Communication for Development Guidelines for Responding to Polio Events and Outbreaks

Post Switch

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INTRODUCTION

A fast, effective response to stop new polio outbreaks in previously polio-free countries is crucial to meet the GPEI's (Global Polio Eradication Initiative's) aim of global eradication. Countries and GPEI partners must stop transmission of poliovirus within 120 days of confirmation of any new outbreak. Both wild poliovirus (WPV) and vaccine-derived polioviruses (VDPVs) can cause clinical illness, including acute flaccid paralysis (AFP), and outbreaks.[1]

The Emergency Committee (EC) for polio, convened under the International Health Regulations (IHR), continues to monitor both WPV and VDPVs with heightened concern. VDPVs capable of causing paralysis continue to emerge and circulate. To respond to this threat, the IHR EC has included circulating VDPV (cVDPV) polioviruses in their remit for monitoring action and progress. cVDPVs are a particular risk in under-immunized populations. The continued use of oral polio vaccine (OPV) type 2 component (OPV2) is responsible for most cVDPV cases and outbreaks. The outbreak response for cVDPV follows the same principles as for WPV. In response to the increased concerns of VDPV-related outbreaks, the May 2014 WHA endorsed a strategy to reduce the risk associated with attenuated poliovirus (Sabin strains) used in oral polio vaccine (OPV).

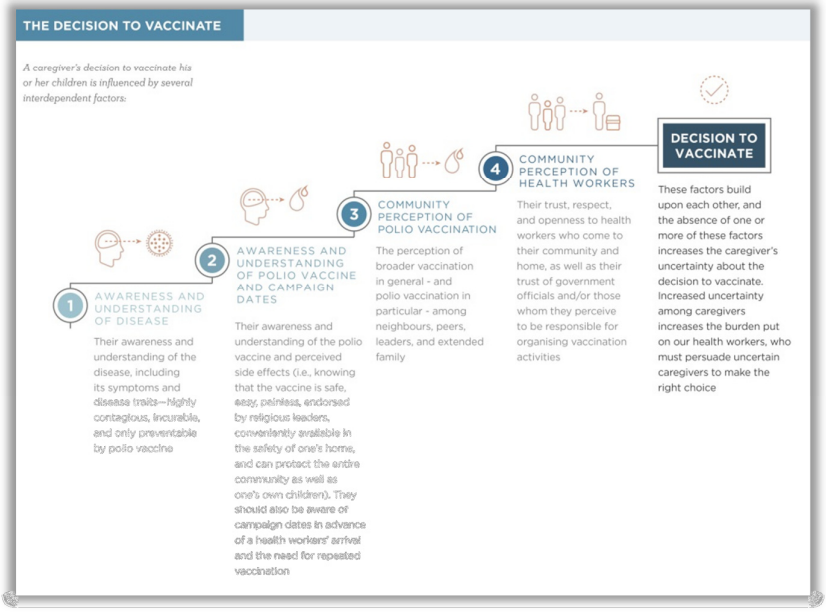
The GPEI Standard Operating Procedures (SOPs) recommend that supplemental immunization activities be implemented within 14 days of identification of a poliovirus that requires an immunization response, for each type of isolate. GPEI must fulfil six critical functions in support of an event or outbreak response: event/ outbreak confirmation, grading, response assessment and closure; coordination and advocacy; technical and human resources; information management; external communication, social mobilization and behaviour change communication; and finances and logistics. Response must be built upon a deep understanding of community needs, positive attitudes and behaviours of parents to agree to give their children the vaccine repeatedly. This set of C4D polio outbreak response guidelines updates earlier standards issued in October 2015. The C4D guidelines are based on the UNICEF's 2015 Global Polio Communicate Guide and April 2016 SOP.

A. COMMUNICATIONS FOR DEVELOPMENT (C4D) FRAMEWORK

C4D for Polio is a systematic, planned and evidence-based strategic process that aims to promote positive and measurable social and behavioural change for maximum coverage of OPV. It relies on a foundation that social and behavioural change is rooted in local context, as well as the consultation and participation of children, families, communities and networks. These principles also apply to communication in a polio response, though the process must be accelerated for an outbreak context.

[1] GEPI factsheet *Vaccine-associated paralytic polio (VAPP) and vaccine-derived poliovirus (VDPV).* http://www.who.int/immunization/diseases/poliomyelitis/endgame_objective2/oral_polio_vaccine/VAPPandcVDPVFactSheet-Feb2015.pdf. Accessed Feb 2016.

Previous polio communications strategies commonly targeted individual caregivers with facts about polio and polio vaccination. The new polio strategy is specifically designed to address the dynamic perceptions and social norms that deter caregivers from vaccinating their children. It builds on the critical first step in any outbreak of raising awareness, and urgency but also goes beyond this to establish a strategic emphasis on building trust for health workers



and the vaccination services they bring. In all phases of an outbreak, our communications must address each of the decision points in this diagram. These factors together will determine whether or not a caregiver decides to give their child repeated doses of OPV. The Polio C4D response is based on the Social Ecological Model (SEM) developed and used by UNICEF to understand and address norms that influence individual and collective behaviours, such as the acceptance or rejection of the polio vaccine and the vaccinator who delivers the vaccine. The SEM model (as depicted in the diagram below) should be used to develop a comprehensive plan to engage with all actors who will ultimately influence a parent's decision to vaccinate repeatedly. During the development of your outbreak response plan, it will be important to consider relevant interventions at all of the framework's levels. Utilizing a multi-faceted approach will help ensure communities and decision-makers at local, national, and regional levels are engaged in dialogue toward promoting vaccination. The polio outbreak communications strategy has two distinct phases: **Immediate Response Communications (IRC) and Adaptive Phase Communications (APC).**

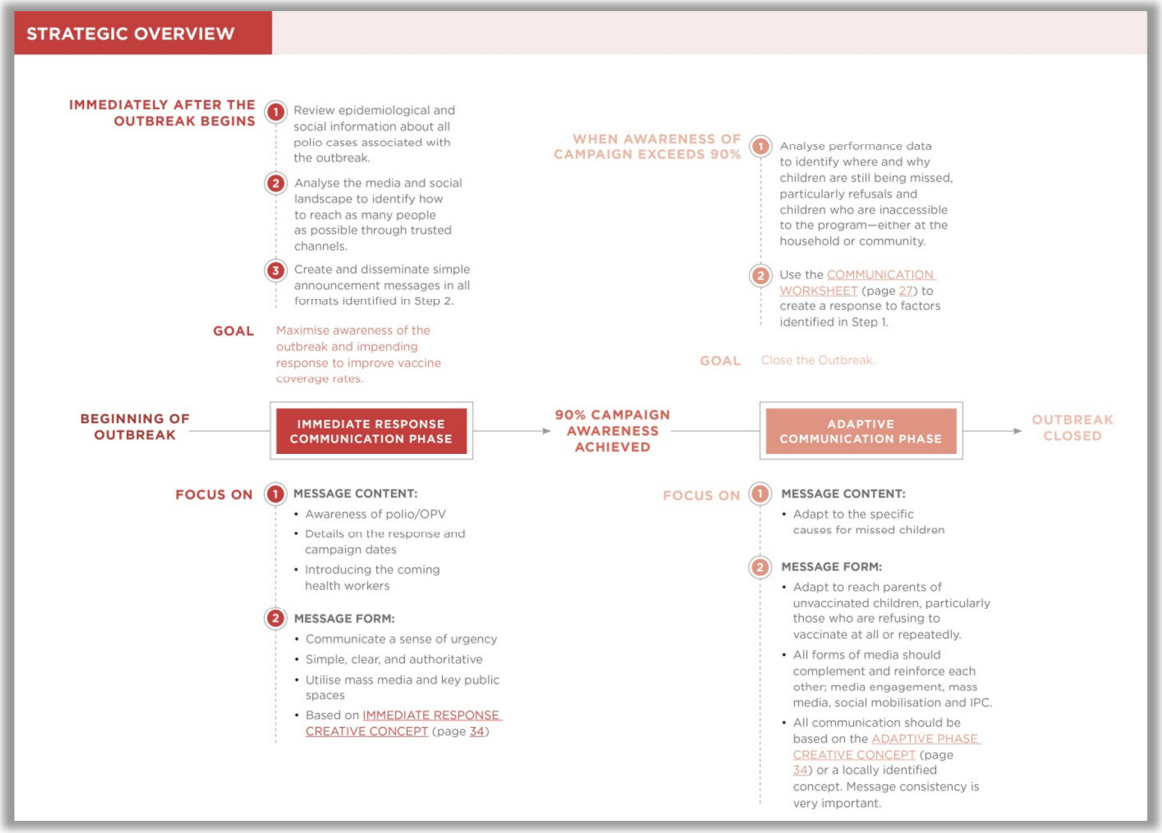
Immediate Response Communications (IRC)

Immediate Response Communications is employed immediately after an outbreak is declared and focuses on building (or rebuilding) caregivers' critical awareness about polio, OPV, and fact that there is an urgent outbreak in a local community that puts children at risk. At the beginning of an outbreak, the goal is immediate mass response to communicate to the population about the outbreak, the planned response to the outbreak, information about polio and the vaccine, and the health workers who will administer delivery

of the vaccine. Within the immediate response phase, communications should be straightforward, clear, and illicit an urgent response from parents and the community at large. The primary goal is to raise awareness of the outbreak, the disease, the vaccine, vaccination dates, and the response to a threshold of at least 90% awareness as quickly as possible.

Adaptive Phase Communications (APC)

Adaptive Phase Communications (APC) begins once the awareness threshold has been achieved. This could be after one month or up to four months, depending on the local context. In this phase, communications will shift to more closely supporting the goal of reaching missed children. Communications will address social barriers and opportunities for promoting vaccination, and will leverage these, respectively, through our communications and engagement approach. Uncovering these barriers requires research and analysis of caregivers and their knowledge, attitudes, and practices about polio that should be conducted as IRC progresses. As barriers are identified, new communications will be required to address them. The APC lasts until the outbreak is concluded.



B. PHASE I- IMMEDIATE RESPONSE COMMUNICATION: 24 HOURS TO ONE MONTH

B.1 Epidemiological and social investigation

As soon as a notification is made, a critical first step is to conduct an epidemiological and social investigation of the infected case. This joint investigation is undertaken between MOH, UNICEF and WHO and aims to rapidly assess the management, operational, and social environment in the area affected by the virus. This tool includes an assessment at community, sub-district and district level. UNICEF is generally responsible for the community assessment, but also participates in each part of the assessment. If UNICEF is unable to attend the assessment, WHO and MOH team must

ensure filling out the social investigation component of the form. Direct observation and interviews in the local area can quickly lead to meaningful insights about the family and the affected community[2]. If feasible, it's important to review existing data of knowledge, attitudes, practices and behaviour (KAPB) surveys, or conduct a rapid assessment, to learn about the social norms that can affect vaccination. Such reviews should be done in parallel, in order to initiate the response quickly.

B.2 Media response in a polio outbreak context

Monitoring and engaging with different forms of media is critical from the onset of the case. Media can pick up the confirmation of polio virus and disseminate it in an unproductive manner if not well-managed. The Ministry of Health, with WHO, will always be the first to announce an outbreak, and they should take the lead in this area. You should immediately establish which agency is leading in the Media response: WHO or UNICEF. This leadership role will depend on capacity in each country, but generally UNICEF leads the media response in addition to the C4D response. However, irrespective of which agency leads, there should be close collaboration and consultation between the two agencies and RO and HQ levels of the two organizations. Joint teleconferences to establish the media strategy should be initiated immediately by the leading agency.

To effectively manage the media response, it would be important to ensure thorough understanding of the media landscape and media influencers by closely monitoring coverage about the outbreak and its tonality. Subsequently, a list of media reporters that cover health, as well as programs with high viewership and listenership should be developed, and continuous communication should be maintained with them to build trust. Ensure the programme and UNICEF have spokespeople identified who have the capacity to work with media, who send the right message about ownership and the 'public face' of the response, and who are media-trained.

B.3 Understanding the communication landscape

It will be important to conduct a thorough communications landscape assessment that will help to make the right choices about which communication tactics to employ. This includes information on media consumption patterns (TV, radio, press, outdoor, transit, social media, magazines, etc.); highly viewed / listened-to programs and channels; influential media personnel who are "public social leaders" and can help the polio cause; available social mobilization committees at national and subnational levels; available community engagement networks in the country, especially in high-risk areas, as well as their readiness and capacity to be deployed…etc.

B.4 Coordination of communication interventions

Creating or reinvigorating a national communication or social mobilization taskforce is critical, starting with the early days of the outbreak. In many contexts, the National Interagency Coordination Committee (ICC) for immunization can create or activate an existing Social Mobilization Committee (SMC).[3] The role of the SMC is to plan, coordinate and ensure the successful implementation and management of media and C4D interventions to support supplementary immunization activities and routine immunization. The SMC should meet regularly throughout the outbreak and should be represented on the ICC or another management taskforce created by the GPEI/MOH. It should also regularly report on key milestones. The SMC and coordination mechanisms above it should be applied to sub-national level to improve the response all the way to the lowest peripheral level. Either way, external communications and social mobilization should always be joined up and undertaken through a cohesive strategic approach.

B.5 Communication for development within the national outbreak response plan

The SOPs require deploying a GPEI team, as soon as an outbreak is confirmed in any country, to support the response. Once the outbreak is assessed and all available data and capacity reviewed, the GPEI team initiates the development of a comprehensive plan that includes C4D. Within the C4D plan, you will need to include the following components:

[2] The methodology for special investigation tools to identify reasons for missed children is included in Annex 1

[3] Adapted from Communication Handbook for Polio Eradication and Routine EPI, Annex 8 (UNICEF/WHO/Polio Partners, November 2000), and Briefing Guide on Planning, Management and Implementation of Communication for EPI/NID, Annex 1, DR Congo (UNICEF, March 2000).

B.5.I Communication objectives and indicators

While it will be important to indicate expected changes in **knowledge, attitudes, practices and behaviour (KAPB)** of the targeted group, it is equally important to link the communication objectives to the programme indicators the full campaign response aims to achieve. For example, the communication objectives should reflect how the C4D interventions would achieve some of the following:

- ✓ Proportion of children missed due to refusal or absence in high risk districts among all targeted children during last SIA is minimal.
- ✓ Percent of caregivers aware of polio campaigns prior to the arrival of vaccinators especially in high risk districts during last SIA is maximized.
- ✓ Percent of high risk districts where the district-level micro-plans incorporate the minimum required social data and sending a complete communication and social mobilization reports from last campaign is high.
- ✓ Percent of districts where IPC training for Social Mobilizers and Vaccinators has been conducted during the last 2 months.

B.5.II Audience analysis

It is important to segment the audience into primary and secondary groups. The audience analysis should also include a list of stakeholders or people who can be ***mobilized*** to support the programme, or with whom it is important to ***advocate*** to get their support. These may include religious and community leaders; teachers; and/or youth volunteers. It is also vital to analyze the barriers that can block triggering the decision by the target audience. Some of these barriers can be social, access or related to the service. In the context of polio outbreaks, and based on analysis of different country and regional experiences, the target audience may fall under one of the following categories:

1. Acceptors
2. Vulnerable acceptors
3. Rejectors
4. Transient

Acceptors represent the majority of a typical country's population. They are motivated to vaccinate their children since they accept vaccines. They trust the health care workers and system, and are aware of the risk of polio as an implication of non-vaccination. This group also has the self-efficacy to accept the vaccine, even in a situation where there are rumors or waves of refusals at the community levels.

Vulnerable Acceptors may lapse in acceptance over time. They could be moderately accepting immunization and the service. However, in the case of anti-vaccine rumours or a community push towards refusals for some other reason, they may become rejectors.

Rejectors are usually a minority of the population. But they often cluster in communities that provide a supportive social and cultural environment for their disbeliefs and suspicions about immunization services, vaccine safety, or the value of vaccination. Rejectors may not always be caregivers. They may be influential community leaders or members, or even vaccinators who are not fully convinced that what they are promoting is right.[4]

Transient populations are on the move, whether because they have been displaced from their homes or are traveling for livelihood or other reasons. For those who are on the move and are not able to go to a permanent vaccination point, the program organizes transit vaccination points. To support this effort, targeted communication is usually carried out for a limited time.

B.5.III Developing key messages and materials

As a principle, existing relevant materials should be the first place to start. Some can be reproduced, with

[4] Polio Communication Global Guide. UNICEF NYHQ. 2016.

modifications to adapt to the new outbreak event. Should additional **new** materials be needed, all new C4D materials or production should be linked to the overall strategic objectives identified in the C4D strategy. There are three principles that all polio materials and communications seek to adhere to[5]:

1. Understand and leverage social perceptions, norms, and beliefs related to polio and polio vaccination.
2. Humanize health workers by emphasizing their social and emotional depth.
3. Continuously refine communications to maintain authenticity and credibility for the target audience(s)

B.5.IV Strategic channel mix and activities in polio outbreak[6]

Various communication channels should be used in a polio outbreak context. The choice depends on several factors. For example, patterns of media consumption; reach and penetration of different media form; profile of audience; and cost may be considered alongside other factors. It is important to use a well-balanced media mix that is cost effective and has the broadest reach. Communication channels most often used in outbreak contexts include: mass media; interpersonal communication (IPC) through community outreach networks; community folk media; and IEC materials.

During the Immediate Response Communication phase, the following key C4D activities could be possible to undertake:

- ✓ Communicating the importance, safety, and efficacy of vaccination from the onset will dispel potential campaign-threatening rumors.
- ✓ Analyze existing Knowledge, Attitudes, and Practices (KAP) study data regarding vaccines, immunization service, and polio to guide message development.
- ✓ Inform the target population about polio, the vaccine, and the health workers who will provide support to vulnerable children.
- ✓ Activate social and community mobilizers in the highest risk areas.
- ✓ Analyze the media landscape to identify how to quickly reach the largest number of people as possible within the target population.
- ✓ Frame the vaccination effort and health workers as heroic and mission-driven to create a supportive environment for the campaign.

Meanwhile, during the Adaptive Phase Communications, the following are some of the key actions that are important to consider:

- ✓ Identify population unreached or under-reached by previous communications.
- ✓ Retarget and refine communications to said populations.
- ✓ Shift communications to address the root causes of refusals and access issues, as identified through KAPs data.
- ✓ Begin targeting and addressing harmful social perceptions and norms.
- ✓ Identify and capitalize on previous communication successes.
- ✓ Close the loop by creating means for caregivers of missed and absent children to get in touch with UNICEF/other parties directly in order to get the vaccine.
- ✓ Shift from an emphasis on the individual consequences of polio to the importance of community protection and social action.
- ✓ Continue to support social and community mobilization and evolve IPC messages to align with mass communications and vice versa.

The continuous discussion with community members after the vaccination process is vital to reinforce norms supportive of vaccination. A comprehensive training package for Front Line Workers (FLWs) is available for RO and CO teams to utilize in order to improve vaccinations capacity, especially for IPC.

[5] A sample of creative materials for initial response and adaptive phase communications is available as part of Polio Communication Global Guide. UNICEF NYHQ. 2016.
[6] Extracted from Behaviour Change Communication in Emergencies: Tool Kit. UNICEF ROSA, 2006.

B.5.V Monitoring and evaluation

Having set the behavioural outcomes, outputs and their corresponding indicators, it is imperative to find out whether or not the results are achieved. Typical indicators for monitoring activities include process indicators, such as the number of communication media materials produced and disseminated (posters, flip charts, TV/radio spots, etc.); and/or the number of training workshops conducted (TOT, peer education, etc.).

B.5.VI Managing the plan

The national plan for a polio outbreak response should include a clear budget and surge capacity plan to support the implementation of interventions at both national and field levels. The plan should be developed jointly among all partners and based on the GPEI Financial Resource Requirement (FRR) process. Generally, there are two categories for budgeting communication and social mobilization activities in the FRR. One is Campaign Social Mobilization and the other is On-going communication activities. The former encompasses activities specifically planned and undertaken around the National Immunization Days (NIDs) and Sub-National Immunization Days (SNIDs) or Supplementary Immunization Activity Days (SIADS). While the latter are activities implemented during the entire period of the outbreak response and are not dependent on SIA dates.

Additionally, the budget may also include the following:

- ✓ Costing for various activities like training, advocacy and social mobilization, production and distribution of various media materials.
- ✓ Costing for human resources and the recruitment plan and duration.

B.6 Surge support to communication interventions[7]

Recognizing the challenges of meeting surge requirements, the GPEI will follow a two-phase surge process: **Rapid Response Phase** (Rapid Response Team – "Team A"): Within 72 hours of the outbreak notification, on a no-regrets basis, the GPEI surges pre-identified, trained and experienced professionals with multiple expertise. The team is drawn primarily from existing GPEI staff on a rapid response deployment roster with pre-negotiated approval for deployment of up to one month.

Surge Response Phase (Surge Team – "Team B"): Within three weeks of the outbreak notification, the GPEI makes available, consistent with the outbreak grade, a multidisciplinary and trained surge team and additional surge staff as needed and outlined in the outbreak response plan. Key roles for both the Rapid Response Team and the Surge Team include:

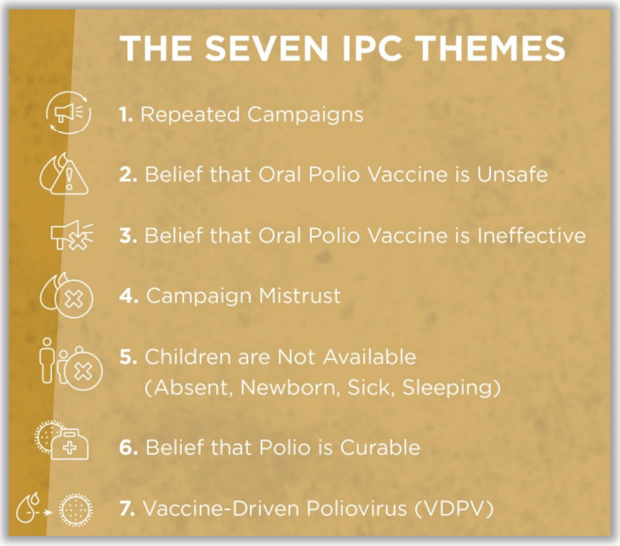
- a polio outbreak technical lead
- a C4D lead[8]
- an operations expert (administrative, finance and operational support) (national level)
- polio SIAs and surveillance experts (subnational level)

A training specialist will be also deployed as part of Team A and possibly Team B to initiate the training of front line workers using global tools which would enhance SIA quality.

[7] For a detailed surge timeline please refer to Annex 2
[8] A detailed Terms of Reference is available in Annex 3

C. PHASE II- ADAPTIVE PHASE OF COMMUNICATION: ONE TO THREE MONTHS

Within one month, C4D plans should be in motion to support immunization activities. Monitoring of results, and modification of interventions accordingly, is critical to effectively reach targeted children. C4D and communication indicators are included as part of the independent monitoring forms. Independent monitoring or LQAS data provide an objective assessment of the achieved results, especially coverage; reasons for missed children; and reaching hard-to-reach and mobile populations. **Therefore, it will be important after the initial response to:**



- ✓ Collect observations and data on campaign performance.
- ✓ Conduct disaggregated analysis to assess community acceptance and understanding of the polio program.
- ✓ Analyze root causes for refusals and access issues and identify key issues underlying barriers to immunization.

Barriers can be due to different reasons such as repeated campaigns over short intervals, mistrust in vaccine or frontline workers or several others shown in the above slide. For each there is a recommended set of interventions as per the global communication guide. It is of most importance that the IPC skills of health providers are up to standards to be able to respond to the SIA activities in complex contexts.

At the three- and six-month markers after an event / outbreak is confirmed, the SOPs require an assessment of how successful applied activities have been in interrupting virus transmission. At this stage, qualitative assessment may be required to gain a better understanding of the reasons behind missed children and any resistance to vaccination. Monitoring of planned activities and inclusion of social data as part of independent of monitoring and other forms is a required activity.

D. PHASE III- CLOSING THE OUTBREAK AND MAINTAINING SUCCESS: THREE TO SIX MONTHS AND BEYOND

By this time, the outbreak intensity should be decreasing and it should be moving towards complete closure. However, continuing to focus on SIA quality, strengthening surveillance, and reaching missed children is critical. Meanwhile, supporting routine immunization will be the backbone to maintaining the interruption of virus transmission. In this regard, the outbreak response plans should indicate how routine immunization services will be promoted, especially for low coverage areas. This should include the training of frontline workers, production and dissemination of IEC materials, and monitoring of services. A plan should be made to integrate polio assets that were specially recruited to support polio activities into the health program. They can, for example, support routine immunization and other community health services. It is equally important to develop preparedness plans that can mitigate the risk of future outbreaks. The final outbreak assessment reviews country improvement plans for routine immunization and longer-term preparedness plans. The maintenance chapter of the Global Polio C4D Strategy provides additional details for this critical phase.

Finally, it's important to document the achievements and lessons learned from social mobilization, advocacy and media and partnership activities at the national, provincial and district levels. Use of photos, anecdotes, testimonials,

press reports and media coverage is critical to maintain national political support and generate donor interest in continuing to support health and immunization programmes.

REFERENCES

- Behaviour Change Communication in Emergencies: Tool Kit. UNICEF ROSA, 2006.
- Essentials for Excellence: Researching, Monitoring and Evaluating Strategic Behaviour and Social Change. UNICEF NYHQ, 2008.
- Polio Communication Global Guide. UNICEF NYHQ. 2016.
- Peter F. Chen, Ph.D., MPH, MA. Handbook on Communication for Development For Programme Managers. Asia-Pacific Development & Communication Centre Dhurakji Pundit University, Bangkok, Thailand. 2014.

C4D RESOURCES FOR ADDITIONAL INFORMATION & GUIDANCE

- http://www.rhizome.work
- http://www.polioeradication.org/

ANNEX 1: METHODOLOGY FOR SPECIAL INVESTIGATION TOOL TO IDENTIFY REASONS FOR MISSED CHILDREN

A. Description of the tool

What is it and why do we need it?

Objective of the tool

The objective of the special investigation tool is to help the GPEI identify the underlying reasons that lead to chronically missing children with OPV in high risk areas for polio transmission. The tool is composed of 3 distinct sections, which need not be administered sequentially, but doing so would enhance the investigators' depth of understanding.

PARTS A and B are designed to evaluate the planning of SIAs, staff capacity, accountability, and leadership at the district (PART A) and sub-district levels (PART B). These parts review microplans and documents related to planning and preparatory activities (e.g. funding, meetings, trainings) conducted prior to the most recent polio SIA and 2) also include rapid interviews with selected field staff.

PART C is designed to assess community perceptions and attitudes towards the polio programme and the vaccine, as well as the wider routine immunization system. It focuses on the community which triggered the investigation, and includes 1) rapid interview with one local, traditional or religious leader of that community and 2) a cluster survey of 20 households in the community.

When is it used?

A special investigation can be initiated by national/state/provincial authorities in response to one or more of the following triggers that identify a potentially serious problem of children being missed with OPV:

1. WPV or cVDPV case/cluster

Within 3 days of confirmation of the index case as positive for WPV or cVDPV. This investigation should be conducted in conjunction with the "detailed epidemiological case investigation" of the case.

2. Zero-dose AFP case/cluster

Within 7 days of an AFP case investigation identifying any children as never having received any dose of OPV (excluding the birth dose).

3. Cluster of missed children as identified by independent monitoring/LQAS

Within 7 days of the identification by external monitors of a community with a predetermined percentage of missed children through post-SIA independent monitoring or LQAS. Depending on the level of risk associated with the area and/or the severity of the problem, the special investigation may be conducted not only once but also immediately after 1 to 3 of the subsequent rounds of SIAs in order to track change. Countries may have different thresholds to classify an area as 'poorly covered' or 'chronically missed'; these should be determined immediately when contextualizing these guidelines for local use.

4. Cluster of refusals during SIAs as identified through supervision or monitoring (IM/other):

Within 7 days of the identification of a community with a predetermined percentage or number of missed children due to refusal during the most recent SIA. Depending on the level of risk associated with the area and/or the severity of the problem, the special investigation may be conducted not only once but also immediately after 1 to 3 of the subsequent rounds of SIAs in order to track change. Countries may have different thresholds to classify a 'cluster of refusal' the definition of a cluster should be determined immediately when contextualizing these guidelines for local use.

5. Other reasons

Any other reason as identified by the country such as "low campaign awareness levels" as identified through locally established thresholds gathered by independent monitoring.

B. Usage of the tool

How should it be conducted?

Once one of the above 5 triggers is reported, a decision is made at the national or state level to conduct a special investigation using the standardized tool that has been adapted to the country/local context. The MOH and its partners, primarily WHO and UNICEF, should be part of each investigation. Any one agency may take the lead in conducting one part of the exercise (e.g. UNICEF conducting Part C) and in consolidating the results and finalizing the report in consultation with the investigation team. The absence of any one partner should be justified and documented (in the cover of the tool). All members of the team taking part in the investigation should be trained on the tool beforehand.

PART A: District/LGA assessment

1. It is conducted by a joint MOH/WHO/UNICEF team appointed by the State/Province
2. Key informants are;
    1) The senior District Official (or equivalent) who is accountable for polio (e.g. the District Coordinator in Pakistan, or the LGA Chairman/deputy Chairman in Nigeria)
    2) The District/LGA Polio focal point (either MOH and Partner agency)
    3) The District/LGA Communication Supervisor (or equivalent, such as supervisor for the communication network)

3. Documents to review include the most recent:
    1) District/LGA micro-plans, including logistics and supply plan
    2) District/LGA social mobilization plan
    3) Minutes of the most recent Task Force meeting
    4) Any pre/post-campaign dashboards, SIA data

PART B: Sub-district assessment

1. This assessment is to be conducted by a joint MOH/WHO/UNICEF team appointed by the State/Province
2. 2. Key informants include:
    1) The sub-district polio focal point (such as EPI Manager)
    2) The Team Supervisor for the most recent campaign from the target community to be surveyed
    3) The sub-district Communication Supervisor (or equivalent, such as Supervisor for the communication network)
3. Documents to review include, the most recent:
    1) Sub-district micro plans, including logistics and supply plan
    2) Sub-district social mobilization plan
    3) Minutes of the most recent Task Force meeting
    4) Any pre/post-campaign dashboards, SIA data
    5) Training plan, attendance records and materials

PART C: Community assessment

1. Conducted by: a joint MOH/WHO/UNICEF team appointed by the State/Province in the case of one of the triggers mentioned above or a stand-alone social barrier emerging in a community.
2. Key informants include:
    1) Local, traditional or religious leaders for the “community risk assessment”
    2) One caregiver (ideally the mother) from each of 20 randomly selected households for the “Community household survey”
3. Selection methodology
    1) Local leaders: Request a social mobilizer (or local health worker if no social mobilizers are present) to identify the top 3 influential leaders for the community. Select one at random for the interview.
    2) Community household survey:
        - 20 households must be selected for the community survey, and the selection must include:
          a) all households with a child meeting the trigger criteria (WPV/cVDPV case, AFP zero dose, missed children, or refusal) AND/OR
          b) additional randomly selected households with children under 5 years of age until 20 households are reached
        - In the case of a zero-dose AFP, WPV/cVDPV case, include the index house and randomly select 20 households with children under 5 yrs of age in the immediate area around the index case.

C. Analysis and reporting

For each investigation conducted, one organization (MOH, WHO or UNICEF) will be made responsible for compiling and analysing the data, using the locally adapted reporting templates. A comprehensive report should be completed and available for sharing within a suggested 1 week of the end of the investigation. The report shall be shared with all partners in country, and to UNICEF/WHO focal points at Regional and HQ. The status of implementation of the actions taken against the recommendations laid out in the report will be tracked according to each country's current monitoring arrangement as defined in the emergency action plans. Additional monitors should be deployed during the next SIA, and results compared to the previous round data. If there is no improvement, an additional special investigation should be supported.

ANNEX 2: RHYTHM OF BUSINESS FOR PRE TEAM A TO TEAM B

Pre team-A phase (0-7 days)
Objective: within 24 hours of declaration of OB, each office - CO, RO and HQ designates a focal person (FP)

KEY ACTIONS	0-7 DAYS
1. HQ, RO,CO communicates name of OB FP within 24h	☑
2. By Day-4, HQ will organize a telecon with RO and CO colleagues.	☑
3. By day-7: CO works with GPEI partners and submits draft response plan with vaccine needs and budget and HR surge requirements.	☑
4. HQ transfers funds to CO for OB response	☑
5. EOMG grading completed. Email from HQ Polio Team Lead to RD and C-Rep confirming grading of the outbreak and decision regarding Team-A/B deployment.	☑
6. In parallel, try to identify Team-A HR surge persons as needed.	☑

Team-A Phase: Day-7 to day 37 (or starts as soon as Team-A FP takes charge; ends when role handed over to Team-B FP.)
Objective: ensure continuity of OB response and start initial outbreak response activities including first SIA round

KEY ACTIONS	Day 7- day 37
1. OB-FP at CO continues or hands over to Team-A lead.	☑
2. GPEI - OB response plan finalized with SIA schedule. Comms strategic plan worked out and vaccine supplies secured.	☑
3. Budget approved for full response plan, with inputs from RO and HQ.	☑
4. Necessary HR surge in Team-A deployed (beyond FP). RO shares Team B options with CO. HQ can also support on Team B identification. CO starts team B recruitment.	☑
5. EOC type mechanism set up within country with MOH and GPEI partners.	☑
6. HQ and RO support streamlining- including participation in monitoring and OB review mission.	☑
7. Independent monitoring data shared and used to fine tune activities.	☑

Team-B Phase: Day-37 (or starts when Team-B FP takes charge) till outbreak closure.

Objective: In this phase key would be quality of SIA and surveillance and implementing the successive OBRA recommendations.

KEY ACTIONS	Team-B Phase: Day-37
1. Team-A transitions to Team-B.	☑
2. Implement OB response plan ensuring quality of SIA and surveillance.	☑
3. Implement successive OBRA recommendations.	☑
4. Strengthening of RI	☑
5. Close outbreak	☑
6. Wrap-up HR surge and close budget	☑
7. Document lessons learned	☑

ANNEX 3: TERMS OF REFERENCE FOR C4D TEAM B

TERMS OF REFERENCE: OUTBREAK COMMUNICATION OFFICER (C4D and External Communication)

Introduction:
The Global Polio Eradication Initiative (GPEI) seeks to ensure that future generations of children will be free from the threat of polio virus infection and paralysis. Achieving this goal depends on interrupting poliovirus transmission in the remaining endemic countries and on ensuring rapid and effective responses to poliovirus outbreaks occurring in polio-free countries. The GPEI has recently revised its Standard Operating Procedures (SOPs) for the response to new polio outbreaks in polio-free countries.[i]

This document describes the Terms of Reference for the Outbreak Communication Officer in the context of the new SOPs.

Purpose of the position:
The Outbreak Communication Officer will lead the polio communication support provided to the country during the response to a poliovirus outbreak, working under the supervision of the Head of the WHO/UNICEF Country Offices and in collaboration with the communication teams of those organizations.

The communication officer's support to the team at the country office will ensure that the response is:
1. Aligned with the government/Ministry of Health (MOH) plans and strategies, and
2. Aligned with the latest outbreak response SOPs.

The communication officer will be deployed to countries as part of the Rapid Response Team (A) or the Surge Team (B).

Summary of assigned duties:

General:
- Assess communication needs and existing capacity at the country level.
- Report to WHO/UNICEF headquarters on progress, achievements, and where additional assistance is required.
- Contribute to the development of a communication plan to underpin the technical response, in collaboration with the WHO/UNICEF offices.
- Provide technical input to the overall response strategy, including the implementation of the operational work plans and provision of authoritative advice and support to operational units.
- Provide leadership and strengthen the existing communication teams by emphasizing team building and collaboration as daily routine with national/international partners.

Communication for Development (C4D):
- Ensure conduct of the required social investigation of polio cases as part of the early outbreak response.
- Develop/update/review data on immunization knowledge and attitudes and behaviour of the target audience, especially for high-risk and mobile populations.
- Facilitate and lead the reinvigoration of a social mobilization and/or communication working group or the expansion of an existing one.
- Initiate the development of the social mobilization component of the 6-month outbreak response plan document, including details for subnational implementation in high-risk areas and mobile populations, as well as the means for monitoring field activities and budget to cover those activities.
- Finalize C4D community engagement and information dissemination strategies to promote polio and routine immunization.

- Develop and tailor health information products for various target populations/audiences, based on careful assessment of community knowledge, practices, and behaviours.
- Ensure that polio microplans (at least in priority areas) include social data and information on social mobilizers and leaders by the time of the first response.
- Provide support for the training of health workers.
- Help implement the strategic communication response plan, including mass communication plans, as appropriate.
- Undertake in-depth reviews of potential refusals of vaccines or issues of mistrust to be addressed.
- Conduct regular analyses of independent monitoring data and other available resources to identify priority areas and devise social mobilization microplans targeting those areas that incorporate social mobilization indicators within program monitoring indicators.
- Set up social mobilization teams with delegated authorities at the sub-national level, as needed, and oversee the structure until the end of the outbreak with performance monitoring.

External Communication:

- Conduct a media landscape analysis.
- Support the outbreak response team to prepare an external communications strategy, including the engagement with political, religious, and community leaders and other stakeholders.
- Develop polio-related media and external communication packages.
- Identify a media focal person and spokesperson from the government, WHO, and UNICEF.
- Work with partners and government counterparts to conduct a press brief/media release, if appropriate, and update donors and partners on work progress.
- Host weekly calls with WHO polio communications counterparts in country offices, regional offices, and HQ.
- Receive and review all media releases/news feeds related to the outbreak and share with focal points. Target other non-media communication channels that could be more effective in certain settings.
- Update talking points and FAQs, as needed (e.g., with changing epidemiology and ahead of vaccination rounds).

Other:

Undertake other assignments and responsibilities as requested by heads of country offices, regional directors, and other partners to support the successful response to the outbreak.

[i] Global Polio Eradication Initiative, Responding to a poliovirus event and outbreak, Standard Operating Procedures (SOPs) Part 1: General SOPs, April 2016, Available at http://www.polioeradication.org/Portals/0/Document/Resources/PolioEradicators/1a.PolioOutbreakGuideline201604part1.pdf
And Global Polio Eradication Initiative, Responding to a poliovirus event and outbreak, Standard Operating Procedures (SOPs) Part 2: Protocol for poliovirus type 2,,April 2016, Available at http://www.polioeradication.org/Portals/0/Document/Resources/PolioEradicators/1a.PolioOutbreakGuideline201604part2.pdf