

CHAPTER: 09

GLOBAL PARTNERSHIPS TO LOCAL INNOVATION OF COMMUNITY ENGAGEMENT FOR POLIO ELIMINATION IN INDIA

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ABSTRACT

Global Polio Eradication Program (GPEI), a partnership between the World Health Organization, United Nations International Children's Emergency Fund, Centre for Disease Control and Rotary International – was launched to eradicate polio worldwide and simultaneously strengthen the health infrastructure. GPEI was announced by WHO in 1988, while India accepted the GPEI only in 1995. Despite numerous implementation challenges, it took us almost 30 years to become a polio-free nation. Many factors contributed to the successful elimination of polio from India. This paper presents a case that revolves around the story of a Strong Global partnership, local partnership for managing the human resources on immunization days and community engagement that optimises the program functioning and reaches the last mile leading to eradication of polio from the country.

Keywords: Polio, Eradication, Partnerships, Community Engagement, Human resource for health, Uttar Pradesh

INTRODUCTION

In the Southeast Asia region, India had been struggling with the disease with more than 200,000 cases before the inception of Global Polio Eradication Initiatives (GPEI) which is collaborative effort by WHO, UNICEF, CDC, BMGF, and Rotary – International. In India, the Oral Polio Vaccine was included in the national immunization schedule of the expanded program in 1978-79. Still, it was started as a campaign mode when the Polio Eradication Initiative launched in 1995. 'Pulsing' is an immunization strategy that works in polio-endemic countries such as Brazil and was recommended for the Global Polio Eradication Initiative to vaccinate the huge population on a mass scale. The strategy involved immunizing all children on a large scale, two times a year. Global Polio Eradication Initiative (GPEI) promised eradication of

poliomyelitis by the year 2000 and “certification” of eradication by 2005—certification meaning no polio cases with virologically confirmed wild virus for three consecutive years (Sathyamala et al., 2005).

The formula for eradicating polio seemed straightforward: consistently vaccinating all children under the age of five years but to achieve this target, four essential preconditions were necessary, a Robust Public Health system, Successful planning of immunization days and management of Political and Operational Challenges and acceptance of vaccines among the community. For all the above conditions, there is a dire need of human resources with high political will, commitment, capacity of execution, sense of ownership towards the program and sustained support to successfully stop the eradication of poliovirus transmission forever (Kalbarczyk, et al., 2021). Polio drive demanded the participation of hundred thousand field workers, health professionals, volunteers to immunize all children under five in the country on a specific date so as to break the transmission. This meant that every child had to be immunized on the same day.

In 1995, the magnitude of first immunization day launched by Government of India and the State Governments has few parallels. Over 87.77 million children, including 79.29 million children less than three years of age, were given a dose of oral polio on one day throughout the country on 9 December 1995. In the second round on 20 January 1996, over 93.118 million children, including 85 million children under three years, were immunized. The program reached out to children in more than 5,57,000 villages and nearly 4000 towns. More than 500,000 immunization posts were set up to avoid overcrowding and to ensure easy accessibility, even to children from remote villages and difficult terrain. More than 2 million persons manned the posts, many volunteers from the community and other government departments. (Sokhey, 1995)

It was a common understanding that to reach every child an enormous human workforce and resources would be required, and Indian health system alone was not enough to overcome with this issue. Indian health care system includes – public at national, subnational (District and Subdistrict hospitals) and frontline level (Primary Health Centre and Subcentres) and private health care functionaries (private hospitals and clinical practitioners). Of a total population of 1 028 610 328 in 2001, there were only 2 069 540 health workers in 20015 which was about half of the WHO prescribed norm of 24.5 per 10,000 population⁶. This created a challenge to implement the GPEI activity at national level.

In 2002, when the world was about to eradicate polio, on the other hand, there was a polio outbreak in India – where there had been just 265 cases in 2000 – accompanied by a six-fold increase in paralytic disease. The goal remained elusive in India, especially in Uttar Pradesh and Bihar, even after a decade of mass immunization despite tens of immunization rounds. (Wasan Parul 2015). The critical requirement for mass vaccination to eradicate polio is administering oral polio vaccine to all children simultaneously within the shortest time possible so that the intestines of most children will resist infection and spread of wild poliovirus. The outbreak localized to the economically disadvantaged northern state of Uttar Pradesh, disproportionately affecting the minority Muslim population (Bahl and Bhatnagar et al., 2021).

5 https://www.who.int/hrh/resources/16058health_workforce_India.pdf

6 <http://uhc-india.org/uploads/SituationAnalysisoftheHealthWorkforceinIndia.pdf>

This case documents the strategies of mobilizing human resources for a nationwide campaign to eliminate polio through partnerships, intersectoral coordination and engagement of community mobilisers for elimination of polio from India.

METHODOLOGY

This paper utilized the Grey literature extracted data and qualitative data collected as a part of STRIPE Project (Synthesis and Translation of Research & Innovation in Polio Eradication) funded by Johns Hopkins University. Key informant interviews were conducted with the major stakeholders between November 2018 and January 2019 who were a part of the Polio Universe to document the experiences of key implementers of polio eradication in India.

Definition of Polio Universe: The working definition of Polio Universe in the project is a group of people who at any level (National, State, block, and field) had been involved in Polio eradication effort in India any time over the total duration (1995-2012) (Majumdar et al., 2023).

Face to face in-depth, semi-structured interview were undertaken with the National change agents (N=11), subnational change agents (N=10) and Frontline workers (N=4). Respondents selected were national-, sub-national-, and frontline actors, representing key positions, organisations and levels within the health system and the ability to speak to core program components and emerging topics. The interviews were conducted in local languages where required and subsequently underwent translation and transcription. Grey Literature is defined as a document that is produced on all levels of government, academics, business, and industry in print and electronic format but not controlled by an academic publisher. A total of 477 documents (Grey literature) were searched and selected from offline and online data sources from 1995-2017 and 219 were further selected for data extraction.

RESULTS AND DISCUSSION

a. Leveraging on partnerships

In 1990s, Government of India (GoI) accelerated the activities for polio eradication by partnering with Rotary International, World Health Organization (WHO), UNICEF, the Centre for Disease Control and Prevention (CDC), Japan International Cooperation Agency (JICA), Danish International Development Agency (DANIDA). Ministry of Health and Family welfare (MoHFW) was responsible for planning and implementing the immunization campaigns; WHO managed the surveillance system by providing the manpower of surveillance medical officer; and UNICEF led mass communication, local media, IEC material production, social mobilization leading to demand generation, raising awareness and reducing resistance in communities. Institutional partners such as the Indian Medical Association (IMA), the Indian Academy of Paediatrics (IAP), and universities such Jamia Milia Islamia and Aligarh Muslim University all contributed to building an environment of trust for the program. Rotary took the lead on advocacy and fund raising. Engaging key religious leaders to get community support for polio eradication, Rotary formed an Ulema Committee in Uttar Pradesh comprising of senior Muslim scholars and religious leaders to address resistance issues. Other partners such as USAID, DFID, Japanese International Cooperation Agency (JICA),

Danish International Development Agency (DANIDA) agreed to support various elements of Polio eradication.

“UNICEF provided IEC materials, Apron, caps etc. were supplied by the rotary because all were partners, Governments, rotary international WHO, UNICEF, CDC, IEC were the key partners, involved in the GPEI”- Stakeholder, Rotary International.

This has become the people’s program, many top luminaries, supported this program like film stars, President, prime-minister, most of the film stars came forward to support this program. – Stakeholder.

b. Intersectoral coordination for human resources

The major implementors of the PPI program were MoHFW’s Department of Family Welfare, state health and family welfare directorate, district health units, community health centres, primary health centres, medical and paramedical personnel, NGOs and voluntary organizations and media units. The network of Family Welfare Offices of the Central and state Governments was responsible for organizing the PPI, providing vaccines, maintaining cold chain and providing logistic support. Medical and paramedical Personnel manning the polio booths were responsible for checking the quality of the vaccine and immunizing children. Because of limited human resources in health department, help was sought from the other government departments like Education, Social welfare, Home Affairs, Defence, Youth affairs, Urban development, Railways, Civil Aviation, Shipping, Commerce etc. to mobilize human and other resources. Many committees were established at the National, state and district level to ensure inter-sectoral coordination and full utilization of resources from partner government and non-government departments and monitor the preparedness of booth activity in each area.

“All the opinion leaders, stakeholders were identified including doctors, politicians, religious leaders, aware them about benefit of giving two doses of polio before actually launching the pulse polio program in Delhi”. Stakeholder, National Level Government Department (Other than the Health Department) involved in NIDs

Education Department: Polio booths were also located in schools/colleges in the vicinity, and the human resources of the education department were involved in booth activities. School teachers/ college students were made part of booth and house-to-house vaccination teams. Army of school children were developed to conduct polio rallies and mobilize the family members to go to polio booth for vaccination.

Panchayati Raj Institutions: Gram Panchayat Vikas Adhikari (Village development secretaries), Lekhpals, Village Pradhan and Panchayat members accompanied the vaccination teams during house-to-house visits and mobilize community to accept OPV. They also created awareness activities, selected the polio booth location and launched the polio activities in their village.

Department of Social Welfare: In some places, polio booth activity was organized in Anganwadi centres. Anganwadi workers also contacted local community leaders and mother’s groups to raise community awareness about NIDs/SNIDs and worked as a part of the house-to-house vaccination team. Everything is having impact on this program, we say that we are working in public health, but it has so much so that it has linkages with the National Government development programs like the PRIs or rural development schemes or the roads or the electricity, everything contributed in GPEI Program.- Stakeholder State level.

“The innovation lies in creating a different pool of influencers based upon the different domains they are working in, religious leaders, PRI members, occupational leaders, and the most innovative one created in Nepal border. There was a whole consortium of religious leaders who got engaged and supported the health programs in religious gatherings like Kumbh Melas”

Stakeholder, UNICEF

Transport, Civil Aviation, Railways, Shipping: Transport department facilitated the setting up of transit booths on all railway platforms, bus terminals, highways, ferry crossings, airports, ports during booth activity to cover children who were on move. OPV was provided in selected trains linking endemic areas by railway health staff. Railway health staff ensured the vaccination all target children in railway staff colonies.

Home Affairs, Mahanagar Telephone Nigam Limited (MTNL), Defence: Government workers from these departments became a part of vaccination teams and helped to cover their own residential colonies. Polio booth is organized in their premise of government department. Defence professionals also provided a vehicle for NID/SNID activities.

Professional Medical bodies like IMA (Indian Medical Association), Academia was involved: National, state and district chapters of all professional bodies communicate formally to all their members and helped in client mobilization. All private and public physicians, private practitioners and other health professionals informed their clients of the dates of NIDs/SNIDs and the need for all children 0-5 years of age to receive a dose of OPV during all NID/SNID rounds, regardless of their prior immunization status. Some of the health professionals also helped in monitoring NID/SNID activities.

“Academia was involved; Muslim Universities like, Aligarh Muslim University, Jamia Hamdard University, Jamia Islamia University would be the one advocating for the vaccine”

Stakeholder, WHO

NGOs/Voluntary Health Organizations: NGOs helped mobilize the parents to the booth and accompany vaccination teams during house-to-house visits, provided transportation, and helped shatter the myths associated with the polio vaccination.

Government officials involved in national immunization days

District Magistrates were made responsible for monitoring the planning and implementation of NID/SNID activities in their districts through weekly review of the progress and problem-solving. Deputation of senior officials from the administration and other sectors were undertaken to supervise the preparations and implementation of the NIDs/SNIDs in various blocks and urban areas of the district. They were also involved in intersectoral coordination of all other departments in the district for mobilization of manpower, transport and social mobilization. The chief medical officer ensured finalization of Micro plans, capacity building of vaccinator and supervisor and finally vaccine procurement, distribution and logistics arrangement.

“District Immunization officers and Block medical officers was responsible for supervising of micro plan, making route chart for vaccine delivery, and collecting and compiling reports from vaccination teams”

Stakeholder, WHO

Polio eradication activities were led, organized, supervised and implemented by the existing routine immunization and surveillance staff and structure and state health department. However, the number of formally trained health workers were often insufficient to fully implement the strategies, particularly in many of the areas with a high burden of polio. Consequently, given the time limit set for achieving the international goal of polio eradication, national eradication efforts relied heavily on the mobilization and management of an “informal” or “volunteer” workforce, especially to implement the NID strategy. First, having recognized that universal implementation of the strategies in many areas would rely heavily on illiterate, unskilled or semiskilled volunteers, tasks were adapted or modified accordingly.

“The biggest lesson learnt from this program was “Skills are not dependent on education or qualification of a person” as the frontline workers were trained and utilized to give two drops of Polio vaccine to the children”

Stakeholder, Govt. of India

Community influencer/mobiliser can be anyone; We have taken support of quacks to run the polio booths in their centres because community members believed them”

Stakeholder, CORE Group

Case Study 1: Engagement of community mobilizers to reach zero Polio cases in Uttar Pradesh

Uttar Pradesh, with a population of 166 million people, was the most populous state in India. 500,000 to 750,000 new births occurred in Uttar Pradesh each month in 2000. Seventy nine percent of Uttar Pradesh’s population lived in rural areas,12 and 65% of residents were employed in cultivation or agriculture in 2001. Uttar Pradesh had large populations of migrant workers who moved frequently between different parts of North India, following the demand for seasonal labour. In Uttar Pradesh people from different backgrounds, castes, and religions often lived in separate communities. A significant percentage of the population descended from lower-caste Hindus. Northern India also had the second-largest Muslim population in the world, behind Indonesia. In such situations, it was a challenge to reach the unreached or marginalized and scattered population. In 2001, after the polio outbreak, implementors thought of engaging community persons to reach and mobilize the marginalized community. UNICEF recruited a team of coordinators for polio-endemic districts, primarily to serve the densely populated western Uttar Pradesh. These temporary staff, called Social Mobilization Coordinators (SMC), were selected for their experiences in running development projects in the district or region to which they were assigned. SMC was created to identify and respond to the areas where resistance to OPV vaccination was most acute. SMC’s major function was to initiate interpersonal contact with families in between the vaccination rounds to pave the way for vaccinators’ house-to-house visit in high-risk, high-resistant blocks and villages. Locations were identified mainly by the government’s block-level Medical Officer-in-Charge (MOIC) and WHO’s Surveillance Medical Officer (SMO) based on recent cases and transmission patterns. The coordinator was also required to participate in joint planning with the district administrator, health authorities, National Polio Surveillance Project office, Rotary, and Core Group of NGOs, which were members of a District Task Force (DTF) for Polio Eradication chaired by the District Magistrate. Those

districts that reported a high number of polio cases such as the “Hot 4”: Badaun, Bareilly, Moradabad and Rampur, the SMCs were supported by a group of community mobilization coordinators (CMC) in villages, a hundred per district. For districts with relatively lower transmission of poliovirus, the SMC worked directly with the CMC in villages. With the intent to eventually transfer capacity to the local government. Recruitment of CMCs in 10 high-risk districts was undertaken by Chief Medical officer (CMO). Initially the functioning of SMC was exhausting and full of hurdles because taking care of 100 CMC belonging to poor and marginalized community with limited mode of communication was unsurmountable task. In India, the administrative structure is divided into state, division, district, block and village; hence coordination with various layers of bureaucracy to drive changes in the lowest administrative division which is village was a painful affair for SMC. The major reason for the ordeal was lack of communication facilities (with no access to mobile phones) and lack of transportation in hard-to-reach areas. It was finally decided to bring another tier of support at block level named as “BMC”- Block Mobilization coordinator. The combined SMC with BMC and CMC structure was first tried out in the “Hot 4” districts, where vaccination efforts had encountered hardcore resistance (Weiss et al. 2011).

The four SMCs were given a quota of hiring a number of block mobilizers (BMC) selected from high-risk, high-resistance blocks to support some 400 community mobilizers (100 CMCs per district), while the other six districts without a BMC continued on with 600 CMC. A Sub-regional Coordinator (SRC) was also appointed to supervise SMCs in the “Hot 4” districts in Uttar Pradesh. The deployment of community mobilizers was based on the number of reported polio cases as well as the complexity of resistance in villages within a block. Social mobilization Network team, along with other community influencers engaged by the government and managed by Chief Medical Officers of 10 districts facilitated high booth attendance in the community.

The SM Network was assigned a fixed set of activities designed around the assumption that an overemphasis on behaviour change, without addressing conditions of poverty and inequities that reinforced negative attitude, would be ineffective. In designing the activity plan, UNICEF was fully aware of the many historic, social, cultural and economic factors that shaped resistance and of which it had no control. Further, mistrust of state-run programmes was not forged overnight. Interventions had to center on building trust and regaining community confidence in the polio eradication programme through intermediaries, respected figures such as Imams, teachers, medical doctors and local activists. Improving understanding and awareness about polio, particularly with mothers and mothers-in-law, continued to be mandatory in order to address concerns about repeated doses, side effects and vaccination when a child had fever. Community resentment over the lack of service other than polio drops was another major consideration that called for special events such as a day-long Health Camp to offer general curative care for children, routine immunization and preventive health counselling for parents (Weiss et al., 2011).



Figure 9.1: CMC bringing children from rickshaw to vaccination booth in Bareilly



Figure 9.2: Muslim women working as CMC in Moradabad district of UP

In early 2003, management of the SM Network was transferred from New Delhi to its Lucknow (UP's capital) state office. The major reason of shifting from central level to state level was to strengthen the network and monitoring of mobilization coordinators. A full team of communication and technical staff was appointed to supervise and monitor the Network's activities, ensuring closer coordination at each level of the 25 districts. The presence of a team had helped improve coordination with the UP government in Lucknow in preparation for each round, as well as shoring up routine immunization of children. In addition to joint planning with the public health sector, the team also built on the on-going collaborative programme with the state education sector, the integrated childhood development services (ICDS) and the Panchayat Raj Institute, to mobilize broad-based support in convincing families across the state to immunize children, including districts without the SM Network. major feature of the SM Network was CMCs who served as the interpersonal communication channel to ensure dialogues and actions. The average age of CMCs was 30 - 35, comprising 45% women, with 60% of the total Muslims and 40% Hindu. The major criteria of selection were they had to reside in the community, demonstrate strong interpersonal communication skills, and be well respected in the community with some formal education. The CMCs were selected and recruited by the BMCs, who had a better grasp of situations in their own block and advertised for the job by word of mouth. A premium was placed on communication skills and/or position of influence in the selection process. Given the generally low education attainment among marginalized communities, it was not always possible to find someone who was completely qualified. The aspiration for achieving a gender composition of 80% women was also made difficult by cultural prohibitions against females from playing an active role outside their home. The BMCs often had few choices but to accept individuals who fulfilled some criteria. In some villages, the Pradhan (Village Headman) had been brought on board as a CMC. one and only schoolteacher, the social worker, and even students, the latter mostly assigned to work with local youth groups that took to a peer, more than an elder. There were also CMCs engaged from beggar communities, from among fishermen along the Ganges, and among nomads to track unvaccinated children in families that were constantly on the move. Each CMC trained on interpersonal and persuasion skills, was also tasked with many social mobilization activities, including working with local NGOs, influencers (opinion leaders, doctors, health workers) and religious leaders to convince resistant families. And many were retained after the vaccination round to continue implementing the IPC plan in preparation for the next round. They also provided a link to accelerating routine immunization coverage and helped facilitate community participation in the promotion of child health. In 2002, as many as four Sub-NIDs were held in UP, from April to November, followed by two NIDs in January and February 2003.

Out of the array of district partners, UNICEF undertook intensive mobilisation jointly with two organizations, Rotary and the CORE Group of NGOs, diving deep into high-risk blocks and underserved communities. One of the most solid measures of CMCs' performance was the tally sheet on booth day. A 100% attendance in his or her village was reflective of general community support for the programme and a decline in localized resistance to polio immunization. Another measure was the reduction in the percentage of missed houses. CMCs' daily contact with families had also contributed to booth location selection. The distance between home and the vaccination booth had always been one of the discouraging factors for parents. Many CMCs had related community's views to their BMCs, who in turn conveyed it to the MOIC at the block, and to the SMC who shared such information with the Chief Medical Officer (CMO). A number of social mobilization groups formed by CMCs had also volunteered to set up their own booth, in locations closer to their communities. The BMCs then notified the SMC, who consulted with the CMO and Surveillance Medical Officer, and down the line to ensure vaccines were delivered to the volunteer-manned booth on immunization day. (Choudhary et al., 2021) The presence of the SM Network had generated a high degree of visibility for the NIDs among the marginalized, underserved communities. It was found that villages with CMC had fewer refusals, places where IPC activities were conducted and mobilizers were present, communities were more willing to open their door for vaccinators and able to achieve the zero case in Uttar Pradesh.

CONCLUSION

India's incredible achievement over Polio Pulse Polio Program is considered as ordinary people's massive movement against the dreaded paralytic disease. Almost every month in India, over 450,000 health workers deliver the Oral Polio Vaccine (OPV) to 58 million children under five. Hence, coordination with partners is the key to all models for polio eradication. Polio eradication activities in the states were coordinated at three levels: the inter-agency level, the inter-departmental level and the district and block levels. At all these levels, committees have been set up and institutionalized and are now seen as integral parts of the state machinery. Taskforces have been established for Advocacy and Media, Social Mobilization and Vaccine Procurement. The tireless efforts of 7300 SMnet community mobilisers reached millions of children, mobilized thousands of local influencers, galvanized hundreds of partners, and collected microdata during each SIA round. This mammoth effort, sustained over several years now, has made the Indian polio programme the largest and one of the most successful public health programmes in the world. The major accomplishment of the programme was to gather human resource from all the sections of the society, various government departments, voluntary organizations, medical and nursing professional bodies, religious leaders, children and youth for an activity perceived to be in the interest of the country's children.

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