 7-8 years. According to him, he himself was resistant to the vaccination and would use harsh language and avoid the BMC. The BMC persevered with repeated counseling until he was convinced several months later about the safety of OPV. Now, Mohammad informs the BMC about other children and feels good to accompany him on the vaccination rounds.

Informers like landlords, shopkeepers, guards, property dealers, Accredited Social Health Activist (ASHA), Anganwadi Worker (AWW), doctors and teachers were strategically chosen. It was always someone from within the community who could provide exact information of the settlement or the movement of the communities. On a weekly basis, the informers would intimate the BMCs and DUCs regarding the movement of migrants and settlers. This timely intimation has facilitated better planning as the information is incorporated into the micro plans. The DUCs continue association with those informers who provide timely, authentic information. Cross checking of information is done by SMNet functionaries and other polio partners at the district and block level. These informers also help the teams in vaccinations, apart from supporting and coordinating communication activities with SMNet. Regular orientation meetings are conducted with the informers by the SMNet team to familiarize them with their roles and responsibilities.

*Interaction with construction worker at a construction site in Ghaziabad, Uttar Pradesh, India*

A district level builders meeting in Noida, UP was also organized under the chairmanship of the District Magistrate to engage the builders in the polio programme. The builders decided that a nodal person would be appointed who will record all the necessary details of the beneficiary mothers and children at the construction sites. The list of nodal persons has been given to the Chief Medical Officer (CMO) of the district. The nodal person would be responsible for providing information and facilitating coverage of children at the construction site during the polio rounds.

## Building partnership with employers

The process of tracking and identifying eligible children among the HRGs involves going into their area of work and interacting with them on the site itself. In the case of slums and nomads, increased participation was dependent upon the rapport struck with the target population by the SMNet and other partner functionaries. In the case of brick kilns, children had to be identified and covered not just at the labour camps but also at the fields where bricks are manufactured. The process was more difficult at construction sites. Labourers live in diverse locations like camps set up by developers, shanties, brick sheds and within and under the construction sites.

In the beginning, many employers were wary of the field workers and their sudden interest in

the labour. They suspected that the BMCs and DUCs were covertly assessing labour welfare issues and whether labour laws were being followed. BMCs and DUCs were often turned away from the site citing security issues. The sense of distrust was so high that employers or their representatives believed this was an attempt to steal the labour for other sites.

For the success of outreach activities, enhanced community participation and a sense of ownership, it was necessary to engage with the employers. The SMNet initiated dialogue with owners and associations of brick kilns, builders, developers and employers to make them act as facilitators and influencers. The task was challenging because the employers were not forthcoming to participate in the programme. With coordinated efforts of the health department, local administration and SMNet, the employers were gradually included in the programme. Nodal persons appointed by the employers at construction sites keep track of the families. The Nodal person regularly updates the BMCs about the families and their movement, which is in turn incorporated in the micro plans.

Mr. Shishir Suman is a Project Manager at Amrapali Silicon City in Noida. According to him, trust, acceptance and the language barrier are among the challenges they face. They have designated a nodal person who coordinates an induction process for all labourers in which they plan to include health and other issues and increase awareness about available services.

The employers provide good support in terms of providing space for polio booths, motivating the workers for OPV and providing other logistics support as required.

At brick kilns, caretakers serve as influencers and the contact point for DUCs. They also support the vaccination team during immunization activities at the kiln site and motivate families to attend booth day activities. Brick kiln association meetings are organized regularly at the block level to engage employers in the polio programme. These meetings have significantly helped in reaching out to brick kiln workers.

The care taker of a brick kiln in GB Nagar talks about how all children under 5 years at the brick kiln site are sent to the nearest Polio booth during the rounds. He is proud to state that a vehicle is arranged to even send children and women to the nearest PHC for routine immunization.

*Interaction with contractor at a brick kiln, Noida, Uttar Pradesh, India*

## Monitoring and feedback during and after rounds

While health department teams travel across villages, set up booths and mobile teams, BMCs and DUCs ensure that all identified eligible children from these villages get vaccinated. Since HRG sites are numerous and widespread, BMCs visit select sites everyday of the round. For smooth functioning of the booth day activity, the vaccination team is notified about informers who can be contacted in case of any problems. Vaccination during SIAs is conducted by team A which conducts a house to house visit for 5 days followed by a Team B, which approaches the left out families, in the following week.

Mr. Zafar Abbas is a 26-year old BMC in New Ganga Vihar, Loni. According to him, involving Nomads was tough since they were not comfortable sharing information about their children and families. He involved a local person as an informer and together they built a rapport by talking about employment, drinking water, etc. Gradually, they could then discuss health issues and talk about immunization, hygiene and sanitation and reduce the resistance to OPV.

The WHO-NPSP field volunteers monitor the activities and in the evening meetings at the block level, data and feedback is analyzed in detail. These meetings are attended by the health department, WHO-NPSP, UNICEF, Rotary and other partners. For areas where the vaccination team encounters problems or children remain unimmunized, the partners collectively make corrective plans.

*BMC holding discussions with Nodal person and informer at construction site, Ghaziabad, Uttar Pradesh, India*

# seven

## GOING BEYOND POLIO

Due to the continuous interaction, migrant communities now acknowledge the selfless intent of the polio workers. The DUCs and BMCs are no more occasional visitors talking about polio. They are friends and in many cases, the go-to person in times of need. As a result of the trust, there has been a dramatic increase in the willingness of migrants to act on essential health messages. Once the rapport was established, SMNet mobilizers started sensitizing the partners about delivering a complete package of services with special emphasis on Routine Immunization (RI). Most of these HRGs were not included in the RI micro plans. In many cases, the shortage or reluctance of the health staff to carry out RI activities were stumbling blocks.

To start with, RI activities were initiated at big sites, with active support of the employers. Later, smaller sites were included and special vehicles were arranged for them to move from one site to another. The BMCs ensure that the ANMs come to the site either early in the morning or late evening to match the timings of the labourers. In addition, they enlist the informers in the area to communicate with the families about the importance and timings of the RI sessions. These informers then become mobilizers if the BMCs are unable to be present during RI sessions.

# Impact

The coordinated efforts of the health department, UNICEF and other partners have enhanced OPV coverage among HRGs. Gradually, the SMNet and health workers have started discussing other essential health practices such as routine immunization, hand washing and nutrition with the HRGs. The impact of the HRG strategy is manifold.

## DECREASE IN THE NUMBER OF MISSED SITE AND CHILDREN

The interventions under USS strategy have produced visible results. The number of sites and children missed during the polio rounds are gradually going down, barring some variations.

The support provided by SMNet to the health department, the enlisting of informers and the mobilization activities have resulted in increased participation in polio rounds.

## MORE SITES INCORPORATED IN THE MICRO PLANS

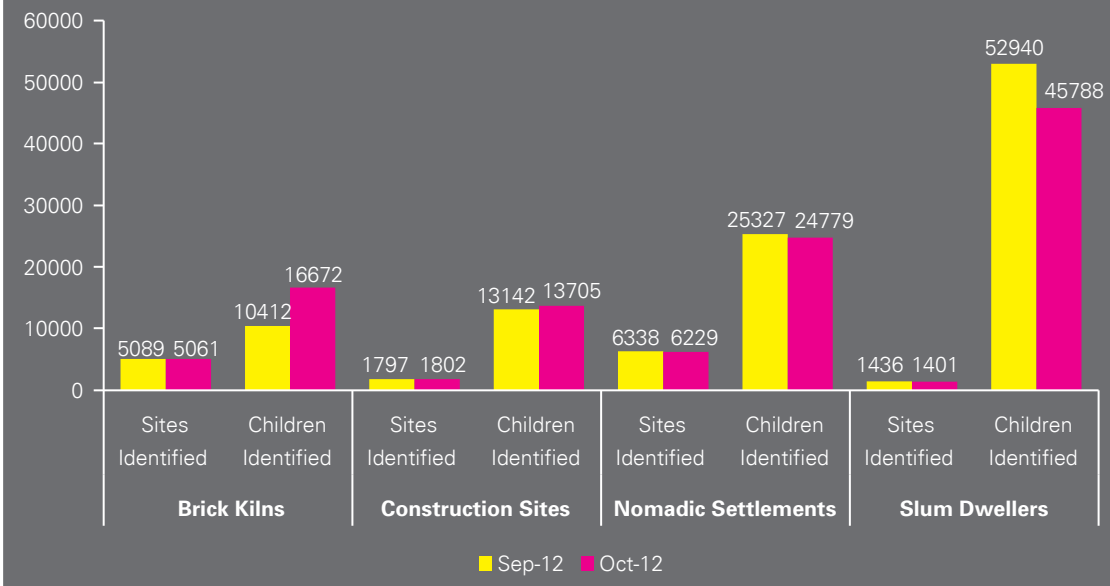
In the year 2012, on an average 15,215 sites were tracked by the SMNet every month. Tracking of sites helped to include these sites in micro plan. The number of sites tracked in each month is depicted in Table 1. In January 2011, when the special purpose BMCs started operating, almost 11,309 sites, 1,46,316 families and 1,45,868 children under five were identified in SMNet present HRAs in UP.

**Table 1: UNICEF Tracking of HRGs**

| Year | Month | Total number of sites identified | Year | Month | Total number of sites identified |
|---|---|---|---|---|---|
| 2011 | January | 11309 | 2012 | January | 15576 |
| 2011 | February | 11443 | 2012 | February | 15473 |
| 2011 | March | 12541 | 2012 | March | 15561 |
| 2011 | April | 12723 | 2012 | April | 15740 |
| 2011 | May | 14209 | 2012 | May | 15904 |
| 2011 | June | 14508 | 2012 | June | 15717 |
| 2011 | July | 14937 | 2012 | July | 15484 |
| 2011 | August | 14820 | 2012 | August | 14620 |
| 2011 | September | 15100 | 2012 | September | 14660 |
| 2011 | October | 14907 | 2012 | October | 14493 |
| 2011 | November | 15276 | 2012 | November | 14777 |
| 2011 | December | 15411 | 2012 | December | 14580 |

Source : UNICEF

**Figure 4: Sites identified in September and October 2012**




*Data source:*

With the inclusion of migrant groups in the polio plan and the subsequent focus on RI, more sites are being included in the RI micro plans. Higher coverage is being ensured by increased focus on mobile RI teams and special vehicles for the ANMs.

## INCREASED AWARENESS AMONG MIGRANT GROUPS

It is evident from the higher coverage for polio rounds and RI that migrant groups are now aware that they can easily avail health services while on the move. The presence of BMCs has ensured that these HRGs get health services. In many HRG sites, the special BMCs were the first and only health volunteers the community had met for the first time.

BMC conducting a meeting with a group of mothers and young children in Ghaziabad, Uttar Pradesh, India

# eight

## CHALLENGES AND WAY FORWARD

The process of tracking, mapping and engaging HRGs has been a slow but gradual one. The outcome is evident from continuous tracking of existing and new sites, to building trust, coaxing employers to become a part of the programme and gradually convincing the communities to adopt healthy practices. The efforts are slowly showing results by way of higher coverage of polio rounds and RI activities. The sustainability and long-term success of these activities, however, depends on how well the challenges are addressed.

The rapid increase in the number of migrant sites in UP especially in the satellite cities of Ghaziabad and Gautam Budha Nagar, where new residential and commercial properties are mushrooming, accurate mapping and tracking of migrant workers is proving to be a monumental task. The task is aggravated by the small pool of BMCs in charge of HRGs there.

For any health intervention to be truly successful, hygiene and sanitation behaviour needs to be correspondingly accepted. The dirty living conditions among the migrant settlements are feeding grounds for various infectious diseases like polio. Poor living conditions lead to decreased immunity and higher susceptibility to diseases, which vitiate the positive effects of other health interventions.

These challenges need to be addressed in the forthcoming years in order to ensure a healthy life to the migrants, nomads and other high risk groups.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