Formative Evaluation of Communication Processes Used for the National Measles Rubella Vaccination Campaign for Inclusion in Routine Immunization

REPORT

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TITLE PAGE

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Any errors in the information or the citation of references in this document are inadvertent and may be ignored.

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CONTENT

CHAPTER 1: INTRODUCTION *01-12*

1.1 India and Measles Rubella movement 13
1.2 Tracing the development of the MR vaccination campaign 13
1.3 Literature review 15
1.4 Secondary data review 18

CHAPTER 2: METHODOLOGY
2.1 Objectives 20
2.2 Scope 20
2.3 Evaluation criteria and questions 21
2.4 Approach 22
2.5 Process 25

CHAPTER 3: KEY COMMUNICATION PROCESSES IDENTIFIED IN THE EVALUATION STATES
3.1 Identification and collaboration with key stakeholders from the state, district to the sub-district and community levels 33
3.2 Training of frontline workers on micro-planning, social mobilization and interpersonal communication 35
3.3 Monitoring of Adverse Event Following Immunization (AEFI), management and media advocacy 37
3.4 Management of Social Media 38
3.5 Maximising the reach through mass media and IEC material 39
3.6 Social Mobilization 40

CHAPTER 4: FINDINGS
4.1 Relevance of Communication Processes 42
4.2 Effectiveness of the Communication Processes 49
4.3 Efficiency 59
4.4 Sustainability of Communication Processes 64

CHAPTER 5: CONCLUSION & RECOMMENDATIONS
5.1 What Worked 69
5.2 What could have been better and needs rework 71

Annexure
1. Composite Index Score For District Selection i
2. Evaluation Matrix iv
3. Content analysis of locally developed IEC materials vii
4. Terms of Reference ix
5. Evaluation Tools xx

LIST OF FIGURES AND TABLES

Fig 1: Timeline 14
Fig 2: Evaluation States 20
Fig 3: Communication Processes 32
Fig 4: Committees and Taskforces 33
Fig 5: Partners in MR campaign 34
Fig 6: FLW Training Components 36
Fig 7: AEFI Components 37
Fig 8: Evaluation Criteria questions 41
Fig 9: Synergy of Activities to reach the farthest and the vulnerable 70

Table 1.1: NFHS-4 Data – 2015-16. 18
Table 1.2: HMIS Data 19
Table 2.1: Evaluation Districts 24
Table 2.2: Respondents 24
Table 2.3: Sample of KIs 25

ACRONYMS

ADPHCO: Assistant District Public Health Communication Officer
AEFI: Adverse Effects Following Immunization
ANC: Antenatal Care
ANM: Auxiliary Nurse Midwife
ASHA: Accredited Social Health Activist
AWW: Anganwadi Worker
BCG: Bacillus Calmette-Guérin
BDO: Block Development Office
CA: Content Analysis
CBPR: Community-based Participatory Research Methods
CDPO: Child Development Project Officer (ICDS)
CHC: Community Health Centre
CMO: Chief Medical Officer
CMS: Centre for Media Studies
CREDAI: Confederation of Real Estate Developers' Associations of India
CRS: Congenital Rubella Syndrome
CSOs: Civil Society Organizations
DGIPR: Directorate General Information and Public Relations
DIO: District Immunization Officer
DPO: District Program Officer (ICDS)
DPT: Diphtheria-Pertussis-Tetanus
DR: Desk Review
eVIN: Electronic Vaccine Intelligence Network
FGD: Focus Group Discussion
FISS: Foundation for Integrated Support and Solution
FLWs: Frontline Workers
FO: Field Officer
GAVI: The Global Alliance for Vaccines and Immunization
GKS: Gram Kalyan Samiti
GoI: Government of India
HIV/AIDS: Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
HMIS: Health Management Information System
HSC: Health Sub Centre
IAP: Indian Academy of Paediatrics
ICDS: Integrated Child Development Services
ICF: Informed Consent form
IDIs: In-depth Interviews
IEC: Information Education and Communication
IMA: Indian Medical Association
IPC: Interpersonal Communication
ITSU: Immunization Technical Support Unit, Govt. of India
JE: Japanese Encephalitis
KI: Key Informants
KII: Key Informant Interviews

MoHFW: Ministry of Health and Family Welfare, Govt. of India
MoHRD: Ministry of Human Resource Development, Govt. of India
MOIC: Medical Officer In-Charge
MoWCD: Ministry of Women and Child Development
MPW: Multipurpose Worker
MR: Measles-Rubella
NCC: National Cadet Corps
NCDC: National Centre for Disease Control
NGO: Non-Governmental Organization
NHFS: National Health and Family Survey
NHM: National Health Mission
NSS: National Service Scheme
NTAGI: National Technical Advisory Group on Immunization
NYKS: Nehru Yuva Kendra Sangathan
OECD-DAC: The Organisation for Economic Co-operation and Development's (OECD)-Development Assistance Committee (DAC)
PCV: Pneumococcal Conjugate Vaccine
PHC: Primary Health Centre
PIS: Participant Information Sheet
PRI: Panchayati Raj Institutions
PTA: Parent Teacher Association
PTMs: Parent Teacher Meetings
PSU: Primary Sampling Unit
RCHO: Reproductive and Child Health Officer
RI: Routine Immunization
RV: Rotavirus
SBCC: Social and Behaviour Change Communication
SEM: Social Ecological Model
SHGs: Self Help Groups
SIA: Supplementary Immunization Activities
SMNet: Social Mobilization Network
SOPs: Standard Operating Procedures
ToR: Terms of Reference
TT: Tetanus Toxoid
UIP: Universal Immunization Programme
UNDP: The United Nations Development Programme
UNICEF: The United Nations Children's Fund
VHSNC: Village Health Sanitation and Nutrition Committee
WCD: Women and Child Development
WHO: World Health Organization

Executive Summary

India, within the past decade, has witnessed high mortality among infants and young children due to measles. In 2011, approximately one-third of measles deaths globally was recorded in India. Further, rubella infection among pregnant mothers has also resulted in a high number of children born with Congenital Rubella Syndrome (CRS) in the country. India, in the past, accounted for almost one-third of all the children born with CRS globally. In 2013, the South-East Asia (SEA) Regional Committee passed a resolution with the goal to eliminate measles and control rubella/CRS by the year 2020. Following the passing of the resolution, the National Technical Advisory Group on Immunization (NTAGI) recommended introducing the Measles-Rubella vaccine through a nationwide campaign. Following the campaign, the combination vaccine was set to replace the existing measles vaccines in the routine immunization programme.

The campaign targeted 410 million children through school and other outreach sites and the wide age range was recommended to enable rapid immunity build-up and reduce transmission of the diseases in the community. The campaign was implemented across all the states and Union Territories in India, except Delhi and West Bengal. The campaign, at large, came to an end by June 2019.

About the Measles Rubella Campaign

The MR vaccine campaign in India was implemented in a phased manner, and targeted children between the ages of nine (09) months and 15 years, regardless of their previous measles vaccination status or illness. The wide age range was recommended to enable rapid immunity build-up and reduce transmission of the diseases in the community.

The first phase of the campaign was launched in February 2017 in Tamil Nadu, Karnataka, Goa, Lakshadweep and Puducherry. However, factors such as negative messages on social media regarding the vaccine, inaccurate reports of Adverse Effects Following Immunization (AEFI) cases, sub-optimal participation of private schools, varied involvement of paediatric association, and limited inter-ministerial coordination hindered the first phase of the campaign. A study conducted in Chennai, Tamil Nadu, revealed that among 75 non-immunized children in the sample, 62.8 per cent and 29.4 per cent were denied vaccination due to inflated information about the adverse events shared in television and social media respectively.[1] Another study conducted in rural Tamil Nadu presents that rumours of adverse effects (47.5%) and fear of adverse effects (53.3%) were two of the highest ranked barriers that prevented

[1] Barathalakshmi, J, Rashmi Gour Patel, S Kanimozhi, and V Sudha. "Measles Rubella Immunization Campaign: Challenges Faced in an Urban Area of Chennai." *Indian Journal of Public Health Research & Development* 9, No. 7 (2018): 18. https://doi.org/10.5958/0976-5506.2018.00606.x.

uptake of the vaccine among parents for their children.[2] These issues were beyond the scope of the communication strategies adopted during this phase and required re-strategizing to place adequate emphasis on communication related activities and involvement of stakeholders at various levels.

In the second phase of the MR campaign, communication was focussed upon significantly, alongside operations. The campaign integrated communications as an essential element within operations. It sought to re-design the strategies based in light of the issues faced in the first phase, as well as successes documented in the literature on Supplementary Immunization Activities (vaccination campaigns) from around the globe. As a result, this phase of the campaign witnessed significant coordination among government departments, civil societies, and community-based organizations, associations of private medical professionals and faith-based leaders. Training of community health workers on the operations and communications, alongside promotional activities to raise community acceptance took precedence in the planning of the campaign too. Further, inclusion of vulnerable and marginalized communities was ensured at every stage of the campaign. The strategies also called for steady media engagement to ensure proper reporting of events and progress of the campaign.

On conclusion of the campaign, UNICEF reports that as of May 2019, the coverage of the MR vaccination among children between the ages of nine months and 15 years, in all study states have crossed the target of 95 per cent.

The Evaluation: UNICEF, as one of the primary campaign implementation partners to the Government of India, commissioned CMS (Centre for Media Studies) to conduct a formative evaluation of the campaign to determine how and to what extent the communication processes for the MR campaign have been relevant, effective, efficient and sustainable to be introduced into routine immunization.

The **Formative Evaluation** was designed to inform the inclusion of the MR vaccine into the routine immunisation programme, provide key lessons and recommendations, and help identify relevant, efficient, effective, and sustainable communication platforms that may be then used in other government programmes and campaigns, such as the routine immunisation programme.

Objectives: The specific objectives of this formative evaluation were to assess what procedures and activities worked and also identify the factors and reasons behind why some

[2] Jasmine, Aliya, and Priyadharshini. "Coverage Survey of Measles-Rubella Mass Vaccination Campaign in a Rural Area in Tamil Nadu." *Journal of Family Medicine and Primary Care* 8, No. 6 (2019): 1884. https://doi.org/10.4103/jfmpc.jfmpc_319_19.

procedures and activities worked and why others did not. It also sought to understand to what extent and to what effect the elements of equity and gender-sensitiveness were incorporated in the procedures and activities. The study was also devised to recommend how the procedures and activities can be further improved to be included in routine immunization.

Scope: The scope of evaluation was limited to determine the extent to which the communication processes for the MR campaign have been relevant, effective, efficient and sustainable. This study focused on the second phase of the campaign and covered all the procedures and activities between the dates of commencement, which was four months before the start date of the second phase of MR Campaign, till the date of commencement of this evaluation.

Methodology: The formative evaluation of the MR campaign was conducted across five states which were purposively chosen based on their involvement in various phases of the MR campaign and the context that they offered. Assam and Odisha were identified as states with 'high proportion of tribal population', Gujarat for demonstrating good governance of the campaign, Maharashtra for offering a stark urban–rural context and Uttar Pradesh for being a high burden state.

Approach: The evaluation adopted qualitative primary data collection methods for addressing the objectives. The approaches used included conducting desk review of existing reports and documents pertaining to MR Campaign alongside primary data collection through semi structured key informant interviews with stakeholders and partners who actively participated in this campaign; and focus group discussions with parents and caregivers. The stakeholders interviewed for the evaluation primarily included government officials at state, district and block levels, development partners, civil society organizations, community influencers and community health workers.

A comprehensive review of existing data and reports pertaining to MR vaccination at global and national levels was conducted and this provided an overall understanding of the MR campaign and vaccine acceptance across the globe and in India. The content analysis of the national communication package of MR campaign was reviewed to understand their purpose, messages and target audience.

Sample: Two districts in each state were covered during evaluation. Their selection was a two-fold process. All the districts were first ranked based on the composite scale, which was derived using social and health indicators. The UNICEF state officers were then provided with this list and were indicated to select one of each district which performed well and poorly. A 'well performing' district was where implementation did not face any interruption and had

demonstrated effective partnerships across governmental departments, development partners, civil societies and community-based structures of governance to achieve high coverage. A district, termed as 'challenging', was where the coverage was achieved after facing logistic or administrative challenges, or challenges in terms of demographic and sociocultural uniqueness, or resistance because of some myths and misinformation.

Primary sampling units like villages in rural areas and wards in urban areas within a district for meeting the community that were either resistant, or vulnerable, or hard to reach or any other unique context that they offered were purposively identified by the research team based on the inputs from the District officials. A total of 33 KIIs were conducted at the state level, 37 KII at the level of the district, 159 in-depth interviews with frontline health workers and 80 focus group discussions with caregivers of children who were vaccinated.

Data Collection, Management and Analysis: Data was collected through a set of four tools developed in English and translated into regional languages along with informed consent and Participant Information Sheet. The tools were tested in two locations and adjusted based on the findings. Two Community-based Participatory Research Methods (CBPR) were applied in FGD setting with caregivers. CBPR technique based on social ecological model (SEM) was applied to bring out the information flow on MR vaccine among family, peer and community and whoever, in each of the circles, influenced their decision. This was a paper-based exercise and the moderators facilitated the discussion.

The data emerging from the FGD and KIIs were analysed qualitatively against the questions under each evaluation criteria. The responses were entered in a matrix developed to record findings under each component from each group of respondents and analysed manually. The findings from the matrix under each area of probe across the respondent categories have been compared and contrasted for identifying the process of MR communication, designs incorporating inclusion of vulnerable population, contextualization, unique initiatives undertaken, challenges faced, lessons learnt, and the resources utilised.

Team Training and Field Work: The team of local researchers and moderators were trained in Delhi in the presence of UNICEF officers on the evaluation purpose, CBPR activities and ethical guidelines.

Data collection started from Gujarat from February 25, 2020, rolled out one by one in the remaining four states. The field work continued till March 18 in Parbhani in Maharashtra and till March 20 in Odisha. Due to COVID19 lockdown, the scheduled IDIs with Khordah district officers and Maharashtra State officers in Pune could not be conducted. The IDIs and FGDs were conducted in a place of convenience to the respondents and were recorded with consent.

Findings

During this formative evaluation, six critical processes were identified that included elements of communication which were necessary for the campaign to be a success. These processes were:

a. Identification and collaboration with key stakeholders — State, district to the sub-district, and community level
b. Training of frontline workers on micro-planning, social mobilization and interpersonal communication
c. Monitoring of Adverse Event Following Immunization (AEFI), Management and Media Advocacy
d. Management of social media
e. Maximising the reach through mass media and materials focusing on information, education, and communication (IEC)
f. Social mobilization

All six of these processes were analysed under the four pre-determined criteria of relevance, effectiveness, efficiency and sustainability and findings are as presented below.

Relevance

The section on relevance investigated the consistency of communication procedures and activities with the overall goals and objectives of the MR campaign. It also enquired into the extent of contextualization of communication procedures and activities to the local needs and challenges of the stakeholders. This section also raised questions on whether the planning and implementation of a campaign was inclusive of vulnerable and marginalised communities, and whether strategies were gender sensitive in nature.

The study found that the **communication procedures and activities were consistent with the overall goals and objectives of the MR campaign**. This should be primarily attributed to the fact that the strategies for the second phase of the campaign were designed in light of the issues and learnings from the first phase as well as strategies delineated in the literature on supplementary immunization activities around the world. The strategies were devised at the national level and provided to the states as Operational and Communication guidelines to be adopted for the campaign. Further, each of these procedures and activities were significantly contextualised to the local needs of the stakeholders. All study states referred to the national guidelines to design their campaign activities, while also formulating unique strategies at the level of the state and districts to address local challenges and nuances.

The state governments witnessed close collaboration between departments of Health, Education and Women and Child Development for positive positioning and maximising

outreach of the campaign. Further collaborations with other departments, such as Social Justice, Tribal Development, Railways, Defence, Public Relations and others proved appropriate in this context. Beyond the functionaries of Government bodies, establishing partnerships with development partners (WHO, UNICEF, UNDP), Civil Society Organizations (Indian Academy of Paediatrics, Indian Medical Association, Rotary Club, Lions Club), Community based bodies (Self-help groups, Mahila Arogya Samiti) and Panchayati Raj Institutions were extremely relevant in the context of positive positioning and promoting acceptance of the vaccine among communities. From a bird's eye view, these collaborations, from the state down till the level of the block, were effective in recognizing and addressing challenges at the local level with nuanced, appropriate and timely measures.

The **training of frontline workers aptly elaborated upon AEFI management and redressal of related myths and misconceptions through interpersonal communication**. The campaign also set up a sound engagement plan with the Media for responsible reporting of AEFI cases. Workshops entailing details about the campaign and press briefings about progress of the campaign were organized by the states and partners to ensure strong communication with the media. The relevance of these strategies is better understood as an emergence from the first phase of the campaign that witnessed glitches due to misconceptions about AEFIs among caregivers.

Further, **regarding mobilization and outreach and to promote community acceptance, all the states planned for and implemented extensive strategies to address the marginalized and vulnerable population**. These activities included conducting mid-media activities where mainstream media was unavailable, focusing heavily on interpersonal communication to promote vaccine acceptance, increasing the availability of mobile vans, seeking endorsements from their local community and religious leaders, and increasing the number of vaccination campaigns conducted in the vulnerable regions. While Amitabh Bachchan was the primary celebrity figure used at the national level, all study states reported having local television and regional movie celebrities promoting the campaign to make these materials more relatable and relevant.

The guideline and resulting plans and actions, **however, were not gender sensitive** in their approach. The campaign activities were aimed at caregivers in general. The only mention of different members of the household were in the guidelines, which specified the target audience of MR posters. The lack of gender-specific activities reflected during interviews with KIs, FLWs and caregivers. Most of the activities were attended by mothers. Only a few activities were directed at men in an ad-hoc manner in places where uptake was reported to be very low.

Effectiveness

The queries on effectiveness of communication strategies explored evidence for the processes having met their objectives during the MR campaign. It enquired into factors that influenced caregivers to accept the vaccine alongside the challenges that were faced along the way. Further, it also investigated how effective the MR campaign strategies were with regard to reaching vulnerable and marginalized communities and how gender-sensitive they were in their approach.

This line of enquiry established that **most of the communication procedures and activities were effective in meeting the campaign objectives**. Interdepartmental coordination and partnerships established at different levels were found to be effective in meeting the campaign goals. With a preparatory time of about eight weeks prior to the launch of the campaign, the collaborations and partnerships with departments, partners, civil society organizations community-based bodies and associations of medical professionals were highly effective in achieving the communication objectives of the campaign. These objectives included positive positioning of the campaign among caregivers by addressing myths and misconceptions about the vaccine, reducing vaccine hesitancy, and maximising outreach by ensuring that the campaign was inclusive of vulnerable and marginalized communities. For instance, in Uttar Pradesh and Gujarat, the state chapters of Indian Academy of Paediatrics worked closely with the government to address queries and concerns about the campaign on the MR. Partnerships with bodies like Rotary Club helped access migrant workers and Lions' Club assisted by funding promotional materials to generate awareness about the campaign.

Most states **effectively engaged and involved media to report the progress and issues and redressal mechanisms of MR campaign**. However, one state reported that while a technical health body was set up to address the media and clarify any news about reported cases of AEFIs, the extent of the success of the group's engagement would have been better if the Department of Information and Public Relations (DIPR) of the state would have been involved in the process. The skill of media management is neither universal nor can be developed in a day's training. While the Health Department did certainly have a better grasp over the technical aspects and issues of programmes, the expertise of DIPR would have appropriately moulded the technical information to be more comprehensible for the community.

With regard to the credibility of the messages, **interpersonal communications undertaken by frontline workers (ASHAs, ANMs and Anganwadi workers) to address the concerns of caregivers and encourage uptake of the vaccine was reported to be the most effective means of communication**. Caregivers in the study states could recall the messages received on issues such as side effects, how to manage them and the purpose of the vaccine. This is an

indication of the effectiveness of training of the health workers on interpersonal communication. Communications from faith-based leaders, local influencers and school administration also played a significant role in addressing concerns and boosting uptake. It is pertinent to note here that the involvement of professional agencies, such as the Indian Academy of Paediatrics (IAP) and Indian Medical Association (IMA) and their role in media management indirectly influenced the caregivers and tackled local challenges as well. For instance, local paediatricians and practitioners endorsing the vaccine and refuting concerns was recalled by some caregivers as factors that promoted acceptance among them.

Content analysis of IEC materials created for communities brought out that they were designed with one simple message on how one vaccine can protect from two diseases. Caregivers recalled seeing posters and banners, but most of them recalled that they received the information from the frontline workers or from authorities of the schools. Additionally, despite simple messaging and organizing engaging activities with the communities, caregivers could not articulate completely the benefits of MR vaccine and confused the rash of measles with chickenpox.

The strategies laid down by the guidelines and their adoption at the level of the states and districts to ensure that the **campaign was inclusive of vulnerable and marginalized communities were relevant and effective as well, as demonstrated through the high coverage reported by each of the states**. These strategies included collaborating with CSOs and CBOs to maximise outreach, while also investing in operations — such as allotting days solely to conduct sessions in hard-to-reach areas, conducting mid media activities to generate awareness, engaging local governing and religious bodies and using mobile vans to maximise outreach among the communities.

In terms of ensuring **gender sensitiveness among children receiving the vaccine, no gender bias was noticed or reported on vaccine denial**. However, the strategy, plans and most of the activities adopted by the campaign were directed at caregivers in general, with no special indication of being inclusive of genders. The parent-teacher meetings in school, community meetings and other promotional activities were attended more by mothers. ASHAs conducting door to door visits in the evening specifically to connect with the fathers, Maulavis speaking on MR vaccine to the men after namaz and meetings at labour chowk were some isolated initiatives undertaken during the campaign. In future, communication initiatives need to adopt strategies to reach out to fathers and other decision-making members of the family in order to ensure gender equity.

Efficiency

The evaluation examined whether resource allocation in terms of finances and human resource were appropriately managed to determine the efficiency of the MR campaign. Further, it probed into the efficiency of the communication processes, which were to ensure delivery of messages and address related challenges faced during implementation. The evaluation, thus, compared the activities against the guidelines to map out the extent to which they were efficient, while also noting issues that may have emerged and the ways in which they were addressed.

In terms of financial efficiency, the analysis reveals that **all the states followed the guidelines suggested by the Government of India. They also created budgets and plans down till the district and block levels.** However, not all states budgeted efficiently to address the local needs. Only a few of the study states anticipated resistance from religious minorities and vulnerable populations located in inaccessible areas, and created separate budget heads for outreach and advocacy with faith leaders, whose endorsements could significantly increase the uptake among their communities. This was, however, not noticed in all the states.

All states reported financial deficits in one or more areas. The deficits in the study states were managed efficiently by piggybacking on to budgets allotted for other activities within the campaign or the larger Routine Immunization campaign. It is pertinent to note that, despite anticipating resistance at schools which led to low coverage due to absence of students of certain communities on the day of vaccination, the states of Uttar Pradesh and Assam did not budget for repeating vaccination sessions. This resulted in extension of the campaign beyond the stipulated timeframe and required re-allocation of financial resources to be addressed. Thus, budgeting in future needs to account for behavioural factors, such as vaccine resistance, not just communication activities. It should anticipate its impact on operational activities as well.

Further, with regard to budgeting for IEC materials, budget analysis revealed that all the states dedicated significant proportion of financial resources to printing of IEC materials, which included posters, flyers, certificates that were given out in schools on successful completion of the vaccination, etc. However, it was found that among all IEC materials created, the school certificate had the most recall value and stickiness. Considering that in this MR campaign, caregivers' recall established social mobilization activities and interpersonal communication as the key activities and processes which impacted them, the budget allocation specifically for printing needs to be re-evaluated in the future.

The MR campaign benefitted from the **partnerships with development bodies, professional organizations, CSOs and community based bodies and faith based institutions in terms of financial support as well as their contribution** towards advocacy, AEFI management, addressing misconceptions, and mobilizing caregivers for vaccination. However, shortage of vaccinators, as reported in the states of Assam and Gujarat, impeded the campaign logistically, and the opportunity to communicate was lost to a great extent. The health system is, thus, required to invest in training buffer health workers to efficiently manage any shortage during a campaign.

Sustainability

The evaluation explored the sustainable aspects of the MR campaign and enquired into the implications of moving from a campaign mode to routine immunisation. It also looked into the potential integration of communication strategies and plans of the campaign for a sustained practice. Finally, the study also investigated how existing community structures and systems were strengthened or mobilised to achieve communication objectives and the support required in future to implement such campaigns effectively.

The study found that **some of the practices based on learnings of the MR have already been institutionalized**. However, there continues to remain a large scope for the campaign strategies and activities to be potentially integrated into Routine Immunization and other health programmes.

The study found that interdepartmental relations and partnerships with CSOs and CBOs established during the MR campaign were being sustained for other vaccination campaigns such as the Intensified Mission Indradhanush. However, as the intensity of these collaborations established and implemented during campaigns cannot be maintained for long durations, sustaining them with lesser intensity with specific roles and responsibilities charted out can help improve the outreach of Routine Immunization programme as well. Further, the mutual learning and skill development during the campaign can be sustained with the support and willingness of the state government. Some of the practices developed based on learnings from the MR campaign, such as partnering within departments and with CSOs and CBOs; following a stringent AEFI monitoring and redressal protocol; dissemination of videos by public figures promoting and endorsing certain messages have already been adopted and are being utilized in the Routine Immunization programme, Intensified Mission Indradhanush campaign and the COVID19 communication related activities.

Additionally, a review of the **guidelines, strategies, plans, budgets, communication materials and activities indicate that the campaign was inclusive of vulnerable and marginalized communities through various operational and communication measures as mentioned before.**

The strong efficacy and relevance of strategies developed to reach out to the relevant communities for the MR campaign prompts that they need to be uniformly adopted and institutionalized in the Routine Immunization programme as well. Some states, such as Uttar Pradesh has already adopted the activity of developing dynamic micro plans. The state of Gujarat reported having increased the number of vaccination sessions as a result of charting out vulnerable communities for the campaign. However, with regard to gender sensitiveness, guidelines in the future need to explicitly mention gender inclusive strategies for it to be reflected during implementation.

Conclusion and Recommendations

Multiple activities being undertaken at the same time during the planning and implementation of the campaign helped it to achieve a large goal within a small span of time. Capacities of human resources, such as frontline workers, CSOs, CBOs, faith-based leaders built during the campaign have been noted to be effective and relevant in maximising outreach. Translation of national level IEC and creation of local materials, alongside advocacy by local administrators, faith-based leaders and celebrities made the campaign more accessible and relatable. Further, the chain of communication and roles established between the state health system and partners through convergences among departments, down till the level of districts and blocks, allowed a more systematic planning, implementation and dynamic response to problems. It helped in the recognizing and addressing any emerging local issues and develop appropriate and contextually relevant responses to address them.

Based on the analysis of the communication processes in terms of the four criteria, the study provides recommendations in terms of planning future activities, charting out strategies for better implementation and finally, modifications that need to be addressed through policy reforms.

Planning

- → The convergences within government departments and roles of certain partners need to be strengthened and charted out more clearly as some states faced issues in this regard. For instance, partnerships with certain organizations were reported not to be as effective as expected. Also, to communicate more effectively with the media, it is essential that committees such as the ones created to address AEFI cases should be formed in coordination with the Department of Information. While the Department of Health certainly

holds the technical expertise to address such issues, Department of Information and related offices are more adept at handling such public relations and crises.

→ The study also notes that the convergences and partnerships formed during a campaign cannot be sustained with the same intensity and zeal through all regular activities. Thus, roles and responsibilities of lesser intensity for each department and partner needs to be charted.

→ Inter-state communication also needs to be encouraged to share innovative and successful practices. For instance, UNDP's presentation on ensuring the quality and safety of the vaccine at PTMs met with success in Uttar Pradesh. Such practices should be encouraged to be replicated in other states as well.

Implementation

→ To sustain media engagement, it is essential to move beyond sensitizing journalists and focus on editors and sub-editors as well, as they are the final decision-makers about the content of the news.

→ Budgeting for communication will require readjustment based on priorities. The focus needs to be based on which activities were more effective. Caregivers recalled their conversations with health workers and other community influencers to be more effective than IEC materials. Further, within IEC materials created, school certificates were recalled much easily by caregivers than posters or leaflets. Budgeting thus, needs to prioritize between IPC activities and printing, depending on what suits the need of the purpose better and have proved to be more effective in the past. In this case, training of the FLWs on IPC and development of micro plan emerges as a key area where investments should be made.

→ The plan for dissemination of messages through social media needs to be recalibrated with regard to the target audience. The evaluation states this in light of focus group discussions conducted with caregivers in all five states, where all but one group could not recall receiving any such positive message on social media during the evaluation.

Policy

→ This evaluation enquired into the gender sensitive approaches undertaken by the MR campaign. The study found that as neither of the two operations or communication guidelines of the campaign outlined any gender-sensitive activities, it did not reflect on the ground in four out of the five states. It is, thus, essential to note that communication strategies and related policies need to explicitly delineate gender-inclusive activities. The plans at every level should have programmes directed towards men, working out ways of reaching them, and with specific content explaining their role in child's immunization.

→ Routine Immunization programme should take note of the implications of the shortage of vaccinators, which lead to overworked staff and impeded timelines. An adequate number of vaccinators need to be trained where there is a shortage.

CHAPTER 1: INTRODUCTION

1.1 India and Measles Rubella movement

Measles is a vaccine-preventable contagious viral disease, which continues to be one of the significant causes of death among children in developing countries. In 2011, approximately one third of measles deaths globally were recorded in India.[3] Contracting measles under the age of five and over the age of twenty makes individuals more susceptible to complications. Symptoms of measles infections include runny nose, cough, red and watery eyes and rash that spreads over a span of time. However, children with lowered immunity levels due to reasons such as insufficient vitamin A or HIV/AIDs, face an increased risk of severe measles. Diarrhoea and dehydration, infections of the ear, acute respiratory infections, encephalitis and blindness are some of the most severe complications that can arise from contracting measles.

Rubella too is an acute contagious air borne viral disease. Its impact on children is mild. However, contracting rubella during pregnancy can have severe implications. Contracting the infection especially during the first trimester can lead to miscarriage, stillbirth, or cause congenital malformation — termed as congenital rubella syndrome (CRS). India, in the past, accounted for almost one third of all the children born with CRS globally. While there is no treatment available for rubella, the infection too can be prevented by immunization.

1.2 Tracing the development of the MR vaccination campaign

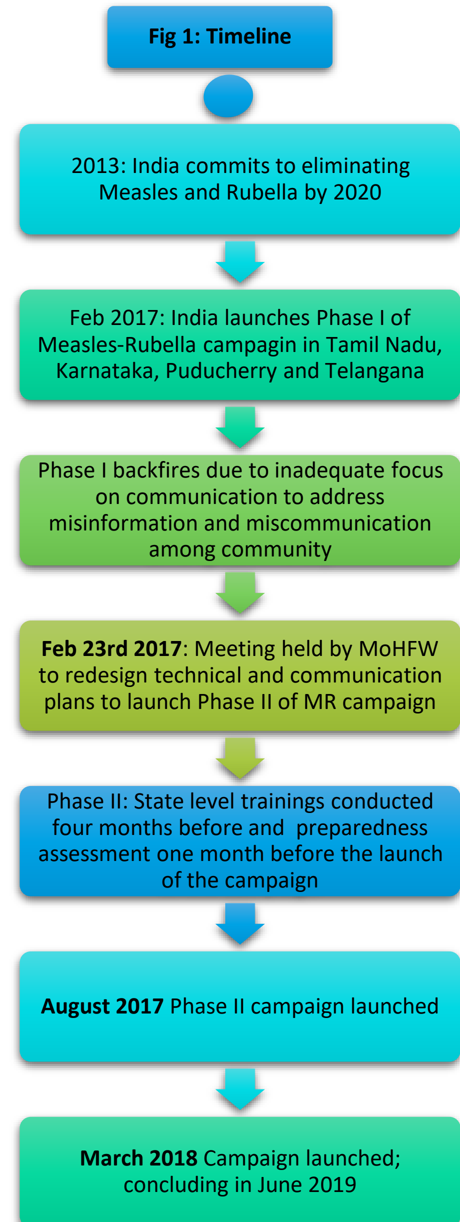
The measles vaccine has been a part of India's Universal Immunization Programme (UIP) since 1985 in all states. Administered to children between the ages of nine (09) and 12 months, the vaccine was effective in reducing the burden of measles in the country. In 2010, India took on a mixed approach of both routine immunization and supplementary activities (campaigns) to provide second dose of measles vaccination in all the states. The coverage of this dose, however, as per HMIS 2015 data, stood at 65 per cent when it required more than 95 per cent to achieve the elimination goal. Thus, there remained a need to increase the coverage of the second dose of measles contained in the vaccine.

In 2013, the South-East Asia (SEA) Regional Committee passed a resolution with the goal to eliminate measles and control rubella/congenital rubella syndrome (CRS) by the year 2020. Following the passing of the resolution, the National Technical Advisory Group on Immunization (NTAGI) recommended introducing measles-rubella vaccine through a nation-wide campaign. Following the campaign, the combination vaccine was set to replace the existing measles vaccine in the routine immunization programme.

[3] "Improving Measles Control in India." World Health Organization, 2013. https://www.who.int/features/2013/india_measles/en/.

The MR vaccine campaign was implemented in a phased manner, and targeted children between the ages of nine (09) months and 15 years, regardless of their previous measles vaccination status or illnesses. The campaign targeted 41 crore (410 million) children through school and other outreach sites, and the wide age range was recommended to enable rapid immunity build up and reduce transmission of the diseases in the community.

The first phase of the campaign was launched in February 2017 in Tamil Nadu, Karnataka, Goa, Lakshadweep and Puducherry.[4] However, factors such as negative messages on social media with regard to the vaccine (such as that it was being administered to promote infertility among religious minorities), inaccurate reports of AEFI cases, sup-optimal participation of private schools, varied involvement of paediatric associations, and limited inter-ministerial coordination hindered the first phase of the campaign. These issues were beyond the scope of the communication strategies adopted during this phase, and required re-strategizing to place adequate emphasis on communication related activities and involvement of stakeholders at various levels.



In February 2017, a national level meeting was called to reflect on the issues. Besides the technical core group headed by WHO, a parallel communication core group was formed to support Ministry of Health and Family Welfare, Government of India. UNICEF and ITSU together provided strategic communication support to increase coverage and achieve the desired MR campaign goals through increased community ownership and demand for immunization. Their communication objectives, in brief, focussed on positive positioning of the campaign among all stakeholders to promote commitment among them, augment acceptance of the vaccine among the communities, promote positive media reporting and combat negative responses. The redesigned communication strategies addressed school teachers, local religious and political leaders, celebrities, children and their parents to promote vaccine confidence among the public. Further, the technical and communication

[4] 'Communication Guidelines for Measles Rubella Vaccination Campaign', UNICEF and Ministry of Health and Family Welfare, Govt. of India (2017)

implementation plan using a bottom-up approach was started at the level of the health sub-centres, locking in the efficacy of the plan.

During this phase, four months before the campaign, each state organised systematic training for all relevant officials in the district and key stakeholders and partners. One month before the launch of the campaign, a preparedness assessment was carried out by the core group, based on 10 major indicators. If the state was found to be inadequately prepared, the launch of the campaign was postponed and the technical and communication strategies were re-evaluated to ensure its success in terms of coverage and communication. The campaign was concluded nationwide by June 2019.

The MR campaign is now over in all states except for New Delhi and West Bengal. The current evaluation is, thus, being conducted to determine how and to what extent the communication processes for the MR campaign have been relevant, effective, efficient and sustainable to be introduced into the routine immunization.

In this context, UNICEF commissioned CMS (Centre for Media Studies) to conduct a formative evaluation. The findings from this formative evaluation will inform the inclusion of the MR vaccine into the routine immunisation programme. For the government, such an evaluation would provide key lessons and recommendations. Additionally, this evaluation will provide results that are not only MR-specific but may influence other communication work as well, such as that for routine immunisation. Lessons learnt from the evaluation would also inform UNICEF's communication for programmes in nutrition, WASH, child protection, and education.

1.3 Literature review

Studies conducted on communication processes adopted by Measles-Rubella/Measles-Mumps-Rubella Supplementary Immunization Activities (SIAs) around the world and in India bring to light the role of social capital and certain enabling and risk factors that affect the uptake of these vaccines.

Gopichandran et al.[5] conducted a case-control study on the impact of social capital on trust in health information, and acceptance of Measles–Rubella vaccination campaign in Tamil Nadu. The study defines social capital as social relationships and shared values, norms, trust and reciprocity in a society. The terminology is further classified as bonding when it exists within a homogeneous group and bridging when it occurs among heterogeneous groups, such as among different communities. They noted that it is through the process of bridging that each different group is linked in a power hierarchy, and with the larger systems, such as the

[5] Gopichandran, V, B Palanisamy, and K Kosalram. "Social Capital, Trust in Health Information, and Acceptance of Measles–Rubella Vaccination Campaign in Tamil Nadu: A Case–Control Study." *Journal of Postgraduate Medicine* 64, no. 4 (2018): 212. https://doi.org/10.4103/jpgm.jpgm_249_17.

government. With respect to the role these two forms of capital play, the authors state that "*While bonding social capital increases physical and emotional support for adapting healthy behaviours, bridging provides assets and more credible information, and linking capital increases compliance to suggested behaviours such as administering vaccines*."

The further results of this study are in tandem with the findings of other global and national level quantitative analysis of the enabling and risk factors that affect the acceptance and uptake of the vaccines. The authors argue that strong physical social capital (a form of bonding social capital) reduces the acceptance of vaccines. This may be attributed to the strongly held local beliefs and misinformation about the vaccine, which may exist within groups.

The first phase of the Measles-Rubella campaign in India was shunted due to high resistance from parents of children studying in elite private schools. This behaviour can be understood in the light of two reasons. First, parents were reported to be hesitant because they had already vaccinated their children against MR/MMR at private clinics. Secondly, the improved living standards, nutrition and healthcare have reduced the measles mortality rate significantly within the group, and they no longer perceive the disease to be a serious threat. Such a misperception leads them to believe that the risks of the vaccine outweigh the invisible benefits.[6] This challenge was overcome in the second phase of Measles-Rubella campaign in India by developing strong inter-sector management and communication between Department of Health and Family Welfare and Department of Education. Information from teachers and schools played a significant role in promoting acceptance of the vaccine among the parents.[7] In places where school teachers have strongly recommended the vaccine, uptake has been over 90 per cent and coverage levels were sustained.[8]

The Measles-Rubella vaccine campaign in India also faced resistance from minority groups. A qualitative study conducted by Krishnendu and George,[9] which looked into the drivers and barriers of the Measles-Rubella vaccine campaign, present that strong religious affiliation played a significant role in hindering coverage. The strong focus on young girls for the vaccine raised a concern regarding 'hidden agenda of population reduction'. Social media was one of the primary tools through which such ideas were propagated.

A study conducted in Zimbabwe regarding increasing acceptance of the vaccine among a group with strong religious affiliation showed that acceptance can be heightened when vaccination

6 Global Measles and Rubella Strategic Plan: 2012-2020. Geneva, Switzerland: World Health Organization (WHO), 2012.
7 Gopichandran, V, B Palanisamy, and K Kosalram. "Social Capital, Trust in Health Information, and Acceptance of Measles–Rubella Vaccination Campaign in Tamil Nadu: A Case–Control Study." *Journal of Postgraduate Medicine 64*, No. 4 (2018): 212. https://doi.org/10.4103/jpgm.jpgm_249_17.
8 Aggarwal, Anil, Aditi Sengar, Preeti Gupta, and Ramniwas Mahore. "'MR Vaccine Campaign in India' – Get Ahead Success." South Asian Res J App Med S 1, No. 1 (2019). https://doi.org/10.36346/SARJMS.2019
9 George, Leyannasusan, and V K Krishnendhu. "Drivers and Barriers for Measles Rubella Vaccination Campaign: A Qualitative Study." *Journal of Family Medicine and Primary Care 8*, No. 3 (2019): 881. https://doi.org/10.4103/jfmpc.jfmpc_73_19.

related advices are offered outside of regular services.[10] Following a similar pattern, the second phase of the Measles-Rubella campaign in India, thus, designed interventions, which focussed on increasing coverage among unvaccinated or under-vaccinated populations through increased vaccination knowledge, convenience and access. The campaign also engaged religious or other influential leaders to promote the Measles-Rubella vaccine, which, in turn, demonstrated an increase of vaccination uptake by more than 25 per cent.[11]

Inflated reports and rumours of adverse events following immunization (AEFI) also strongly affected the uptake of Measles-Rubella vaccine in India during the first phase. A study conducted in Chennai, the capital of Tamil Nadu, revealed that among 75 non-immunized children in the sample, 62.8% and 29.4% were denied vaccination due to inflated information about the adverse events shared through television and social media respectively.[12] Another study conducted in rural Tamil Nadu presents that rumours of adverse effects (47.5%) and fear of adverse effects (53.3%) were two of the highest ranked barriers that prevented uptake of the vaccine among parents for their children.[13]

Gopichandran et al.[14] thus argue the need to engage with the community at a large-scale, especially through village level and door-to-door information, education, and communication activities. Methods of information dissemination adopted by the campaign need to be locally relevant, such as public talks, street theatre and video shows. The authors add that interpersonal communication should be used to spread information and in locations where effective bridging networks, such as women's self-help groups are available, they need to be utilized optimally for the dissemination of credible information about the vaccine.

The second phase of the Measles-Rubella campaign in India re-evaluated and formulated its strategies based on the insights from the first phase of the campaign and experiences documented within and outside India during other vaccination campaigns. As demonstrated in the operational and communication guidelines, the campaign recalibrated its operations by focussing on developing effective and multi-tiered governance and monitoring systems. It sought out partnerships within and outside the government, allowing a broader scope for outreach and ensuring equity. In terms of communication strategies, it was not seen as an

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[10] Gerede, Regina, Zorodzai Machekanyanga, Serigne Ndiaye, Kenneth Chindedza, Colline Chigodo, Messeret E. Shibeshi, James Goodson, Fussum Daniel, and Reinhard Kaiser. “How to Increase Vaccination Acceptance among Apostolic Communities: Quantitative Results from an Assessment in Three Provinces in Zimbabwe.” *Journal of Religion and Health* 56, No. 5 (2017): 1692–1700. https://doi.org/10.1007/s10943-017-0435-8.

[11] Sreedevi, A. “Measles-Rubella Vaccination Campaign: A Trust Deficit?” *Journal of Postgraduate Medicine* 64, No. 4 (2018): 202. https://doi.org/10.4103/jpgm.jpgm_104_18.

[12] Barathalakshmi, J, Rashmi Gour Patel, S Kanimozhi, and V Sudha. “Measles Rubella Immunization Campaign: Challenges Faced in an Urban Area of Chennai.” *Indian Journal of Public Health Research and Development* 9, No. 7 (2018): 18. https://doi.org/10.5958/0976-5506.2018.00606.x.

[13] Jasmine, Aliya, and Priyadharshini. “Coverage Survey of Measles-Rubella Mass Vaccination Campaign in a Rural Area in Tamil Nadu.” *Journal of Family Medicine and Primary Care* 8, No. 6 (2019): 1884. https://doi.org/10.4103/jfmpc.jfmpc_319_19.

[14] Gopichandran, V, B Palanisamy, and K Kosalram. “Social Capital, Trust in Health Information, and Acceptance of Measles–Rubella Vaccination Campaign in Tamil Nadu: A Case–Control Study.” *Journal of Postgraduate Medicine* 64, No. 4 (2018): 212. https://doi.org/10.4103/jpgm.jpgm_249_17.

isolated process. Instead, it was an integral part of operations, with an effective and appropriate line developed for each chain of action.

1.4 Secondary data review

The fourth National Family Health Survey (NFHS-4, 2015-16), with regard to the larger routine immunization programme in India, reported that 62 per cent of the children between the ages of 12-23 months received all basic vaccinations. Further, the coverage for full immunization stood at 61 per cent in rural areas and 64 per cent in urban areas. The coverage for individual vaccines were recorded to be higher by the survey. It was recorded to be the highest for the BCG vaccine at 92 per cent, and lowest for the third dose of polio vaccine at 73 per cent. However, despite the high coverage of individual vaccines, the coverage of complete immunization in India continues to be low, contributing to the high burden of vaccine preventable diseases among children.

Table 1.1: NFHS-4 Data – 2015-16

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card seen in India, 2015-16: NFHS-4 (%)	
All basic vaccinations	62
BCG	91.9
Hepatitis B (0)	65.6
Hepatitis B (1)	82.5
Hepatitis B (2)	77.1
Hepatitis B (3)	62.7
DPT (1)	89.5
DPT (2)	85.7
DPT (3)	78.4
Polio (0)	79.1
Polio (1)	90.8
Polio (2)	86.0
Polio (3)	72.8
Measles	81.1
By background characteristics, India, 2015-16: NFHS-4 (%)	
Scheduled caste	81.5
Scheduled tribe	77.4
Other backward class	81.1
Other	82.8
Don't know	71.6

Measles coverage as per, NFHS-4 (2015-16) was 81 per cent. The coverage of this vaccine remained predominantly uniform across all social groups, with the differences ranging from 77.4 per cent among Scheduled Tribes to 81.5 per cent among Scheduled Castes.[15] The coverage of the second dose of Measles vaccine (MCV 2), as per the Health Management Information System (HMIS) in 2014, was recorded to be at about 66 per cent. The data of routine immunization recorded the coverage to be even lower, at about 40 per cent.[16]

With the launch of the Measles-Rubella vaccination campaign in 2017 and its completion in 2019, the recent data from the HMIS (Table below) present the increase in the coverage of Measles-Rubella vaccine over the span of these two years. The national coverage of the vaccine at the end of financial year 2018-19 stood at 89.10 per cent, an increase of almost 8 per cent since 2015-16. Further, three of the five states being studied in this evaluation —

[15] Table 9.4, Page 267: India Report. International Institute for Population Sciences (IIPS) and ICF. 2017; National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS.
[16] National Health Mission, Ministry of Health and Family Welfare, Govt. of India. (2017). Introduction of Measles-Rubella Vaccine: National Operational Guidelines.

Maharashtra, Gujarat and Uttar Pradesh reported reaching over 90 per cent of the children classified under 'Need Assessed', while the remaining two states — Assam and Odisha reached over 85 per cent.

Table 1.2: HMIS Data

Performance Related to Immunisation: Measles + MR Period: April to March for the year 2018-19 and 2017-18 as on 27 Dec. 2019, 2:12 PM					
State	**Need Assessed**	**Achievement during April to March**			**% Achievement of need assessed**
	(2018-19)	**(2018-19)**	**(2017-18)**	**% Change**	**(2018-19)**
	(A)	**(B)**	**(C)**	**(D=((B-C)/C)*100)**	**(E=(B/A)*100)**
All India	26277000	23421214	23230191	0.80	89.10
Assam	706000	601575	584833	2.90	85.20
Odisha	793000	696614	472974	47.30	87.80
Maharashtra	1926000	1844582	1884448	-2.10	95.80
Gujarat	1290000	1198439	1155281	3.70	92.90
Uttar Pradesh	5660000	5231787	4699832	11.30	92.40
Need Assessed = Estimated number of children up to one year of age during current year					

Further data from UNICEF reports that as of May 2019, the coverage of the MR vaccine among children between the ages of nine months and 15 years, in all study states have crossed the global target of 95 per cent in an elimination setting.

Against this background, the evaluation explores the relevance, effectiveness, efficacy and sustainability of the communication processes that enabled the vaccination coverage to increase.

CHAPTER 2: METHODOLOGY

2.1 Objectives

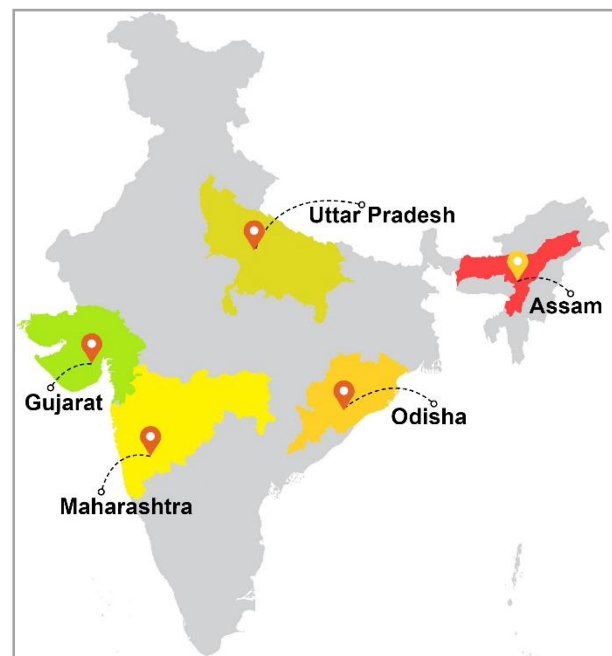
The specific objectives of this formative evaluation are:

a) Assess what communication procedures and activities worked.
b) Identify the factors and reasons behind why some procedures and activities worked and why others did not
c) Understand to what extent and to what effect gender element was incorporated in the procedures and activities
d) Understand if, equity (to what extent, and to what effect) was incorporated in the procedures and activities
e) Recommend how the procedures and activities can be further improved

2.2 Scope

The formative evaluation of the MR campaign was conducted across five states — Assam, Gujarat, Maharashtra, Odisha and Uttar Pradesh. These five states were purposively chosen based on their involvement in various phases of the MR campaign and the context that they offered. Two districts in each state were covered during evaluation.

Fig 2: Evaluation States



The scope of evaluation was limited to determine the extent to which the communication processes for the second phase MR campaign have been relevant, effective, efficient and sustainable. The evaluation focussed on all the communication processes (*See* ToR in Annex) from 'pre-campaign preparation to outreach' for the national MR vaccine campaign and evaluate whether the communication objectives were met. It did not seek to assess UNICEF's support specifically; however, where findings were found relevant for UNICEF's work, they were considered.

The 'Communication Guidelines for Measles Rubella Vaccination Campaign' mentions details on timelines for each of the key procedures and activities. This evaluation covered all the procedures and activities between the dates of commencement, which was four months before the start date of the MR Campaign till the date of commencement of this evaluation.

Being a formative evaluation, the report will highlight challenges experienced, provide essential lessons learnt from implementation and document local innovations that can be replicated or avoided in future, especially in Routine Immunization. The formative evaluation did not measure any impact, but tried to understand what worked and what did not and the reasons behind it.

2.3 Evaluation criteria and questions

The formative evaluation would inform the inclusion of MR vaccine into the routine immunisation programme, provide key lessons and recommendations, and help identify relevant, efficient, effective, and sustainable communication platforms that may be then used in other government programmes and campaigns, such as the routine immunisation programme.

The evaluation attempted to answer the **relevance** of campaign; **effectiveness** in terms of communication strategies meeting the campaign objectives with regard to positive positioning, promoting community acceptance and building an enabling environment; **efficiency** in managing the processes and time within the allotted resources; and the **sustainability** of this communication process when it moves from a campaign mode to routine immunization format. While doing so, the evaluation looked into how positive positioning of the MR campaign among the stakeholders were achieved; how social mobilisation interventions facilitated community acceptance, if at all; how enabling environment through positive reporting and involvement of key stakeholders were built and how negative response myths amongst all stakeholders were countered. The queries were developed around the evaluation criteria and questions under each of the OECD-DAC Criteria for Evaluating Development Assistance, except impact since this was a formative evaluation. The evaluation questions and the areas of enquiry are in the Annexure.

The evaluation questions under each criteria have been adapted from the ToR to achieve the objectives set for this evaluation. The table on the next page maps the questions under each evaluation objective, identifies the sources of data and the methods of data collection. Some of the questions essentially lead to the analysis of the findings and has not been included in the matrix (Annexure).

2.4 Approach

The evaluation adopted both primary and secondary data collection approach for addressing the evaluation objectives. The approaches used were:

- Collection and desk review review of secondary data and reports from centre and states
- Semi Structured Key Informant Interviews with stakeholders and partners
- Focus group discussions (FGD) with parents and caregivers

a) Desk review

A comprehensive review of existing data and reports pertaining to MR vaccination at global and national levels was conducted and this provided an overall understanding of the MR campaign and vaccine acceptance across the globe and in India. Further, it gave an understanding of the MR communication campaign processes, partnerships and activities in India and informs the development of evaluation tools. Besides the global literature, the National Operational Guidelines (2017), National Health Mission, Planning and Implementing High-Quality Supplementary Immunization Activities for Injectable Vaccines Using an Example of Measles and Rubella Vaccines — WHO, Communication Guidelines for Measles Rubella Vaccination Campaign — UNICEF, Measles Rubella SIA Campaign Phase II Report India — 2017, the MR Campaign in Gujarat: Experiences in Partnership — UNICEF and Global Measles and Rubella Strategic Plan: 2012-2020, Geneva, Switzerland: World Health Organization (WHO), 2012 were looked into. For the purpose of secondary data analysis, data from NFHS-4 and the national HMIS were utilised.

The content analysis of the national communication package of MR campaign was reviewed to understand their purpose, messages and target audience. This helped in analysing and comparing the local adoption of IEC materials and to identify whether any innovative communication materials were designed and produced to meet the communication gaps.

Available state level communication plans and reports were collected during field visits and reviewed to understand the implementation plans, activities, innovative strategies adopted by the states.

b) Primary Data Collection

Primary data was collected through conducting semi structured key informant interviews with stakeholders and partners and focus group discussions (FGD) with parents and caregivers.

- **Sampling**

Sampling for this formative evaluation was customized as follows:

→ Data was collected from five states which were purposively selected by UNICEF — Assam, Gujarat, Maharashtra, Odisha and Uttar Pradesh. These five states were chosen based on their involvement in various phases of the MR campaign and the context that they offered, such as urban and rural divide, high disease burden, good governance, and presence of marginalized and vulnerable population. Assam and Odisha have been identified as states with 'high proportion of tribal population', Gujarat for demonstrating good governance with regard to the campaign, Maharashtra for offering a stark urban-rural context and Uttar Pradesh for being a high burden state.

→ One good and one poor performing districts were selected using a composite score based on social and health related indicators.[17] The social indicators considered for developing the composite score included adult literacy rate (age 15+), population density (persons per sq. km.) and proportion of households having TV. The health indicators were — complete primary immunization (BCG, DPT, Measles and Polio); Measles vaccine rate; rate of vaccines at a public health facility; percentage of women who have received all four ANC; proportion of institutional deliveries and exclusive breastfeeding rate. Using the "Division by mean method technique,"[18] individual scores were computed for each indicator by district. The individual scores were then collapsed into a composite score for each district (Annexure).

→ The district scores were shared with the State for the selection of one well performing and one challenging district on the basis of pre-assigned behaviour to do with resistance or hesitancy in certain communities during MR communication campaign implementation. A "well performing" district is where implementation did not face any interruption and had demonstrated effective partnerships, across governmental departments (Dept. of Education, ICDS, etc.), partners (WHO and UNICEF), civil societies and community-based structures of governance (PRI, VHSNC, etc.) to achieve high coverage. A "challenging" district is one where the coverage was achieved after facing logistic or administrative challenges, or challenges in terms of demographic and socio-cultural uniqueness, or resistance because of some myths and misinformation. As the communication strategies for second phase had been designed anticipating most of the challenges faced during implementation, the analysis tested their relevance, effectiveness, efficiency and sustainability by enquiring into their roles in each of the well performing as well as challenging districts. Since the evaluation findings would ultimately feed into the routine immunization, it was essential that the challenges faced and the strategies applied to

[17] Census of India 2011, National Family Health Survey - 4, 2002-2004, Ministry of Health and Family Welfare, Government of India, New Delhi 2006

[18] Division by Mean Method: Each of the indicators has been made scale free by dividing individual values by their mean. These have then been added up to get a composite score for each district and then sorted in ascending order. The district corresponding to the lowest value is poor and the one with the highest value is best district in a state in terms of social development and health.

overcome them are well documented. The districts chosen for the evaluation are tabulated below.

Table 2.1: Evaluation Districts

STATES	TYPE	DISTRICTS	REASONS
Assam	Challenging	Hailakandi	Vaccine hesitancy & resistant community. Initially very low coverage
	Good	Dibrugarh	Implementation without any interruption
Gujarat	Challenging	Dohad	High tribal population, dispersed settlements, and high migrant population
	Good	Surat	Systematic process of mobilising active support from multiple stakeholders
Maharashtra	Challenging	Parbhani	Vaccine resistance and resistant community
	Good	Kolhapur	Commitment of administrators at all levels
Odisha	Challenging	Gajapati	Resistance from Christian communities
	Good	Khordah	Ease of reach, monitoring & branding and good mobilisation
Uttar Pradesh	Challenging	Bahraich	Poor coordination with schools, resistance from communities
	Good	Gorakhpur	Good macro plan, involvement of district admin & partners

→ Primary sampling units (PSU) like villages/wards in urban areas within a district for meeting the community were purposively identified by the research team based on the inputs from the District officials. The research team sought information about the location of communities that were either resistant to accept the vaccine for socio-cultural religious reasons; were vulnerable in terms of their social identity; were hard to reach due to their geographical location or any other unique context that they offered. Out of the list of communities/locations suggested by them, villages/wards were randomly chosen for conducting FGDs among communities which were exposed to the MR campaign activities. This was done to look into how the campaign was moulded to ensure that it was equitable, gender sensitive and accessible for all. Eight such PSUs were visited in a district.

→ The key informants were the government and non-government partners **who actively participated** in this campaign. Interviews were held to get their opinion about communication processes, planning and implications. 'Active participation in the campaign' was key, as effectiveness of a campaign was evaluated from their opinion. Besides the key informants, the service providers and the right-holders are the respondents in this evaluation.

Table 2.2: Respondents

CATEGORIES	RESPONDENTS
Key Informants	Govt. Officials at state, district and block level – Representatives from Departments of MoHFW, MOWCD, MoHRD (immunization officer, child health, social media), CMO's Dist. Immunization officers etc.
	Partners – Representatives from WHO, UNDP, Media, IAP, IMA, Local Lion & Rotary Clubs
	Community influencers – local leaders, religious leaders, Panchayat Leaders, teachers, frontline health workers (ANM, AWW)
Community	Father, mother and caregivers of children aged nine months and <15 years.

- **Sample selection process**

a) Selection of parents of children between the ages of nine months and 15 years was done through the following steps:

- Identify and contact households with children aged nine months-15 years in a PSU
- Select 10-12 eligible households who are available, willing to participate and give consent. Select one caregiver according to availability and invite for FGD. Finally select at least 7-8 participants for focus group discussions.
- Hold separate FGDs for male and female caregivers.

b) ASHA and ANMs of the selected PSUs were contacted and interviewed at a convenient place.

c) The key partners in MR campaign in each state and district were mapped with the help of UNICEF field officers. They were selected on the basis of their involvement in the campaign. This was essential, since the evaluation derived from the institutional memory. At Block and PSU levels, the officers and community representatives (VHSNC, PRI, Religious leaders, etc.) were contacted for interview only when their names emerged in the discussion with community and officers in the district.

In-depth interview were carried out at state, district and block levels. All the respondents were interviewed at their office.

- **Sample distribution**

The sample achieved from each state, district and block are as below.

Table 2.3: Sample of KIs

STATES	State KIIs	TYPE	DISTRICTS	District KIIs	FGD Community	ANM/ASHA IDI
Assam	7	Challenging	Hailakandi	1	8	16
		Good	Dibrugarh	2	8	16
Gujarat	9	Challenging	Dohad	8	8	16
		Good	Surat	7	8	16
Maharashtra	4	Challenging	Parbhani	4	8	16
		Good	Kolhapur	5	8	16
Odisha	5	Challenging	Gajapati	3	8	16
		Good	Khurdah	**1**	7	15
Uttar Pradesh	8	Challenging	Bahraich	4	8	16
		Good	Gorakhpur	2	9	16
TOTAL	**33**			**37**	**80**	**159**

2.5 Process

- **Tool development**

A set of four tools were used for collecting data. The guidelines were developed in English in consultation with UNICEF and were translated in regional languages for administration (Assamese, Gujarati, Marathi, Oriya, and Hindi). The tools for evaluation are:

i) Informed Consent form (ICF) and Participant Information Sheet (PIS) for Community and KIIs
ii) Free flowing guideline for in depth interviews with State/District officers and UNICEF
iii) Free flowing guideline for in depth interviews with Partners like WHO, UNDP, etc.
iv) Free flowing guideline for in depth interviews with the Front-line functionaries.
v) Free flowing FGD guideline with CBPR activities for parents and caregivers.

A Content Analysis Matrix was created for analysing the content of any locally developed Campaign materials/messages collected from the states. This was done to identify the key issues and themes dealt in the series and supplement the findings of the parents and caregivers and whether they found the messages relevant to their context.

The tool for community FGD incorporated areas of enquiry for the evaluation. Two Community-based Participatory Research Methods (CBPR) were applied in FGD setting with caregivers. CBPR technique based on social ecological model (SEM) was applied to bring out the information flow on MR vaccine among family, peer and community and who in each of the circles influenced their decision. This was a paper based exercise and the moderators facilitated the discussion.

The evaluation tools were pretested before finalizing in Odisha and Uttar Pradesh to understand the logical flow of the questions, ease in understanding by the respondents and comprehensiveness in terms of information coverage. The sequence of questions in the FGD guideline was adjusted after pre-test

- **Team training**

A four days training was conducted for the researchers, moderators, supervisors and CMS Communication Researchers from 11-13 February, 2020 in New Delhi. The orientation was conducted by the Project Director. UNICEF officers joined to give insights into the MR Campaign. The team was oriented towards the purpose and content of the study and the respondents. Detailed discussion happened on selection of respondents. Each and every guidelines were discussed in detail. The Researchers and Moderators were also trained to conduct CBPR activities. Detailed training was given to them on 'How to conduct' CBPR.

Human Subject Training and Ethical guidelines was shared with the entire team and the team discussed about: a. Role of the Data Collector, b. Importance of Respect, c. Voluntary Participation, d. Informed Consent, Vulnerable Populations, f. Personal Privacy, g. Protection of Personal Information, h. Response to Participant Questions, i. Data Integrity, j. Respect for the Science of the Study, k. Collecting, Recording, and Storing Study Data, and l. Deviations from Study Procedures. Mock CBPR exercise and IDI were conducted to familiarize the team with the process and also identify the gaps in the tone of administration.

- **Data Collection**

The field survey started first in Gujarat from February 25, 2020. First the state level officers were interviewed in Gandhinagar. Then the team moved to the district. The teams set up appointments with potential key respondents in the state and districts and interviewed them. The venue and location of two FGDs with community were decided in consultation with the district officials. The field work rolled out one by one in the remaining four states. The field work continued till March 18 in Parbhani in Maharashtra and till March 20 in Odisha. Due to a total lockdown for Coronavirus, the scheduled IDIs with Khordah district officers and Maharashtra State officers in Pune could not be conducted.

Data was collected through FGDs and IDIs. The FGDs were conducted in a place of convenience to the respondents. The IDIs were conducted at the offices of the respondents or over the telephone as in the case of Odisha. Both IDIs and FGDs were recorded with consent.

- **Analytical approaches**

The data emerging from the FGD and KIIs were analysed thematically. Stages of qualitative data analysis consisted of completing and compiling notes taken during KIIs and FGDs, transcription, translation (from local language to English/Hindi), organizing, familiarization and entering them under the thematic queries (evaluation criteria and questions). The responses were entered in a matrix developed to record findings under each component from each group of respondents and analysed manually. State-wise and category-wise analysis was further done by sorting the entered responses as relevant. Relevant verbatim quotes were culled out for the report.

The data collected on the identified communication processes were analysed based on the four evaluation criteria: relevance, effectiveness, efficiency and sustainability. Further, as the interviews were conducted at all the levels- starting from state, district, up till the level of communities, and with the development partners as well, it helped validate the findings and analyse them accordingly.

The findings from the matrix under each area of probe across respondent categories have been compared and contrasted for identifying the process of MR communication, designs incorporating inclusion of vulnerable population, contextualization done, unique initiatives taken, challenges faced, lessons learnt, resources utilised, etc. The state level variations and commonalities related to all the communication processes were elaborated and supplemented with available evidence.

The findings from the Community Based Participatory Research (**CBPR) activities** have been photographed and numbered and documented for analysis. The analysis of the quantifiable data from the FGDs have been counted and analysed.

The **local communication materials** and messages collected from the states have been analysed using indicators like: type, language, message, target audience and producer.

Review of literature related to the MR campaign, drafted by the Government of India and UNICEF, laid out the methods adopted by the campaign to be equitable and gender sensitive. Information on 'inclusion of gender and equity' component has been gathered from both desk review of plans and reports and interviews with partners, stakeholders and caregivers. Based on this understanding, the KII guidelines created enquire into the methods adopted by the states to ensure the same during different phases of the campaign, which includes planning, preparing communication materials, training the staff, and documented designs of macro and micro level plans and implementing the campaign. The KII guidelines enquired into how gender and equity have been included in different phases of the campaign, which includes planning, preparing communication materials, training and implementing the campaign. The FLWs and caregivers also responded to queries on the involvement of vulnerable communities and men; if and to what extent was vaccine hesitancy or refusal a gendered issue. The caregivers responded to queries on the involvement of vulnerable communities and men. The responses received to these specific set of questions, along with the responses from caregivers pertaining to exposure and involvement in campaign activities, acceptance, and ease of availing the vaccine was then analysed to develop a comprehensive understanding of the extent to which the campaign in regions were equitable and gender sensitive in their approach.

The operational definitions of 'Equitable' and 'Gender Sensitive' are as below:

- The campaign will be **'Equitable'** when the plans and processes consider all the vulnerable communities (based on gender, religion, caste and economic status) in the region and when the communities themselves report being included in and exposed to the MR Campaign.
- 'Gender Sensitivity' is a subset of 'Equity'. The campaign will be **'Gender Sensitive'** with respect to caregivers when both male and female caregivers are approached, involved and exposed to the messages of campaign.
- The campaign will be **'Gender Sensitive' with respect to children** when the campaign provides commensurate attention to both boys and girls in terms of uptake of vaccination. The checklist to analyse how gender sensitive and equitable the campaign process is has been included (Annex. 7).

The relevance of the campaign has been assessed with reference to how well the campaign was customized to meet the needs of the context where it was implemented. The evaluation has also assessed how effectively the campaign was implemented to meet the local needs and reach the marginalized groups. The responses have been analysed to develop a comprehensive understanding of the different measures adopted by the five states and the extent to which the campaign in the region was relevant and effective.

The sustainability of the intervention and its alignment with Government of India programmes have been examined against the resources allocated and the current status of the programme.

Since the evaluation took place after a 24-month lag, variables such as the commencement of another campaign/training could have affected community's recall of the campaign. This was an area of concern. In order to address this, the team of researchers used school certificates as a stimulus to initiate recall. Recall among caregivers is discussed in greater detail in later sections of the report.

- **Ethics**

The researchers sought verbal informed consent of participants (Key Informants and FLWs), which ensured a clear understanding of the purpose of the research, voluntary participation, nature and extent of participation, duration of participation, extent of confidentiality, right to anonymity, and right to withdraw participation at any time. With regard to caregivers of children, the study considered the potential hesitation while answering. The participants were thus informed of their rights regarding participation; that participation is voluntary and that they may refuse to participate in the survey, they may refuse to answer selected questions. They were also informed that refusal to participate and/or refusal to answer certain questions after agreeing to participate will not result in any negative consequences for them. The information was read step by step to each potential participant in local language, while checking to ascertain understanding at each step by asking if s/he understands, or has any question. The questions designed for the focus group discussions were non-sensitive in nature. It only enquired about the information about their understanding of the Routine Immunization programme and the MR vaccine, their sources of information about MR vaccine and exposure to activities during the campaign. It did not seek to understand any sensitive experiences of caregivers. Further, confidentiality of the information obtained from caregivers was maintained to minimize risk and to ensure the rights of study participants. The evaluation was carried out according to ethical principles and standards established by the United Nations Evaluation Group (UNEG).

- **Evaluators obligation**

CMS did not have any conflict of interest as it was not associated with the management or implementation of the MR vaccination program. The organization's independence and impartiality were upheld to maintain the credibility of the study. The norms were upheld at every stage of the study- from the rigorous development of the methodology, to conducting the evaluation and formulating findings and recommendations. The organization provided the deliverables on time and in a relevant manner to ensure their accountability and to enable informed decision making for similar activities in the future. This study was led and supported by female researchers. The moderators were both male and female and respondents were gender matched.

- **Limitation of Study**

The purpose of this formative evaluation is to learn from the successes and shortfalls of the communication processes within the MR campaign and feed them into Routine Immunisation. Among the study states, except for Maharashtra and Uttar Pradesh, the MR campaign concluded by end of 2018. The study was overall dependent upon key stakeholders who were involved in the planning and implementation of the campaign and were available to be interviewed at the time of data collection. In Assam retired officers (two) were not interested to be interviewed.

India went into *Janata* Curfew on March 20, 2020 and a total lockdown was declared from March 22, 2020. Relevant health officers in Maharashtra (two State officers) and Odisha (one WHO officer) were unavailable for any interview even over the phone during the lockdown period.

While the selection of districts went through a rigorous two-stage process, the first being through composite set of structured data, the second stage was based on pre-assigned behaviour like vaccine resistance and hesitancy that were faced during implementation of the campaign.

The data of social media analytics or monitoring reports from the partners were not available for analysis.

This evaluation is limited to assessing only the MR communication processes within the larger MR campaign. These communication processes are situated within the larger operational framework of the 'success' of the MR Campaign, and the several factors that led to it, such as — vaccine availability, availability of human resources and finances, etc.

While care has been taken to purposively select the states (according to all UNICEF typologies) and subsequent districts (based on the variety of local challenges faced during the MR campaign), they are not representative of the entire country, and the various demographic, social, and cultural contexts that it offers. The findings do not attempt to quantify or generalise these qualitative findings.

CHAPTER 3: KEY COMMUNICATION PROCESSES IDENTIFIED IN THE EVALUATION STATES

In 2017, UNICEF developed the '*Communication Guidelines for Measles Rubella Vaccination Campaign*' with the Ministry of Health and Family Welfare, Government of India. This document was formulated in light of the insights and lessons learned during the first phase of the campaign, implemented in the states of Tamil Nadu, Karnataka, Goa, Lakshadweep and Puducherry. The guidelines, while charting out communication strategies, laid down the prototype for the creation of a uniform governing, monitoring and evaluating system for the campaign across states and also pre-empting challenges through described processes to address them effectively. All states were to refer to this document to design their pre-campaign activities and map out communication strategies, while also formulating strategies at the level of the state and districts to address local challenges.

SHIFT FROM PHASE 1 to PHASE 2
Feb 2017-August 2017

Negative messages on social media with regard to the vaccine, inaccurate reports of AEFI cases, sup-optimal participation of private schools, low involvement of private doctors, and limited inter-ministerial coordination hindered the Phase 1 (Feb 2017) of the campaign and were beyond the scope of the communication strategies to address.

Phase 2 (August 2017) of the campaign recognised requirement of re-strategizing to place adequate emphasis on communication related activities and involvement of stakeholders at various levels. Parallel to technical core group, a communication core group was formed to provide strategic support to MoHFW. To increase coverage and achieve the desired MR campaign goals, the objectives focused on positive positioning of the campaign among all stakeholders, augment acceptance of the vaccine among the communities, promote positive media reporting and combat negative responses. The redesigned strategies addressed school teachers, local religious and political leaders, celebrities, children and their parents to promote vaccine confidence among the public, and the technical and communication implementation plan was designed using a bottom-up approach, starting at the level of the health sub-centres.

The Ministry of Health and Family Welfare (MoHFW), with the technical support of WHO and UNICEF, also developed the '*National Operational Guidelines (2017)*' for the introduction of the Measles-Rubella vaccine through campaign and in routine immunization. This was formulated to assist national, state and district level programme managers by delineating the tasks and responsibilities to be completed by functionaries at all levels during the different stages of the MR vaccination campaign, and subsequent introduction of MR vaccine in routine immunization. The guidelines indicated setting up of committees and taskforces at different levels for successful planning, coordination, implementation and high coverage.

The national operational guidelines laid out extensive and specific strategies to address the marginalized and vulnerable demography across the state. The guidelines used the terminology '*High-Risk Area/Population*' to describe hard-to-reach areas due to difficult geographical locations, such as forests, tribal, far-flung isolated pockets, tea estates, riverine-

islands. It also included unserved or underserved areas or areas with a shortage or prolonged vacancy of health workers. It also recognized some parts of urban areas, especially unauthorized slums, railway/bus stations, make-shift huts, brothels, floating populations such as street children along with migratory populations or internally displaced populations including nomads, temporary harvesters, rice mill/brick kiln workers, daily wage labourers at large construction sites.

Gender is addressed as a sub head of equity, and an enquiry into the guidelines for strategies that address gender equity in planning and implementation points that the guidelines were directed at caregivers in general. Both the communication and the national operational guidelines did not specify any gender specific strategies.

The guidelines listed several campaign components.[19] The evaluation identified the following **critical processes** that included elements of communication which were necessary for the campaign to be a success.

Fig 3: Communication Processes

Process	Description
PROCESS 1	•Identification and collaboration with key stakeholders- State, district to the sub-district, and community level
PROCESS 2	•Training of frontline workers on micro-planning, social mobilization and interpersonal communication
PROCESS 3	•Monitoring of Adverse Event Following Immunization AEFI, Management & Media Advocacy
PROCESS 4	•Management of Social Media
PROCESS 5	•Maximising the reach through mass media and IEC material
PROCESS 6	•Social Mobilization

It can be noted here that while some of the processes were explicitly based on communication, others, such as training of FLWs on micro plan, AEFI management, monitoring of AEFIs or inter departmental convergences could be classified under operations. However, the evaluation recognizes that while these processes were certainly an intricate part of the operations, it had a significant component that focused on communications.

[19] *See* Terms of Reference in Annex

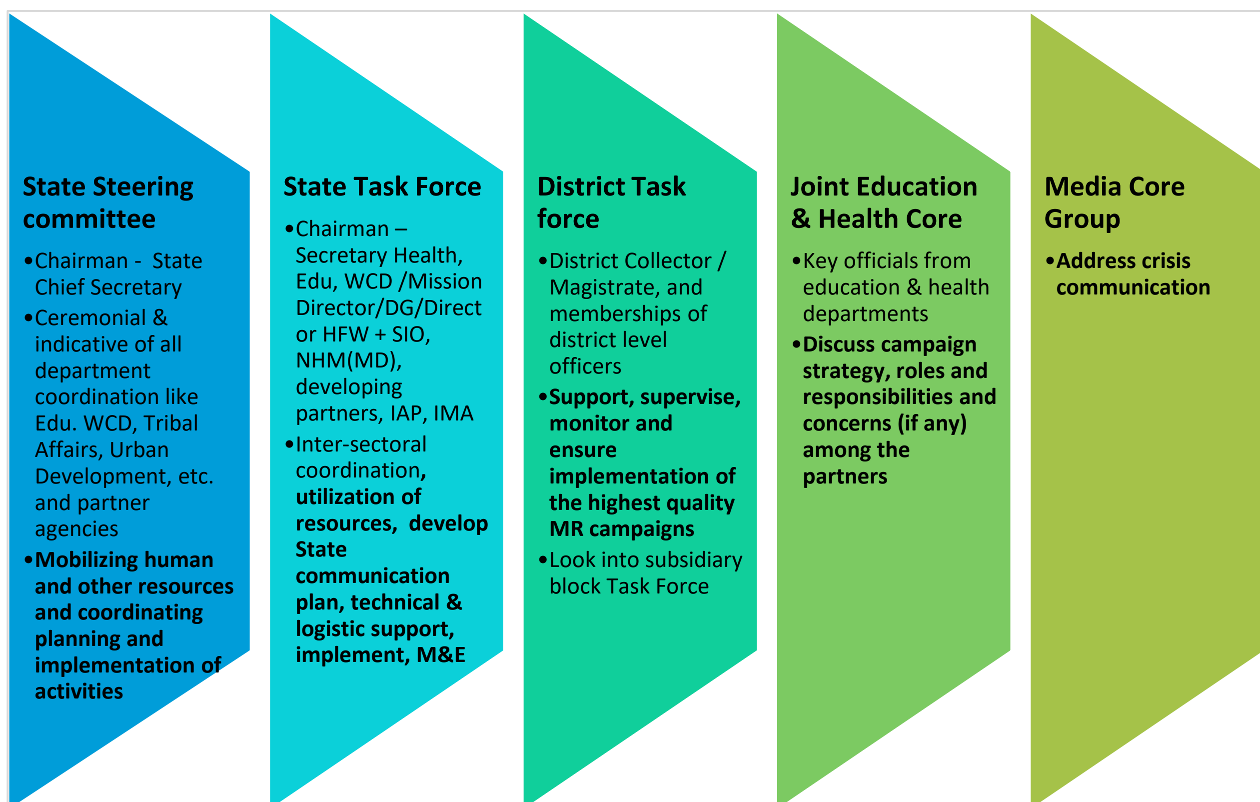
3.1 Identification and collaboration with key stakeholders from the state, district to the sub-district and community levels

Government Departments

- As per the national operation guidelines, the coordination between government departments, especially among the departments of Health, Education and Integrated Child Development Services (ICDS) of the Department of Women and Child Development (WCD) was to be critical engagements in all the states. With a preparatory time of approximately six to eight weeks prior to campaign rollout, all states were required to formulate Steering Committees, Task Forces, and Core Groups.

- Bodies, such as **State Steering Committee** and **State Task Forces** for Immunization, District Task Forces, Block Task Forces were put in place, which witnessed different departments – Health, WCD and Education, etc. coming together for governance and monitoring. The purpose was to mobilise human and other resources, coordinating and developing plans, providing technical and logistic support and implementation of activities with other departments.

Fig 4: Committees and Taskforces



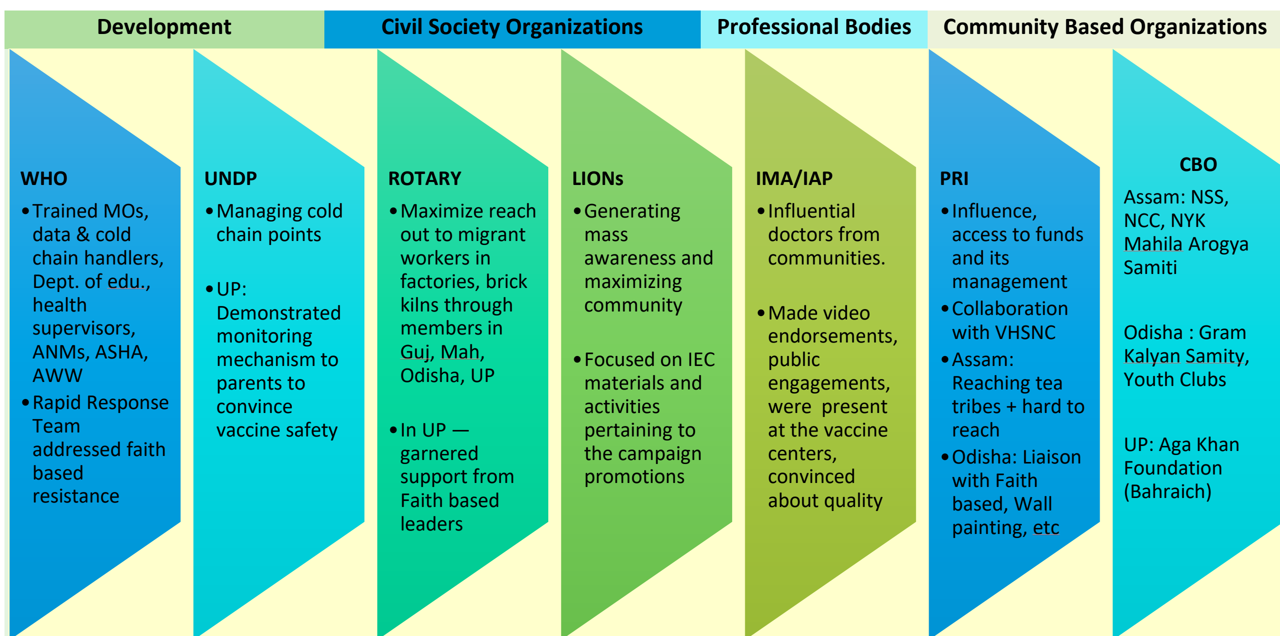
- Joint Education and Health core groups were to be formed with some key officials from the education department, private schools, and respective health department officials to discuss campaign strategy, their roles and responsibilities and address concerns (if any) among the partners while core group for media management addressed crisis communication.

- All five study states reported having effective bodies in place for campaign governance and monitoring activities. The discussion with state officers highlighted the existence and coordination of task forces at the district level and even beyond. States of Uttar Pradesh and Gujarat also substantiated this finding by providing minutes of meetings conducted among officials.

Partnerships

The National Operational Guideline recognized the need for partnerships with development partners (WHO, UNICEF and UNDP), civil society organizations (Rotary and Lions Club), professional bodies (Indian Medical Association and Indian Academy of Paediatrics) and other community-based bodies in terms of providing technical support, communications, maximizing outreach and impact. Besides their efficacy, the guidelines also sought these partnerships to be sustainable and to be implemented for future programmes and campaigns. While some of these partnerships already existed and were recalibrated to suit the needs of the campaign, others were created at the time of the campaign, with the hope for it to be sustainable in the future.

Fig 5: Partners in MR campaign



Partnerships with all the identified partners and organizations were reported from the study states. The role that each partner played in the five study states are as follows:

- **World Health Organization (WHO),** along with UNICEF, were two operational partners at the national and state levels. WHO personnel trained medical officers, data handlers, cold chain handlers, education department personnel, health supervisors, ANMs, ASHAs, and AWW in all study states. The Rapid Response Team of the organization also helped in addressing faith based and other forms of resistance, to maximize the vaccine uptake.

- **UNDP** has been electronically managing cold chain points, using eVIN which would allow them to monitor the stocks available, the temperature at which the vaccines were being kept, analyse the usage of vaccines, and replenish or manage the stocks accordingly in all the study states.

- **Rotary Club** in all the states, except for Assam, helped maximize outreach towards migrant workers in factories or brick kilns; assisted in setting up of border based booths to make the vaccines accessible to migrant workers; promoted the vaccine among parents in schools owned by the members in the study states and assisted in garnering the support of faith based leaders.

- The **Lions Club International Foundation** in India supported in generating mass awareness and maximizing community outreach. They focused heavily on IEC materials and activities pertaining to the campaign promotions.

- The private medical officers affiliated through **Indian Academy of Paediatrics (IAP) and Indian Medical Association (IMA)** were involved in the MR campaign. Influential doctors from the communities were made a part of the MR core groups. They provided technical support to the state, gave video endorsements, held public meetings, and were present at the vaccination centres.

- Collaboration with local **Community based organizations/bodies** and **self-help** groups were seen in all the states such as the Mahila Arogya Samiti, National Service Scheme (NSS), Nehru Yuva Kendra Sangathan (NYK) and National Cadet Corps (NCC) in Assam, Mahila Arogya Samiti, Gram Sanjeevan Samiti in Gujarat, Gram Kalyani Samiti in Odisha and CREDAI in Maharashtra. They played an important role in communication around the MR campaign and maximizing outreach.

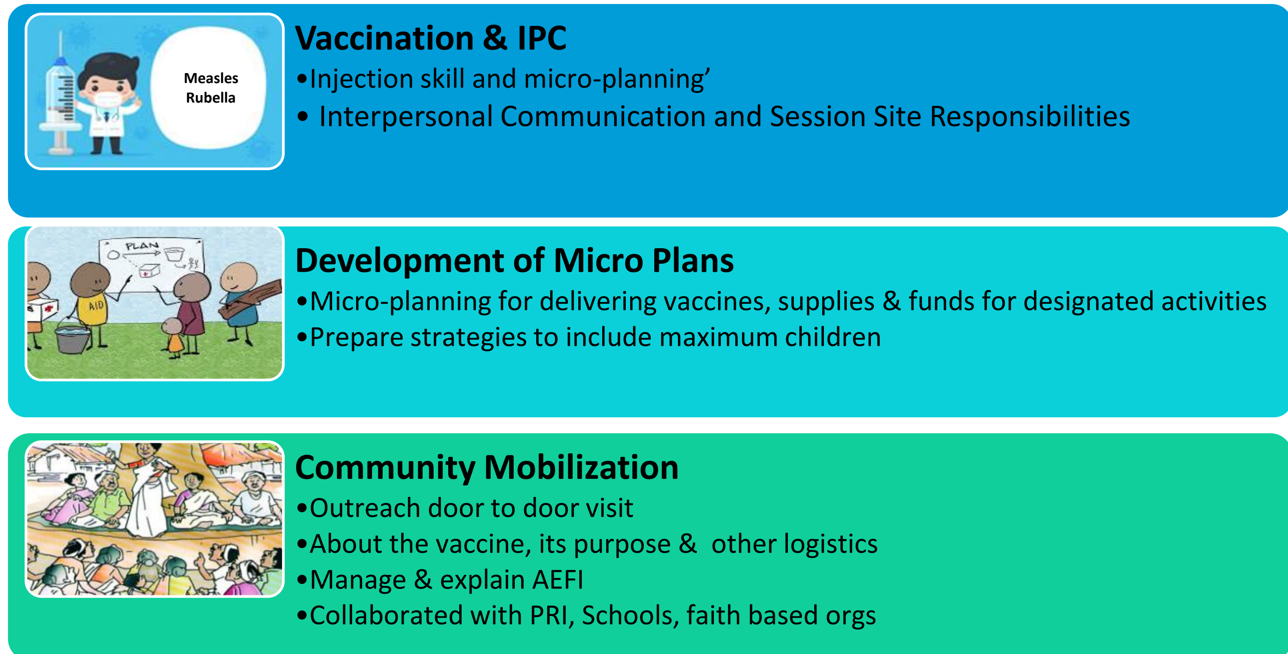
- Panchayati Raj Institution (PRI), VHSNC, were roped across all the study states to increase coverage.

3.2 Training of frontline workers on micro-planning, social mobilization and interpersonal communication

Vaccinators such as ANMs, Health Workers, and nurses were to receive technical training on 'Injection skill and micro-planning' and 'Interpersonal Communication and Session Site Responsibilities' at the block. The ANMs were trained to develop micro plans to cover the educational institutes during the first week, existing health facilities and all other additional outreach and mobile sites in the second and third week, and carry out mop ups to cover left out

areas with suboptimal coverage. For fixed outreach and mobile sessions, ASHAs, AWWs and other volunteers were to mobilize the targeted children, help ANMs organize vaccination sessions and manage the crowd.

Fig 6: FLW Training Components



- **Vaccination and IPC**: The evaluation brought out that the FLWs were certainly trained on the primary topics and strategies delineated by the guidelines. The health workers recalled being told about the two diseases, the technicalities of the vaccine — such as the site of vaccination quantity, safety, conditions under which vaccination was to be avoided, AEFI management, follow up of referral in case of any emergency, and interpersonal communication. The health workers were asked to provide four key messages, as is the norm during Routine Immunization as well. These messages included: i) diseases prevented by this vaccine, ii) side effects, iii) tackling the side effects and iv) date for the next vaccination.

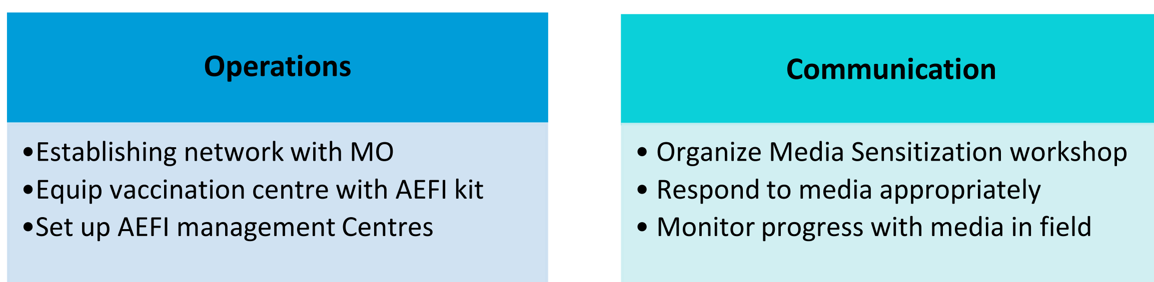
- **Development of Micro Plans:** ANMs reportedly developed micro plans for their regions, with the assistance of the ASHAs and AWWs. Micro-planning, starting from the lowest level up, set up plans for delivering vaccines, supplies and funds for designated activities. They accounted for the number of children in their region and developed strategies to vaccinate the maximum number possible within a day to achieve their target. Most of the frontline workers reportedly did the planning according to their ability.

- **Community Mobilization:** The FLWs reported collaborating with local governing and religious authorities like Panchayati Raj Institutions, schools and faith based institutions, and conducting household visits as per the convenience of the caregivers to maximize outreach and increase uptake. They communicated about the vaccine, its purpose and other logistical details to the caregivers. This information was recalled by caregivers during the FGDs as well. They were trained to address any queries regarding side-effects/AEFIs and rumours. Further, the FLWs reported that in case the health workers faced vehement resistance from any of the households, they were asked not to display any signs of force. Instead, they were to record their data and report it to the managing health facility.

3.3 Monitoring of Adverse Event Following Immunization (AEFI), management and media advocacy

Most of the crisis which emerged from negative media coverage across all the states and hindered implementation in the first phase of the campaign had been due to inappropriate reporting of adverse events following immunization (AEFI) cases or cases that were misidentified as AEFIs. To address such issues in the second phase of the campaign, the campaign guidelines indicated promoting the measures adopted by the states to address any AEFI case through media and interpersonal communication. The guidelines also directed a sound engagement plan with the press to address any query, concern or rumour that could potentially hinder the campaign. There were two aspects of AEFI management: Operations and Communication.

Fig 7: AEFI Components



- **Operations:** Though a technical issue, the knowledge and understanding of the operational aspect helped effective management of AEFI**.** To manage AEFI cases that could occur during the campaign, the AEFI surveillance, response and management guidelines delineated establishing a network of trained medical officers (MOs) from both government and private sectors. Each vaccination centre was to be equipped with standardized AEFI management kits and health workers were trained to use them. For cases that required further attention, all government health facilities and centres of the national immunization programme (except sub-centres) and additional private set-ups were required to be set up as AEFI management centres. This stringent AEFI surveillance protocol was formulated to ensure prompt management and reporting of AEFI cases. All five study states reported following the AEFI protocol developed for the campaign. Presence of Medical professionals and those associated with IMA and IAP in the vaccination sites were also reported.

- **Communications:** As negative media coverage of AEFIs was a highly pre-empted issue that could potentially derail the campaign, the guidelines directed the states to organize media sensitization workshops, about two or three weeks prior to the launch of the campaigns. These workshops and events were to be conducted to position the campaign positively among the media.

- **State Task Forces** were set up to respond appropriately to the media regarding any instance of AEFI and **Media sensitization workshops** were conducted in all five states. The workshops addressed issues of Routine Immunization alongside information on the MR campaign to develop an overall perspective on vaccination. It promoted responsible reporting of AEFI cases. Media kits were also to be created for this workshop, entailing the press release and background material on MR campaign. The campaign also received a media launch by Chief Ministers of the states of Gujarat, Uttar Pradesh, Maharashtra and Odisha.

- Additionally, **press briefings and time to time meetings were organized** by the states and partners to ensure strong communication with the media during the campaign.

3.4 Management of Social Media

- Phase one of the campaign faced strong vaccine resistance as misinformation about the campaign had spread through social media. In the second phase, the campaign took cognizance of the leverage that social media offered through sharing facts and achievements, building awareness around the need for the vaccine, monitoring negative media and WhatsApp messages, identifying active WhatsApp groups to counter negative messages and amplifying positive message dissemination. Detailed strategies to be

implemented on social media were laid out in the national guidelines for the second phase. Inquiry into the extent of adoption of these strategies in the study states found that all five states had devised plans and monitoring activities based on the operational and communication guidelines.

- The stakeholders and partners at the state level from all the study states reportedly regularly monitored messages being circulated primarily on WhatsApp and also on other platforms, such as Facebook and Instagram and took measures to counter any negative messages. Attempts were made through Search Engine Optimization to ensure that the initial results for a Google search on MR Vaccine and Campaign were positive instead of the negative report that created problems during the first phase of the MR campaign.

3.5 Maximising the reach through mass media and IEC material

In order to maximize the reach of MR campaign using different mass media channels and to ensure visibility, a series of communication materials (IEC materials) were developed. UNICEF, as the primary communication partner of the MoHFW, GOI, assisted in the development of a central repository of IEC materials in Hindi, English and Urdu for the MR campaign. These materials included banners; posters for schools, communities and doctors; leaflets for community health workers, parents and leaders for announcement activities; teacher's handbook; the booklet for religious leaders; the MR information card and MR Vaccination certificates and most importantly the Myth v/s Fact document. All states were required to develop a communication plan including mass media and mid media and monitor its implementation and translate these materials to their local languages, without changing the content of the message or the structure.

Besides the print materials, video spots, factoid videos, standard WhatsApp messages, training resources, media kit for training of media personnel, handbook for training of frontline workers, testimonials from MoHFW, IAP, NCDC, institutions and religious leaders, MR scroll-TV ticker, newspaper advertisement, video and radio jingles by brand ambassador Mr. Amitabh Bachchan, and curtain raiser videos on MR campaign were developed. For the convenience of the states to adopt the national level materials in state language or dialects, open files were shared with the states. The MR Communication guidelines listed down all the materials and for each material/product, detailed out the target audience, usage among whom and where and the point of availability.

Each of the states translated the IEC materials developed at the national level, keeping the content of the message and design of the material intact. All five states agreed that the materials sent to them were sufficient. Some of the study states reportedly developed local materials and local advertisements with local television and regional movie celebrities calling for people to vaccinate their children during the MR campaign. The actions undertaken by the states and their relevance and effectiveness are discussed further in the next chapter.

3.6 Social Mobilization

Interviews with state officials and development partners highlighted other activities undertaken at the level of the state to promote the campaign and address challenges. There were instances of need based advocacy with faith based leaders, professional doctors, school principals of urban elite schools, organising events, promotion of campaigns in religious gatherings, conducting community meetings, announcements, organising street plays, rallies, organising competitions in schools. All these were to mobilize the stakeholders and caregivers and to maximise coverage.

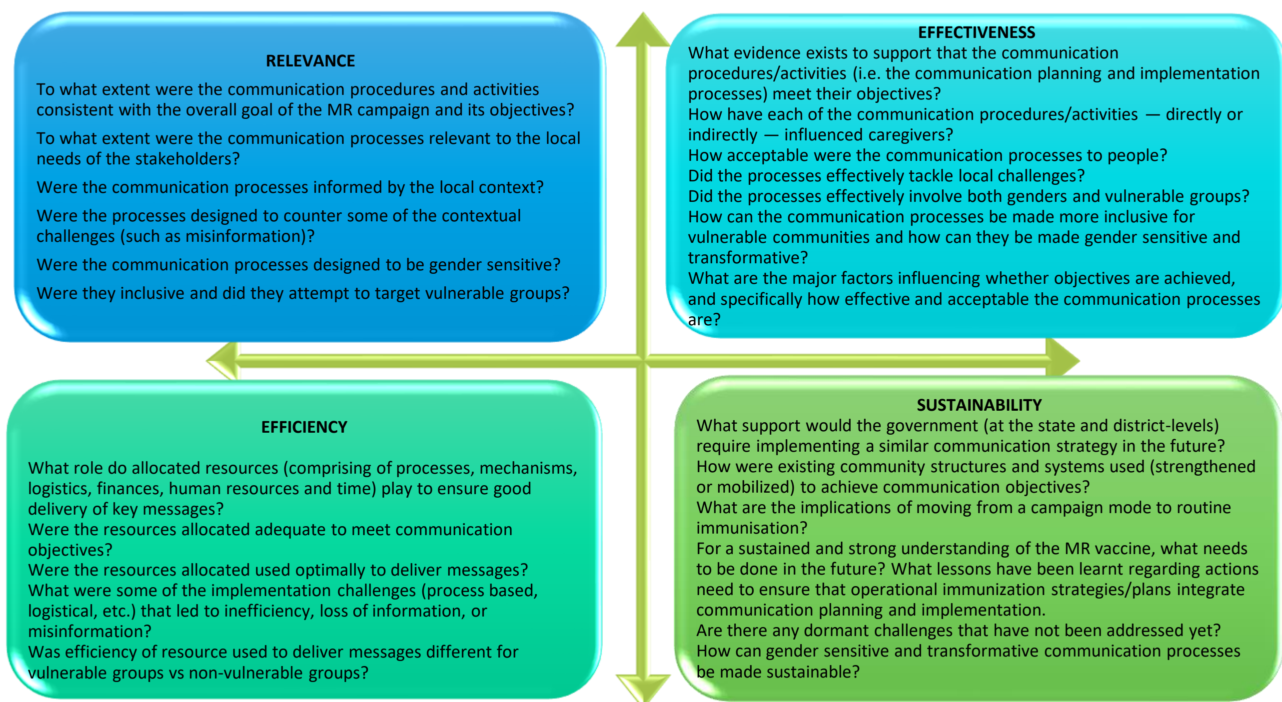
The next chapter details out which of these communication processes were relevant, effective, efficient and sustainable to be included in the Routine Immunization. The extent to which they were effective and efficient has also been analysed in the light of the discussions with the key stakeholders and the caregivers.

CHAPTER 4: FINDINGS

The findings from the in-depth interviews of the key informants at state, district and sub district levels and the discussions with the caregivers from representative communities are presented to answer the evaluation questions that were to be addressed. The evaluation questions have been categorised under the relevant heads as per the OECD-DAC criteria. The responses for each of the evaluation questions have been structured in the form of the key messages that have emerged from the analysis, while taking care to account for the views of all the key stakeholder groups interviewed as part of the evaluation.

The evaluation attempted to answer the **relevance** of campaign, **effectiveness** in terms of the extent to which the communication strategies met the campaign objectives of positive positioning of the campaign, augmenting community acceptance and building an enabling environment, **efficiency** in managing the processes and time within the allotted resources and the **sustainability** of this communication process when it moves from a campaign mode to routine immunization format. While doing so, the evaluation has also attempted to look into how positive positioning of the MR campaign among the stakeholders were achieved, how social mobilisation interventions facilitate community acceptance, if at all, how enabling environment through positive reporting and involvement of key stakeholders were built and how negative responses myths amongst all stakeholders were countered. The queries were developed around the evaluation criteria and questions under each of the OECD-DAC Criteria for Evaluating Development Assistance, except impact since this is a formative evaluation.

Fig 8: Evaluation Criteria questions



The evaluation questions under each criterion have been adapted from the ToR to achieve the objectives set for this evaluation. The evaluation matrix[20] mapping the questions under each evaluation objective, identified sources of data and the methods of data collection have been annexed. Some of the questions essentially lead to the analysis of the findings, and these have not been included in the matrix.

4.1 Relevance of Communication Processes

The evaluation questions under 'relevance' looks into the consistency of communication procedures and activities, the overall goals and objectives of the MR campaign. It also enquires into the extent of contextualization of communication procedures and activities to the local needs and challenges of the stakeholders. Further, whether the planning and implementation of a campaign was inclusive of vulnerable and marginalised communities and the gender sensitiveness of communication processes are analysed for the purpose of the evaluation.

4.1.1 Communication procedures and activities were consistent with the overall goals and objectives, i.e., positive positioning of the MR campaign, promoting community acceptance and building an enabling environment

→ The communication strategies for the second phase of the MR campaign, which is currently being evaluated, were formulated in light of the insights and lessons learned during the first phase of the campaign. The *'Communication Guidelines for Measles Rubella Vaccination Campaign'* laid down communication strategies to address pre-empted challenges. The states, thus, devised their plans based on these guidelines, and implemented strategies which were relevant to the operations and communication aspects of the campaign.

→ The evaluation observed that positive positioning of the MR campaign among the stakeholders, development partners, schools, communities and media ensured strong commitment among partners and thereby creating an enabling environment around the campaign. It was noted that the political commitment was instrumental in bringing in such collaborations. The Steering Committees and Task Forces till the block level comprised of leaderships from all mentioned partners proved successful in devising appropriate and relevant plans for each region within states.

→ Each state partnered with departments and organizations keeping in mind the overall goals and to reap optimal benefits out of the partnership. **The Lions Club International Foundation** supported in generating mass awareness through IEC materials (Gujarat, Odisha, Maharashtra and Uttar Pradesh); **Rotary club** helped reach migrant workers

[20] Evaluation questions were from ToR under evaluation Criteria. This was broken up, revised and re arranged in evaluation matrix under the Evaluation Objectives along with possible source of information- an exercise done in the inception stage. It also helped in developing the tools.

through its existing members; **Panchayati Raj Institutions (PRI)** with their presence, power, influence, and access to funds helped maximise reach among the vulnerable population; **Community based organizations/bodies** and self-help groups, such as the Mahila Arogya Samiti in Assam and Gujarat, Gram Sanjeevan Samiti in Gujarat, organizations such as CREDAI in Maharashtra for construction workers played an important role in communication around the MR campaign and maximizing outreach and promoting community acceptance.

→ Collaboration with Char Development Board, Border Security Forces, Forest and Police Departments, Foundation for Integrated Support and Solution (FISS — which has a total 535 schools under them) for MR Campaign (Assam), with Revenue Department to assist in the formation of Block Task Forces (Odisha), with Department of Tribal Affairs and Minorities (Maharashtra) and Departments of **Railways** and **Defence** (Uttar Pradesh) were very relevant and consistent to the campaign goals of positive positioning and promoting community acceptance.

4.1.2 An enabling environment was built through involvement of key stakeholders and influencers and positive media reporting

→ For creating an enabling environment, communication processes, activities and partnerships were designed to address pre-empted challenges and increase acceptance of the vaccine among communities.

→ The training of ANM/ASHA was designed to address operations as well as the communication aspect of the campaign. As the first phase of the campaign witnessed glitches due to misconceptions about AEFIs among parents, the training of ASHAs and ANMs very aptly elaborated upon AEFI management referral chain, management of vaccination sites, clarifications of rumours and misconception about the MR vaccine, and methods of maximizing outreach through interpersonal communications.

→ Building up on the learnings from the first phase, wherein crisis had emerged from negative media coverage, the second phase of the campaign appropriately promoted the measures adopted by the states to address any AEFI case through media. The campaign also witnessed a sound engagement plan with the press to address any query, concern or rumour that could potentially hinder the campaign. Media sensitization workshops were conducted in all the five study states. The workshops promoted responsible reporting of AEFI cases. Media kits were also to be created for this workshop, entailing the press release and background material on MR campaign. Further, press briefings and meetings were organized by the states and partners to ensure strong communication with the media during the campaign.

→ Setting up partnerships with medical professionals of **IAP and IMA** assisted in creating an environment where their endorsements in the media and presence to address any AEFI at the vaccination centres helped increase the acceptance of the vaccine among caregivers.

→ Positive positioning of the MR campaign was achieved through engaging with faith-based leaders. Creation of appeal videos by different faith leaders helped to bring them on board. The local level faith leaders and influencers were involved from time to time for convincing the resistant caregivers and maximising uptake.

- *"If we could not manage the case, we were told to call 108 ambulance or contact the AEFI team. The doctor and other staff were in a mobile van and they could reach the spot if we called."* ANM, Khurda, Odisha
- *"During the campaign, we were told about what our role would be in this campaign. They also told us about common MR related rumours in the community. They trained us on talking to the parents, addressing rumour and generating awareness regarding the vaccine. We were trained to convince them to vaccinate their child without hurting their emotions."* ASHA, Surat, Gujarat
- *"We were told that any child with high temperature should not be vaccinated. If they had any other physical issues, we had to discuss the cases with paediatricians appointed at vaccination centres."* ANM, Sayyednagar, Surat, Gujarat

4.1.3 Resistance among caregivers due to negative information and myths about the campaign were addressed through interpersonal communication and social mobilisation activities

→ The centrally prepared materials addressed all relevant information for possible stakeholders in the campaign. They were sufficient too. Relevant materials were developed for each event and activity. While there was a 'facts and myths' document, it was meant for the health workers. The resistance and vaccine hesitancy among the caregivers were addressed through interpersonal communication. The 'trustworthy people' like ANM, ASHA, private doctors of similar faith and the faith leaders clarified the misconceptions from time to time.

→ To counter negative information, photos of bureaucrats vaccinating their children in booths (Assam, Gujarat, and Uttar Pradesh), promotion of campaign at religious/community gatherings and festivals, school based engagement activities like debates and quizzes, rallies were organised.

→ Parents of children enrolled in elite private schools were hesitant towards the vaccine as many had already vaccinated their children against MR/MMR at private clinics at designated ages.[21] The campaign, through PTMs majorly and their publication '*Myth & Facts*'[22] clarified that the MR vaccine could be administered again despite any previous history of administration of the same vaccine.

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[21] 'Communication Guidelines for Measles Rubella Vaccination Campaign' (2017) UNICEF, Ministry of Health and Family Welfare, Govt. of India

[22] Measles & Rubella Vaccination Campaign: Myth vs Facts (Publication). (n.d.). Ministry of Health and Family Welfare, Govt. of India.

- Positioning the campaign positively through putting up hoardings at an international cricket match, clearing doubts and queries in TV shows, involving FM radio channels and community radio to promote the campaign in rural and tribal locations and engaging with revered teachers, doctors, faith based leaders and Pradhans to address hesitancy were recorded from various states.

4.1.4 Communication procedures and activities were significantly contextualised to the local needs

- Each of the states translated the IEC materials developed at the national level, keeping the content of the message and design of the material intact. Besides that, some of the study states developed some local materials. National and local celebrities making an appeal to communities to vaccinate their children during the MR campaign too played a significant role in convincing resistant communities. While Amitabh Bachchan was the Brand Ambassador used at the national level, all study states reported having local television and regional movie celebrities promoting the campaign to make these materials more relatable and relevant.

- **Assam** created six videos with ministers, teachers, sports person, faith based leaders and celebrities (Indian Idol winner Nahid Afrin) appealing the community to get their child vaccinated, and several posters and banners using local faces. They also made appeal videos and an entire Bihu song endorsing the vaccine.

- **Gujarat** did not develop any new materials, they adapted the content of the national level materials and gave location context to those with photographs of local politicians, community, etc. They posted photos of health officials and other dignitaries taking their children/grandchildren for MR vaccination and sensitized local 'Social Media Enthusiasts', with a high number of followers who helped propagate awareness regarding the MR vaccine though retweeting official messages and generate awareness on MR vaccine among social media users.

- **Odisha too** created appeal videos with winner of national level Indian Idol music contest, Film actor Babushan and Shri Jitendra Haripal, folk musician from western Odisha and famous sand artist Sudarsan Pattnaik in Odisha. They convinced the audience about the benefits of MR vaccine and informed the dates.

> *"Mr. Amitabh Bachchan was the brand ambassador at the national level, but his video byte telecasted was in Hindi. We then opted to go for local celebrities like Jitendra Haripal, Ananya, Sabysachi, Satyajit, Anuradha, Sudarsan Pattnaik and others as they spoke Odiya and were more relatable and acceptable in rural Odisha."* Dr. Saroj Nayak, Director SIHFW, Odisha

- Uttar Pradesh organized field visits for the media to schools and hospitals to monitor the campaign in progress; motivated them to broadcast live stories from schools and interviewed parents of vaccinated children. IAP provided technical assistance to the Government to address and clarify any rumour while the members of the Social Mobilization Network (SMNet) in Uttar Pradesh assisted the Government draft press releases, coordinated and liaised with the media, and assisted in conducting the press brief in the evening. There was a press release, or a note from the Government in newspapers for AEFI-related explanations or clarifications or advertisements on the campaign every day. Every alternate day, the media met up with government officials to discuss the campaign. These practices generated confidence within the media.

- However, there were some barriers in **contextualising communication materials.** E.g., in Assam, usage of photos of children with measles caused some communities to perceive the rashes as a side effect of the vaccine and, in turn, generated resistance among them. The state administration thus decided to revoke the photo and replace it with a photo of a healthy child instead. Gujarat reported dearth of human resources to translate the national level materials into local languages and this delayed the implementation of the campaign by a few months. Maharashtra wanted more flexibility to create locally relevant content and more time to translate.

4.1.5 Planning and implementation of the campaign was inclusive of vulnerable and marginalised communities

- → The evaluation notices that the guidelines and plans made provisions for including vulnerable population in the MR campaign. Attempts were made to include tribal communities, religious minorities and other vulnerable population, residing often in the interiors and hard to access areas.

- → The evaluation noticed collaboration with relevant departments like Panchayati Raj, Tribal Development Department, Department of Education, Departments of Social Justice and Minority affairs to reach out to vulnerable, hard to reach communities, identification of geographic pockets, increasing number of session, budgeting for a mobile van to conduct the vaccination sessions in high-risk and vulnerable areas in each block.
- → Mid media activities, involvement of folk artists, communicating in tribal language were some appropriate strategies applied. Additionally, collaborations were made with organizations like CREDAI and Rotary Club to reach out to the migrant population, especially those working in construction areas, factories and kilns.

- → Odisha devised separate plans for coastal and tribal areas. While mass media strategies were more intensively applied in coastal regions, strategies for tribal areas focussed more on interpersonal communication. The MR campaign tapped into the state's integrated community mobilization programme that focuses on augmenting dialogue and interaction amongst most vulnerable communities in tribal districts of Odisha.

- → Odisha reported using their pre-existing programme on communication and advocacy for media-based communications on the MR campaign. They also collaborated with the 'Odisha Artist Federation', under which the Government of Odisha formed district and block-level cultural associations, supported by the state cultural department. UNICEF worked closely with them in areas where mass media was not accessible. These associations assisted UNICEF set up performances by local artists to generate awareness about the campaign in the local tribal languages.

- → In **Uttar Pradesh**, the migratory population was high along the borders and in the industrial towns. During the outreach activities, border based booths were formed at bus stands and railways stations. Further, there were separate plans for hamlets and tribal areas where mid media activities such as *nukkad nataks* (street plays) and folk shows were conducted.

4.1.6 The guidelines and the communication processes of the campaign were gender neutral

- → The communication and the national operational guidelines did not specify or outline any gender specific strategies. Instead, they were directed at caregivers in general. The only

mention of different members of a household, such as mothers, mothers-in-law, grandmothers and fathers, was in specifying the target audience for posters and leaflets of key messages of the campaign. The study states reflected similar opinion except for Odisha. Odisha was the only state that reported to have planned meetings with men as one of the ways of maximising outreach and generating vaccine acceptance. All study states, considered events such as Parent Teachers Meetings to be one of the platforms for engaging men.

KEY FINDINGS RELEVANCE

1. The communication strategies for the second phase of the MR campaign were formulated in light of the insights and lessons learned during the first phase of the campaign. The states, thus devised, and implemented strategies, which were deemed relevant to the operations and communication aspects of the campaign. The strategies were devised at the national level and provided to the states as the Operational and Communication guidelines to be adopted for the campaign.

2. Within state governments, collaboration between departments of Health, Education and Women and Child Development were deemed critical for positive positioning of the campaign. Further collaborations with other departments, such as Social Justice, Tribal Development, Railways, Defence and others proved appropriate in this context.

3. Partnerships with development partners like WHO, UNDP, Civil Society Organizations, CBOs and PRIs were extremely relevant in the context of positive positioning and promoting acceptance of the vaccine among communities.

4. As the first phase of the campaign witnessed glitches due to misconceptions about AEFIs among parents, the training of ASHAs and ANMs very aptly elaborated upon AEFI management and redressal of related myths and misconceptions through interpersonal communication.

5. The campaign set up a sound engagement plan with the Media for responsible reporting of AEFI cases. Workshops entailing details about the campaign and press briefings about progress of the campaign were organized by the states and partners to ensure strong communication with the media.

6. Communication procedures and activities were significantly contextualised to the local needs of the stakeholders All states referred to the national guidelines to design their campaign activities, while also formulating unique strategies at the levels of the state and districts to address local challenges.

7. While Amitabh Bachchan was the primary celebrity figure used at the national level, all study states reported having local television and regional movie celebrities promoting the campaign to make these materials more relatable and relevant.

8. The campaign in all the states planned for and implemented extensive strategies to address the marginalized and vulnerable demographies. These activities included conducting mid-media activities where mainstream media was unavailable, focusing heavily on interpersonal communication to promote vaccine acceptance, increasing the availability of mobile vans and increasing the number of vaccination campaigns conducted in the vulnerable regions. While this worked to a great extent to include vulnerable and marginalised communities, there was no evidence of gender specific strategies in the plan.

4.2 Effectiveness of the Communication Processes

This section explores evidence for communication processes having met their objectives during the MR campaign. It looks into factors that influenced caregivers to accept the vaccine alongside the challenges that were faced along the way. Further, this section also enquires into how effective the MR campaign strategies were with regard to reaching vulnerable and marginalized communities and how gender-sensitive they were in their approach.

4.2.1 Most of the communication procedures and activities were effective in meeting the objective to positively position the campaign

Interdepartmental coordination and partnerships established at different levels were found to be effective in meeting the campaign goals. The evaluation points out towards a variety of collaboration in the states which were planned for effective implementation of the campaign objectives.

- → All five study states reported placing effective task forces and bodies from state to district to sub district level for campaign governance and monitoring activities. They worked in coordination and synergy, which was effective in planning and implementing the campaign successfully in their states. The discussion with state officers highlighted the existence and coordination of task forces at the district level and even beyond.

- → **Each department, development partners and organizations who participated in the campaign** came in with different skill sets, capacities and resources which were utilised to effectively implement the communication activities.

- → In **Assam**, the health department and UNICEF collaborated with all the line departments, especially with education, district administration, police and border task force. They reportedly worked in close collaboration with John Snow India, Media, Department of

> – "*The Department of Education organized a video conference for District Education Officers, wherein they were indicated to ensure participation of all schools in the MR campaign. Instructions were sent out to minimize absence on the day of the vaccination.*" Shri M.I. Joshi, Director (Education), Govt. of Gujarat.
>
> – "*When it comes to communicating with the media, the Health Department needs to coordinate with the Department of Information. While the Health Department certainly provides the technical support, the Department of Information is much more adept at dealing with issues of communication and media.*" Ankush Singh, Communication, Advocacy and Partnership Specialist, UNICEF, Gujarat.
>
> – "*The investment in DGIPR was significant – we built a partnership which is sustainable in the long run. Working with the state mechanisms built the capacity of the Govt. Depts. The partnerships are sustainable and are channels which have maximum reach and impact. The Government would be more comfortable working within the departmental trust and interdependency.*" Harsha Mehta, C4D Officer, UNICEF, Maharashtra.

Labour, SHGs, CBOs, and Faith-based organizations, the Border Security Forces, the Char Development Authority and PRIs to reach the hard to reach communities and the tea tribes.

→ However, according to the campaign stakeholders of Assam, the engagement with the Department of Education was not effectively utilised. The gap was partially plugged through collaboration with the Foundation for Integrated Support and Solution (FISS, which has a total 535 schools under them). In Assam, while the National Service Scheme (NSS), Nehru Yuva Kendra Sangathan (NYK) and National Cadet Corps (NCC) were also looped in outreach although their partnership **was reported as not being effective** in terms of their low participation.

→ Maharashtra reported collaborating with the department of education, labour, ICDS, and especially with the Directorate General of Information and Public Relations with matters related to communications and IEC. The collaboration with DGIPR helped them to control and monitor the entire communication processes centrally and effectively.

- *Our communication plan was designed to reach each and every community. We formed District Task Forces and conducted meetings. We also trained the ICDS and school teachers to ensure we could reach everyone*." Sudhir Jena, ADPHCO, Gajapati, Odisha.
- *"From top to bottom, every possible stakeholder like govt. or private were involved. We worked with our NGO partners in districts like Kalahandi, Koraput, Rayagada, Malkangiri and Nabarangpur, worked with Rotary club and oriented them for the campaign, involved SHG groups and PRI members, for community mobilization in villages, involved the MLAs and even corporate sector ……… Lions club and Rotary club; these two clubs worked with us intensively in this MR campaign."* Lopamudra Tripathy, C4D, UNICEF Odisha

→ Odisha reported involving the Revenue Department in terms of assisting in the formation of Block Task Forces besides collaborating with the department of Education and ICDS and involved the skilled front line functionaries and community influencers of the CSOs for **effective monitoring and outreach.**

→ Uttar Pradesh worked closely with the State chapter of Ministry of Defence in an attempt to maximize vaccination outreach to schools under it. To reach out to the migratory population, **effective collaboration** was noticed in UP where the Department of Railways had set up vaccination sites in all their colonies, and allowed railway stations and coaches to be used for **display of posters and IEC materials related** to the MR campaign.

→ Although UNDP's role was more technical, the UNDP Program Officers and Vaccine Cold Chain Managers demonstrated their monitoring mechanism at Parent-Teacher Meetings in Uttar Pradesh. This convinced the parents about the safety of the vaccination. This communication process voluntarily taken up by **UNDP was found effective**.

→ **Community based organizations/bodies** like Mahila Arogya Samiti in Assam and Gujarat, Gram Sanjeevan Samiti in Gujarat, Gram Kalyani Samiti in Odisha, organizations such as

CREDAI in Maharashtra played an important role in communication around the MR campaign and maximizing outreach. In Uttar Pradesh, Aga Khan Foundation assisted in addressing faith-based resistance in the community.

4.2.2 Frontline IPC, AEFI management and micro plan influenced the caregivers and tackled local challenges effectively

→ The training of the frontline workers/health workers emerged as an effective process which had directly influenced the caregivers. The training focused strongly on interpersonal communication. In terms of vaccination, the health workers were indicated to provide four key messages, as is the norm during Routine Immunization as well. These messages included:

1. Diseases prevented by this vaccine
2. Some of the side effects of the vaccine
3. Tackling the side effects
4. Due date for the next vaccination

→ The training also addressed AEFI management. The health workers across states noted that it was a learning that was useful and remained to be so in the long run. They were trained to follow a well-established chain of referral in case of any emergency, which they noted was an important and effective learning for them.

→ Most of the frontline workers reportedly did micro planning according to their ability. While there were planning glitches like exclusion of children of migrant workers during counting in the micro plan (Gujarat) or shortage of vaccinators (Assam and Gujarat), **they were effectively manage**d. ANMS managed to place requests for extra vials than they had originally asked for. The shortage of vaccinators led to burdened FLWs and the critical time for communicating with the caregivers on benefits of vaccine, its side effects and how to manage them was compromised. This was a major challenge in the situation, specifically in urban areas, as the time frame of the campaign was fixed. In Assam, the shortage of vaccinators, especially in urban and outreach areas, was tackled by outsourcing ANMs from nearby areas.

→ With respect to community mobilisation, across all five study states the FLWs reportedly collaborated with local governing and religious authorities like Panchayati Raj Institutions, schools and faith based institutions to maximize outreach and increase uptake.

→ The impact of communicating the four key immunization messages have emerged strongly during the focus group discussions conducted with the parents in the study states. Caregivers across all the states, districts and locations said that the FLWs were the key source of information about the MR vaccine, its benefits and its side effects. All the groups

in Odisha could recall symptoms of mild AEFIs and methods to manage them. They could also recall measures adopted by the vaccination centres to address any emergencies. The caregivers also relied on the FLWs for clarifying their doubts that resulted from the spread of negative WhatsApp messages and rumours about side effects of vaccination.

- Most of the community groups also reported that they got their child immunised only because the ASHA told them to do so.

- The FLWs, through their strong interpersonal communication skills and information, positively impacted the caregiver's perception of vaccination. This was reported by all groups during the FGDs. Their training was effective in dealing with caregivers' concern about their children's health. The FLWs effectively explained to the caregivers on post immunization care as well as assuaging concerns and fears among caregivers.

4.2.3 Involvement of professional agencies and media management indirectly influenced the caregivers and tackled local challenges

- Professional agencies like **Indian Academy of Paediatrics (IAP) and Indian Medical Association** were involved at the state and district levels. Involvement of private medical officers affiliated through IAP and IMA were ensured for maximizing outreach for Routine Immunization and was put in practice for the MR campaign. The evaluation found that their role in the MR campaign was extensive. Influential doctors from the communities were made a part of the MR core groups. Their video endorsements, public engagements, and presence at the vaccination centres helped instil faith in people about the quality of the programme. IAP played a significant role in ensuring transparent and effective reporting of AEFI cases and provided technical assistance to the Government to address and clarify any rumour. The newspaper ad carried statements from the Director General (Family Welfare) and the IAP president, which convinced and generated confidence among people and doctors alike.

- Even though in some cases the vaccination had to be ceased due to negative media reporting, the respective authorities like the district administration and medical officers effectively managed to address every issue with the help of media. Medical Officers in the area conducted awareness sessions, addressing concerns and queries and restarted the vaccination sessions two weeks later (Assam); news channels broadcast video bytes of doctors clarifying the issue; Additional Chief Secretary (H&FW) and Deputy Commissioner (Immunization) conducted press briefs (Gujarat, Odisha) and formed AEFI Committee to handle media in a factually sound and transparent way, held regular press briefings with media about the progress of the campaign.

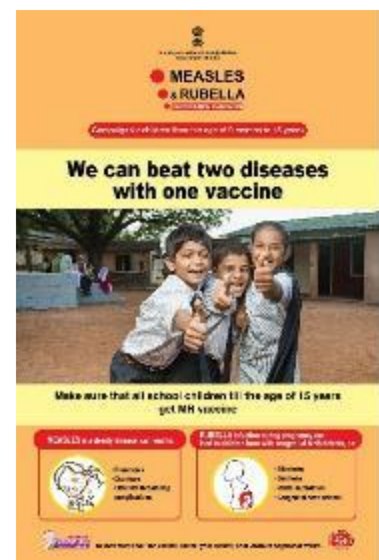
- A positive move organized by UNICEF, Uttar Pradesh, included organizing field visits for the media and took them to the schools and hospitals to monitor the campaign in progress; motivated them to broadcast live stories from schools and interviewed parents of vaccinated children. After 3-4 days, the press started visiting hospitals and schools by themselves to see how the MR campaign was running.

- **Rapid Response Team of WHO** was effective in addressing faith based and other forms of resistance. This further helped to maximize the vaccine uptake. They also played a significant role in ensuring that AEFI kits are present at all vaccination centres.

- These agencies did not directly work with the community, but their efforts and initiatives did influence the mind-set of caregivers, helped remove the concerns about the vaccine and brought the campaign back on its track.

4.2.4 The interpersonal communication by FLWs, local innovation and promotional activities were more effective and acceptable communication processes

- The **content analysis** of the centrally prepared materials highlights that for the caregivers and community, two sets of posters were created to be installed in Panchayat Ghar, Health Centres, outside religious institutions, temples, mosques, gurudwaras, churches and common gathering points in the village, etc. The initiative which stood out was the invitation card and a school certificate that were issued to the children as it had the greatest recall among caregivers. There were leaflets to be distributed among caregivers during house to house visits. Besides these, there were posters for schools and banners prepared for group meetings with caregivers. The message was simple and straight forward — beating two diseases with one vaccine. There was an appeal to the caregivers to ensure that their child (between age of nine months to 15 years) availed this without fail. The two boxes below explain (poster on right) what all can happen if a child gets Measles or Rubella.



→ In a community based participatory exercise among 80 groups, 38 groups identified polio as the most known topic followed by BCG (33 groups) followed by BCG and Measles and Rubella. Measles and Rubella was ranked third in 21 groups.

→ The recall of the vaccine was triggered by the school certificate that was distributed among vaccinated children. The gap in understanding of what Measles or Rubella can lead to, confusing it with chicken pox, indicated lack of complete information on the vaccine. However, as reported by the FLWs during the interviews as well as caregivers during FGDs, persuasion by the ASHAs who explained about 'disease prevention and the benefits of immunity' was effective in influencing the attitude of caregivers towards the MR vaccine.

→ There were rumours about the side effects of the vaccine, which the caregivers reportedly heard from 'word of mouth' or got through WhatsApp messages, but caregivers stated that the convincing ability of the ASHA/ANM effectively countered this.

→ The source of information for MR vaccination among the caregivers was ASHA, ANM, AWW, Doctors and, to some extent, health facilities. School teachers, banners, posters were also mentioned. A few also mentioned about attending street plays on MR vaccine.

→ To garner community acceptance among the tribal communities, endorsements from their faith-based leaders such as the *Bhopa* in Dahod, Gujarat and Dishari and *Biduri* in Odisha helped in addressing resistance. Further, the MR vaccine was promoted by health officials during *Bhavai*, a faith-based gathering among the tribal communities in the region of Dahod.

→ Activities like door to door visits by ASHA/ANM, meeting organised by the village Pradhans, the parent teachers associations in schools and the Maulanas of masjids, street plays, and announcement about the vaccine through rickshaw and Masjid, and rallies by students were recalled and attended by the caregivers.

→ The caregivers reportedly participated in the activities meant for the caregivers irrespective of their religion, gender or castes. They reportedly played the role of silent receivers of information passed on to them by the FLWs, school teachers and Pradhans in meetings. There was no active participation reported in the activities by the community

members. A few from Gujarat and Maharashtra reported that after getting information through these meetings, they further validated it from other sources (google/doctors).

→ In spite of initial resistance due to rumours or influence of faith based organizations, the caregivers believed what was being told about the benefits of the vaccine. The trust on the front line functionaries and their own people (Faith leaders, influencers) was the main reason for believing the messages.

→ Nevertheless, the caregivers neither mentioned anything about the public service message given by the Brand Ambassador, Amitabh Bachchan, or receiving any positive WhatsApp messages that the stakeholders claimed to have circulated to counter rumours and AEFI cases.

→ Setting up social media monitoring bodies at the levels of the state and districts was highly effective in terms of tracing negative messages and countering them within a short span of time. Locally developed appeals countering any negative videos or message were reportedly prompt and addressed issues succinctly.

→ Different activities were reported from states. MR Facebook page with appeals by the District Collector and Maulanas (Assam), setting up 'Social Media Enthusiasts', with entrepreneurs and other users with a high number of followers retweeting official messages, to generate awareness on MR vaccine among social media users (Gujarat); creating plans for social media including Facebook, Instagram, Twitter, WhatsApp and Google (Maharashtra); placing designated nodal officer to monitor content (Odisha) and creating 1200 videos at the local level, including participants of popular programmes, local actors, child artists, and MLAs (UP) were reported. While these are commendable efforts, the evidence of their effectiveness was not found. None except from one group in Maharashtra received any counter factual message against the negative messages that they had received.

4.2.5 Plans had no mention of 'gender inclusiveness' strategies, but there were few instances of involving men

→ The evaluation enquired the guidelines for strategies that address gender equity in planning and implementation. Both the communication and the national operational guidelines did not specify any gender specific strategies. Rather they were directed at caregivers in general. The only mention of different members of a household, such as mothers, mothers-in-law, grandmothers and fathers, was in specifying the target audience for posters and leaflets of key messages of the campaign.

→ The analysis of the state adopted **IEC materials meant for caregivers were gender representative, i.e., focussed on both boys and girls**. Further, while misconceptions such as the vaccine causing infertility among children belonging to minority communities was prevalent across all the states, interpersonal communication by the community health workers and local officials and larger outreach activities helped address these concerns.

→ With regard to **gendered vaccine denial**, nothing was reported, observed or noticed in this evaluation. The resistance or hesitancy was based on the rumours and the concern was child's overall health.

→ Similar findings were also reflected when officials across all the study states were asked on the measures and strategies adopted by the state to ensure gender equity. All the states reported that there were no separate plan for engaging men and women. They considered events such as Parent Teachers meetings to be one of the platforms for engaging men.

→ Some initiatives were, however, taken but these were on off events, need based and only taken to counter low acceptance of vaccination. Signing of teachers' notes by fathers, door to door visits by ASHAs in the evening hours and information shared after Namaz (Assam), meetings organized by the PHC officers for the men at a central location (Labour chowk) where they frequented (Gujarat), banners and announcements made at the central chowks in low acceptance areas (Maharashtra), PRI, local paediatricians and faith based leaders reaching out to men (UP) and meetings with the fathers at each hamlet discussing their roles to assist in maximizing the uptake of the vaccine were some of the initiatives reported by the stakeholders.

→ However, when it came to the effectiveness of ad hoc one time communication processes, the caregivers from all states presented that more women than men participated in the communication outreach activities, meetings and PTMs in schools. Men/fathers reported that they missed these meetings as they were in their workplace when the activities were taking place, or were avoiding meetings following the dictates of their religious head.

4.2.6 Communication Processes effectively involved vulnerable groups

→ The national operational guidelines laid out extensive and specific guidelines to address the marginalized and vulnerable demographies across the state, described hard-to-reach areas due to difficult geographical locations, included unserved or underserved areas, areas with a shortage or prolonged vacancy of health workers, recognised parts of urban areas especially unauthorized slums, railway/bus stations, make-shift huts, brothels, floating

populations, such as street children along with migratory populations or internally displaced populations including nomads, temporary harvesters, rice mill/brick kiln workers, and daily wage labourers at large construction sites.

→ Discussions with stakeholders brought out that Assam, Gujarat, Maharashtra, and Odisha worked out strategies to be inclusive and attempted to leave no one behind. They have significant proportion of the tribal and other vulnerable populations, residing often in the interiors of the state.

→ They collaborated with PRI, (to reach tea tribes in Assam) with Tribal Development Department and Departments of Social Justice and Minority Affairs to maximise outreach in Tribal residential schools (Maharashtra), involved organizations like CREDAI and Rotary Club, to reach out to the migrant population, especially those working in construction areas, factories and kilns (Maharashtra), devised separate plans for coastal and tribal areas focussing on IPC (Odisha), organised mid media, local folk art (such as local mask-form drama *Bhaona* in Assam and Folk Art in Odisha), mid media activities such as nukkad nataks (street theatre) and folk shows in hamlets and tribal areas (UP), tapped pre-existing programme on communication and advocacy to initiate community dialogue and interaction, set up border based booths at bus stands and railways stations to address the migratory population (UP).

→ Effective outreach strategies included endorsements from the Archbishops in Odisha, Uttar Pradesh, Assam, and Gujarat to reduce resistance among missionary schools and Christian tribal communities; endorsements from private medical professionals and school principals across all the study states during Parent-Teacher Meetings helped address the resistance among parents whose children were enrolled in elite private schools; calls from Muslim Sectarian leaders at the state and local level helped nullify misconceptions such as the vaccine causing infertility among children across the study states and advocacy with Sikh leaders in Nanded and Jain leaders in Maharashtra helped in increasing the uptake of vaccination in their community.

→ The FLWs played effective role in addressing faith based resistance among communities through interpersonal communication (Bahraich, Uttar Pradesh, ASHA); clarified misconceptions during home visits linked with demise of a few children with MR vaccine

(Dahod, Gujarat, and Hailakandi, Assam); reached out to families which could not attend community meetings due to work or any other reasons (Assam).

→ To promote acceptance among religious minorities in Surat, Gujarat, frontline workers used the same vials for their children as the ones used for Hindu children. The vaccine was first administered to a Hindu child. This reduced their fear that the vaccine was being administered to control their population.

KEY FINDINGS EFFECTIVENESS

1. With a preparatory time of approximately six to eight weeks prior to campaign rollout, the collaborations, partnerships with departments, partners, civil society organizations, community-based bodies and associations of medical professionals were highly effective in achieving the communication objectives of the campaign. These objectives included positive positioning of the campaign, maximising outreach, addressing myths and misconceptions about the vaccine, reducing vaccine hesitancy and ensuring that the campaign was inclusive of vulnerable and marginalized communities.

2. With regard to the believability of the messages, interpersonal communications undertaken by frontline workers to address the concerns of caregivers and encourage uptake of the vaccine was the most effective means of communication. Caregivers in the study states could recall the messages received on issues, such as side effects, how to manage them and also the purpose of the vaccine. This is a clear indication of the effectiveness of training of the health workers on interpersonal communication. Communications from faith based leaders, local influencers and school administration also played a significant role in addressing concerns and boosting uptake.

3. Content analysis of IEC materials created for communities brought out that they were designed with one simple message on how one vaccine can protect from two diseases. Caregivers recalled seeing posters and banners, but a majority of them got the information from the frontline workers or from school. However, despite simple messaging and organizing engaging activities with the communities, caregivers could not articulate completely the benefits of MR vaccine and confused the rash of measles with chickenpox.

4. The strategies laid down by the guidelines and their adoption at the levels of the states and districts to ensure that the campaign was inclusive of vulnerable and marginalized communities were relevant and, thus, effective. These strategies included collaborating with CSOs and CBOs to maximise outreach, while also investing in operations among the communities.

5. With regard to ensuring gender sensitiveness among children receiving the vaccine, no gender bias was noticed or reported on vaccine denial. However, the strategy, plans and most of the activities adopted by the campaign were directed at caregivers in general, with no special indication of being inclusive of genders. The parent-teachers meetings in schools, community meetings and other promotional activities were attended more by mothers. ASHAs conducting door to door visits in the evening specifically to connect with the fathers; Maulavis speaking on MR vaccine to the men after namaz; and meetings at labour chowk were some isolated initiatives undertaken during the campaign. In future, communication initiatives need to adopt strategies to reach out to fathers and other decision-making members of the family in order to ensure gender equity.

4.3 Efficiency

To determine the efficiency of the MR communication campaign, the evaluation sought to answer whether resource allocation in terms of finances and human resource were appropriately managed. Further, it enquired into the efficiency of the communication processes which were to ensure delivery of messages and the related challenges faced during implementation. The evaluation thus compared the activities against the guidelines to map out the extent to which they were efficient, while also noting issues that may have emerged and the ways in which they were addressed.

The Ministry of Health and Family Welfare, with the technical support of WHO and UNICEF, developed the *National Operational Guidelines (2017)* for the introduction of the measles-rubella vaccine through campaign and in routine immunization. The guidelines were formulated to assist national, state and district level programme managers by delineating the tasks and responsibilities to be completed by functionaries at all levels during the different stages of the MR vaccination campaign, and subsequent introduction of MR vaccine in routine immunization. The guidelines indicated setting up of committees and taskforces at different levels of state, district and sub district, delineated time lines within which each activity was to be achieved for successful planning, coordination, implementation and achieving high coverage. Indication of possible collaborations and partnerships at all levels were noted.

The budget and operational costs for the MR campaign were to be set up six months prior to the launch by the central task forces. It is pertinent to note here that estimated amount of budget needed for communication activities based on the plan provided by the states was approved at the national level, and communicated to the states. For the MR campaign, the micro-plan was designed to be the basis for any operational and budgetary planning and was to be created at lower levels through a bottom-up approach. The template of the micro-plan was designed to contain calculation of resources, using standard micro-plan templates, of communication and other operational planning components. Additionally, as per the template of the micro-plans laid out by the operational guidelines, the campaign was to be implemented between three to four weeks. The ANMs, thus, developed micro plans to cover the educational institutes during the first week, existing health facilities and all other additional outreach and mobile sites in the second and third week. The last week was to be designated for mop ups to cover left out areas with sub-optimal coverage.

4.3.1 Budget allocation was according to the identified state priorities

→ As per the exceptionally detailed operational guidelines, the financial norms for operational funds under the MR campaign primarily included micro planning, vaccine transport and delivery, cold chain, meetings and training, mobile team, IEC and mobilization of beneficiaries, support for monitoring, injection safety and contingencies and other incidental expenses. The states were allowed to have the flexibility of 20 per cent within the overall budget allocated for the activity with the approval of the State Health Secretary.

→ Officials across all the study states reported that the budget of communication was created as per the guidelines provided by the Government of India. The data collected from the states on allotted budget came in under different heads. The only common head identified in the data is budget for IEC and meetings/workshop.

→ An analysis of the data on communication budget highlights that budget allocation for communication activities were available till the block level. Under the larger umbrella of IEC, different states clubbed different activities as per their convenience and local needs. Assam counted mike announcements, meetings and posters; Gujarat added IEC and Social mobilization while Maharashtra clubbed IEC/social mobilization, mass media, monitoring and supervision, promotions, radio, print media briefings, etc.

→ MR campaign in Maharashtra efficiently involved the government agency, Directorate General of Information and Public Relations (DGIPR) for the creation of materials which helped in saving the funds.

→ Assam conducted more number of meetings with faith leaders to reach religious minorities compared to other demographics and, thus, planned for higher budget.

→ Gujarat and Odisha had separate budget heads to cover high risk areas and to mobilize inaccessible areas. Assam, Gujarat and Odisha also had separate budget for advocacy workshop with religious leaders at district level. Odisha also had provisions for workshops with influencers till the block level.

→ Partnerships with private medical professionals, community based organizations, faith based leaders, and civil society organizations were efficiently planned to maximise reach. Lion International used their own fund; IAP and IMA provided technical, operations and communication support and endorsements voluntarily; and CREDAI, Rotary Club all relied on their respective network of members to promote the campaign.

4.3.1 Lack of foresightedness in some of the processes and logistics caused delay, budget deficit, loss of information and misinformation

- Despite anticipating resistance at schools and among certain communities, the states of Uttar Pradesh and Assam did not keep a buffer for repeating vaccination session. In both the states, resistance and absenteeism was reported which led to repetition of vaccination sessions, which was unaccounted for. In Uttar Pradesh, this resulted in the campaign being implemented over a span of two months instead of the recommended four weeks. Further, the state of Assam addressed the resulting deficits by reallocating funds from the routine immunization programme. The state of Uttar Pradesh allowed districts to tap into other allocations within the campaign activities where there had been surplus. Although such deficits were addressed by piggybacking on budgets allotted for other activities within the campaign or the larger Routine Immunization campaign, this inefficient plan disturbed the campaign to some extent.

- The analysis of budget allocation under heads points towards the fact that print of IEC material comprised a major portion of the budget. In spite of that, Maharashtra faced a deficit with regard to IEC materials and activities. To address the deficits to print IEC materials and vaccination certificates, the state of Maharashtra received funds from GAVI and ICICI foundation (INR 96.4 million). The Government of **Odisha** added almost INR 105 million from the state budget for the printing of certificates and invitation cards.

- Shortage of vaccinators during campaign was one area where lack of efficient planning was noticed. This is a challenge specifically in campaign mode where the time frame is stagnant within which targets have to be achieved. Shortage of vaccinators was noticed in Gujarat and Assam due to which the front line functionaries were burdened and had very little or no time for explaining the caregivers about the benefits of vaccine, its side effects and how to manage them. The communication process was compromised as a result of this. In urban areas, this stands as a major challenge, which witness migration in high numbers, causing the workload on the vaccinators to multiply. Assam tackled this dearth of vaccinators in urban and outreach areas by outsourcing ANMs from nearby areas. While this would not be a problem in normal Routine Immunization programmes since they are not time bound, campaigns such as Intensified Mission Indradhanush will require more efficient planning.

- While micro-planning was one of the key elements in the MR campaign and most of the frontline workers did the plan to their ability, the ANM of Dahod, Gujarat, reportedly did not account for children of migrant labourers, who were not available in their village and came back during the vaccination camps. There was shortage of vials and the ANMs had to place requests for extra.

→ Gujarat did not develop any new IEC materials, but adapted the content of the national level materials and added locational context with photographs of local politicians, community, etc. Lack of skilled human resources for translating the IEC material into local languages was noted, which delayed implementation of the campaign by a few months. The state, despite knowing the requirements, did not efficiently plan for this in advance.

→ Interviews with officers of UNICEF, Gujarat, also brought to light that while the strategy of having a committee addressing each AEFI case was mostly efficient, handling the media required expertise that was not attainable after one round of training. Such sensitive dialogue with the media required better coordination with the Department of Information of the state. **Gujarat** had sound collaborations with the primary departments, such as education, but their collaboration with Department of Information as a communication strategist caused the efficiency of crisis communication to be compromised at times.

→ The strategies developed to address negative messages on social media were based on the understandings established from the first phase of the campaign. In terms of planning, task forces and monitoring bodies were in place and there was no dearth of effort and innovation. Social media monitoring bodies at the levels of the state and districts efficiently tracked negative messages and countered them within a short span of time, but the logistics of dissemination was not efficient. While the caregivers acknowledge receiving negative messages, they did not recall receiving any message or video, which countered misconception.

KEY FINDINGS EFFICIENCY

1. In terms of financial efficiency, the analysis reveals that while all the states followed the guidelines suggested by the Government of India and provided the budgets and plans down till the district and block levels, they reported budget deficit in one or more areas of the plan.
2. The budgets of a few states were very efficiently planned according to the local needs. A few states anticipated resistance from religious minorities and vulnerable populations located in inaccessible areas and created separate budget heads for outreach and advocacy with faith leaders, whose endorsements could significantly increase the uptake among their communities. This was not noticed in all the states.
3. Despite anticipating resistance at schools which led to low coverage due to absence of students of certain communities on the day of vaccination, the states of Uttar Pradesh and Assam did not budget for repeating vaccination sessions. This resulted in extension of the campaign beyond the stipulated timeframe.
4. The deficits in the study states were managed efficiently by piggybacking on to budgets allotted for other activities within the campaign or the larger Routine Immunization campaign.
5. However, budgeting in future needs to account for behavioural factors, such as vaccine resistance, in not just communication activities. It should anticipate its impact on operational activities as well.
6. Shortage of vaccinators, as reported in the states of Assam and Gujarat, holds the potential to impede future vaccination campaigns. The health system is, thus, required to invest in training buffer health workers to efficiently manage any shortage during a campaign.
7. Among the printed IEC materials, the ‘School Certificate’ had some recall value and stickiness. Considering that in this MR campaign, social mobilization and interpersonal communication were the key activities and processes which maximised reach, the budget allocation specifically for printing needs to be re-evaluated in the future.
8. The lack of skilled human resources for the translation of national level IEC materials into local languages impeded the pace at which the campaign was to be implemented in certain states. In future, the states need to make these considerations while drawing the plan for the state beforehand.
9. A few states very efficiently engaged and involved media to report the progress and issues of MR campaign in a positive tone. The skill of media management is neither universal nor can be developed in a day’s training. While the Health Department will certainly have a better grasp over the technical aspects and issues of programmes, the expertise of departments of information/public relations will appropriately mould the information to be more comprehensible for consumers.
10. The MR campaign benefitted from the partnerships with development bodies, professional organizations, CSOs and community based bodies. Besides financial support, their contribution in kind towards advocacy with faith leaders and caregivers, AEFI Management, addressing misconceptions, and mobilizing caregivers for vaccination were optimally utilised to deliver messages.
11. All states relied on the national guidelines of campaigns to develop and implement operations and communication activities. Thus, for child health campaigns to be more gender sensitive with regard to involvement of caregivers, it is essential for national guidelines to specify such strategies. Lack of gender-specific guidelines reflected strongly in the implementation of the campaign as in majority of the study states, engagement with men was planned only as a response to low vaccine acceptance rate.

4.4 Sustainability of Communication Processes

The evaluation of sustainable aspects of the MR campaign explores the implications of moving from a campaign mode to routine immunisation. It enquires into potential integration of communication strategies and plans for a sustained understanding. It looks into how existing community structures and systems were strengthened or mobilised to achieve communication objectives and the support that maybe required in future to implement such campaigns effectively. The section on sustainability is derived from the analysis of the communication processes identified in Chapter 3.

4.4.1 Community structures and systems were strengthened and mobilised to achieve the campaign's communication objectives. Partnerships with these bodies need to be sustained and strengthened in the future to improve the effectiveness and efficiency of the Routine Immunization Programme.

→ Roles of CSOs, CBOs, frontline workers and local governing bodies such as the Panchayati Raj were delineated extensively during the campaign. They were trained on issues of communications, in attempt to positively position the campaign, bust myths and misconceptions about the vaccine, promoting community acceptance and increase its uptake. These interdepartmental relations established during the MR campaign are being sustained for other campaigns such as the Intensified Mission Indradhanush. However, as the intensity of these collaborations established and implemented during campaigns cannot be maintained for longer durations, sustaining them with a lesser intensity can help improve the outreach.

→ The network was established comprising of private medical officers, those working in the public health system, and medical colleges. This network addressed AEFIs at vaccination centres. The presence of medical officers at the centres assuages concerns and fears of caregivers regarding AEFIs. The talks of institutionalizing these partnerships and employing them in the Routine Immunization Programme are currently underway.

→ The line of communication established between the Government, partners, and the media has proved to be successful and should be retained for future purposes. However, as noted by key informants, not all states had the capacity to handle media, and to sustain media engagement, it is essential to move beyond sensitizing journalists and focus on editors and sub-editors as well as they are the final decision-makers with regard to the content of the news.

4.4.2 Practices developed based on learnings of the MR campaign needs to be integrated into the Routine Immunization and other health programmes. Some of these practices developed during the campaign have already been adopted and are being utilized as well.

→ **Interpersonal communication** was key for promoting the acceptance of the MR vaccine among caregivers across all communities. The frontline workers acknowledged that the training helped them brave the resistance, counter misconceptions and convince the caregivers for the vaccine. Building the capacity of these health workers on AEFI management, interpersonal communication and mobilization needs to be sustained and continued in the future in order to improve and maintain the uptake of not only MR, but other vaccines as well.

→ With regard to **session planning and outreach activities,** the MR campaign built upon the existing guidelines of Routine Immunization focusing on developing inclusive micro-plans, which require updating twice a year. This practice has also been sustainably adopted in 70 districts of Uttar Pradesh as frontline workers have been specially trained on '*Communication Planning Exercise*'. The *'Boosting Routine Immunization Demand Generation'* (BRIDGE) programme by the Government of India is also focussing on IPC skills training for frontline workers. Further, Mission Indradhanush too is already meticulously planning campaign activities at all levels. These practices, thus, need to be adopted in other states for the larger RI programme as well.

→ **Monitoring of Adverse Event Following Immunization (AEFI)** was a major area that the second phase of the MR campaign invested in. Besides training the frontline workers on AEFI management and communication, the states implemented stringent AEFI surveillance protocol to ensure prompt management of AEFI cases that may occur during the campaign. With regard to their sustainable adoption, in Uttar Pradesh, constant monitoring by WHO's National Public Health Surveillance team has ensured that AEFI kits are currently available in 80 per cent of the vaccination centres. The process of sustainably adopting these practices into the Routine Immunization programme should be deliberated upon and developed further in the remaining states.

→ **Monitoring and outreach practices** in Odisha through skilled front line functionaries trained in SBCC of the CSO's were effective and now these are being used for mobilizing community.

→ The MR campaign witnessed **development of videos** countering negative messages, and endorsements from officials, medical professionals, politicians and celebrities at the levels

of the state and districts to promote community acceptance of the vaccine. This practice has been adopted as part of the COVID communication strategies as well with regard to social distancing and adopting hygienic practices. Such practices should be further utilized in other health programmes as well.

4.4.3 Inclusive practices developed to reach out to vulnerable and marginalized communities have also witnessed success during the MR campaign and needs to be institutionalized in the larger Routine Immunization and other health programmes

→ A review of the guidelines, strategies, plans, budgets, communication materials and activities indicate that the campaign was inclusive of vulnerable and marginalized communities. The measures included:

- Setting up of mobile vans to increase outreach in tough geographical locations
- Increasing the number of vaccination sessions in these areas
- Engaging with the Panchayati Raj Institutions and the networks of Rotary Club, Lions International, IAP, IMA and other community based bodies to reach out to vulnerable communities. However, engagement with bodies such as NSS, NCC and others need to strengthened further or re-evaluated altogether as they were reported to be not very effective.
- Involving faith-based leaders to garner acceptance among communities.
- Training community health workers to be sensitive to the needs of the community during interpersonal communication.

→ Some of these practices have been adopted by a few states in the Routine Immunization programme. Considering the efficacy and relevance of these measures manifested during the campaign, they need to be uniformly adopted and institutionalized in the Routine Immunization programme.

→ Regarding **gender sensitiveness,** however, the MR campaign did not address gender inclusiveness. The lack of guidelines on the issue reflected on operations and communication activities. The strategy, plans and most of the activities adopted by the campaign were directed at caregivers in general, with no special indication of being inclusive of genders. Guidelines in the future thus need to be mindful and explicitly mention gender inclusive strategies for it to be reflected during implementation.

KEY FINDINGS SUSTAINABILITY

1. Interdepartmental relations and partnerships with CSOs and CBOs established during the MR campaign are being sustained for other campaigns, such as the Intensified Mission Indradhanush. However, as the intensity of these collaborations established and implemented during campaigns cannot be maintained for longer durations, sustaining them with lesser intensity can help improve the outreach of the Routine Immunization programme as well.

2. The mutual learning and skill development that happened during the campaign can be sustained with the support and willingness of the state government. Some of the practices developed based on learnings from the MR campaign (such as partnering within departments and with CSOs and CBOs, following a stringent AEFI monitoring and redressal protocol, dissemination of videos by public figures promoting/endorsing certain messages) have already been adopted and are being utilized in the Routine Immunization programme, Intensified Mission Indradhanush campaign and the COVID19 communication related activities.

3. Building the capacity of these health workers on AEFI management, interpersonal communication and mobilizations needs to be sustained and continued in the future in order to improve and maintain the uptake of not only MR but other vaccines as well.

4. The strong efficacy and relevance of strategies developed to reach out to vulnerable and marginalised communities for the MR campaign prompts that they need to be uniformly adopted and institutionalized in the Routine Immunization programme as well. However, with regard to gender sensitiveness, guidelines in the future need to explicitly mention gender inclusive strategies for it to be reflected during implementation.

CHAPTER 5: CONCLUSION & RECOMMENDATIONS

The Universal Immunization Programme of India introduced the measles vaccine into its schedule in 1985. The NFHS 4 data (2015-16), noted the uptake of the first dose of this vaccine at 81 per cent with variations among Scheduled Tribes (77.4%) and Scheduled Castes (81.5%). While the coverage of the second dose of Measles vaccine (MCV 2), as per the Health Management Information System (HMIS) in 2014, was recorded to be at about 66 per cent, the data of routine immunization recorded the coverage to be even lower, at about 40 per cent.

India as a signatory to the South-East Asia (SEA) Regional Committee (2013) sought to introduce the combination vaccine of Measles and Rubella through a campaign mode with the goal to eliminate measles and control rubella/CRS by the year 2023. The MR vaccine was set to replace the existing measles vaccine in the routine immunization programme of India after the campaign. The first phase of the MR campaign was implemented in the states of Tamil Nadu, Karnataka, Goa, Lakshadweep and Puducherry in February, 2017. However, this phase of the campaign was brought to a halt due to negative coverage of AEFIs, heavy circulation of rumours about the vaccine on social media and resistance among caregivers.

Literature on SIAs from around the globe note that vaccination through campaigns have been subject to much contention over the years. While those in favour argue that campaigns successfully mobilize the political, human, and financial resources to substantially boost coverage, critics counter that these gains may be short-lived and that campaigns may divert resources and trust away from routine health programmes.[23] Campaign mode, in contrast to routine immunization, calls for administration of vaccine doses to a large population over a short period of time. This opens up significant challenges with regard to AEFI surveillance, which becomes more noticeable to the public.[24] Interest groups may raise concerns about AEFI, which if not addressed promptly and succinctly, can be detrimental to the programme at large.[25] Improper management of rumours and misconception can result in similar situations as well. The first phase of the MR campaign in India faced these very issues, causing the campaign to halt and re-evaluate its strategies.

[23] Shepard, D & Robertson, R & Cameron, C & Saturno, Pedro & Pollack, M & Manceau, J & Martínez, P & Meissner, Paul & Perrone, J. (1989). "Cost-effectiveness of routine and campaign vaccination strategies in Ecuador." Bulletin of the World Health Organization. 67. 649-62.

[24] Mass Vaccination Campaigns: WHO. (n.d.). Retrieved June 05, 2020, from https://vaccine-safety-training.org/mass-vaccination-campaigns.html

[25] Mass Vaccination Campaigns: WHO. (n.d.). Retrieved June 05, 2020, from https://vaccine-safety-training.org/mass-vaccination-campaigns.html

For the second phase of this campaign, communication was one of the central themes, alongside operations. Instead of treating these elements separately, the campaign integrated communications within operations. This phase of the campaign witnessed significant coordination among government departments, civil societies, and community-based organizations, associations of private medical professionals and faith-based leaders. Training of community health workers on the operations and communications, alongside promotional activities to raise community acceptance took precedence in the planning of the campaign too. Further, inclusion of vulnerable and marginalized communities was ensured at every stage of the campaign. The strategies also called for steady media engagement to ensure proper reporting of events and progress of the campaign. On conclusion of the campaign in May 2019, the coverage of the MR vaccine among children between the ages of nine months and 15 years, in all study states has crossed the target of 95 per cent.

The concluding chapter of this evaluation lists below the processes which worked in reaching campaign's goal and strategies that need to be built upon further in the future.

5.1 What Worked

Convergence among Government departments: The evaluation enquired into the governance and monitoring mechanisms of the campaign, especially regarding issues of communication. The study found that convergences among departments, which were formed at the national and state levels down till the levels of districts and blocks, allowed a more nuanced form of governance. It helped in the monitoring of any emerging local issues and develop appropriate and contextually relevant responses to address them.

- For instance, the campaign established partnerships beyond the line departments mentioned in the guidelines, such as with Char Development Board, Border Security Forces, Forest and Police Departments, Foundation for Integrated Support and Solution in Assam, Department of Revenue in Odisha and Directorate General of Information and Public Relations in Maharashtra, were effective. The interdepartmental trusts that were built during the campaign should seek to continue as sustainable collaborations for future programmes.

- **Decentralized planning:** The campaign truly utilised the bottom-up approach for planning and implementation. Decentralized planning of the campaign, especially through the development of micro plans by the frontline workers, allowed the campaign to make true estimates of the requirements. It helped in charting out vulnerable communities and areas that are otherwise hard to access. Such mapping has assisted in the allocation of

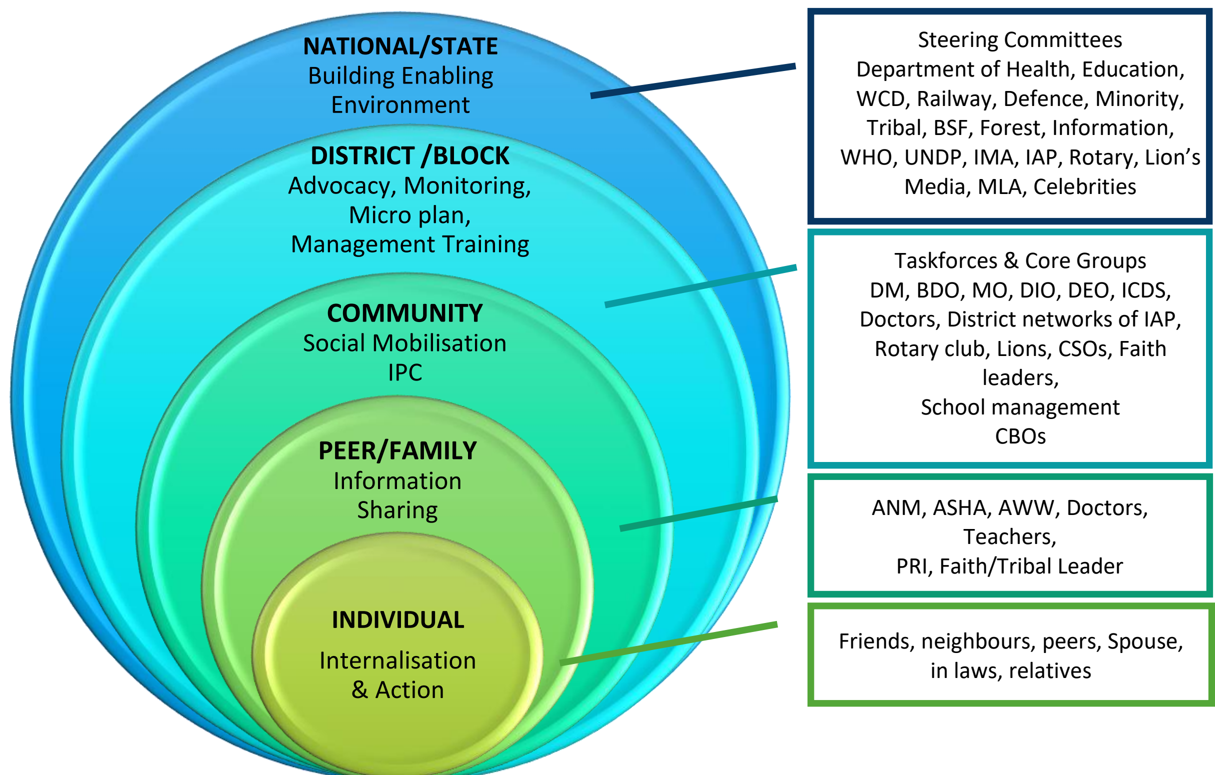
resources to reach out to the communities appropriately and becomes a baseline data for future intervention.

- **Training of frontline workers:** Training of community health workers on micro planning, AEFI management and IPC (such as addressing hesitance among caregivers by clarifying their doubts and ensuring appropriate care for their children) was relevant and effective in achieving the campaign's objectives. This finding was in tandem with recall among caregivers wherein they most often cited frontline workers as their most trusted source of information about health in general and immunization as well.

- **Advocacy at the Local Level:** Translation of the national level IEC and creation of local materials, alongside advocacy by local administrators, faith-based leaders and celebrities was not only relatable, but also motivating and doable. Advocacy by faith leaders at the national level motivated leaders at the local level to endorse the campaign as well.

- **Synergy among activities at all levels:** The campaign witnessed multiple activities being undertaken at the same time, causing the campaign to achieve a large goal within a small span of time. As shown in the figure below, the campaign was supported by several parallel activities and strategies at the levels of the state, districts, blocks and communities, which were crucial to its success.

Fig 9: Synergy of Activities to reach the farthest and the vulnerable



- **The network of private medical officers** and those working in the public health system and medical colleges established to address AEFIs at vaccination centres need to be sustained for future RI activities.

- **Capacities of human resources** (such as frontline workers, CSOs, CBOs, faith-based leaders, personnel from government departments) built during the campaign have been noted to be effective. The chain of communication and roles established between the state health system and these partners should be retained for further use.

- Finally, as opposed to the first phase, which witnessed setbacks, the result of all communications and operations working in tandem with each other helped in achieving the desired coverage of more than 95 per cent in each state.

5.2 What could have been better and needs rework

The recommendations emerging from the evaluation have been clustered under three sections. The first section looks into elements that need to be looked into while planning future activities. The second section highlights strategies that need to be charted out more clearly during the implementation of health programmes. The final section points towards modifications that need to be addressed through policy reforms.

5.2.1 Planning

- The **convergences within government departments** and roles of certain partners need to be strengthened and charted out more clearly as some states faced issues in this regard. For instance, to communicate more effectively with the media, it is essential that committees such as the ones created to address AEFI cases should be formed in coordination with the Department of Information or skilled personnel be deployed for the job. While the Department of Health certainly holds the technical expertise to address such issues, Department of Information and related offices are more adept at handling such public relations and crises. The state needs to work out ways to effectively use organizations like NCC, NSS and NYK to maximize reach out, which were reported not to be as effective as expected.

- The evaluation also notes that the convergences and partnerships formed during a campaign cannot be sustained with the same intensity and zeal through all regular activities. Thus, roles and responsibilities of lesser intensity for each department and partner needs to be charted.

- **Inter-state communication to share innovative and successful practices** needs to be encouraged. For instance, UNDP's presentation on ensuring the quality and safety of the vaccine at PTMs met with success in Uttar Pradesh. Such practices should be encouraged to be replicated in other states as well to address similar resistance.

5.2.2 Implementation

- To sustain **media engagement**, it is essential to move beyond sensitizing journalists, and focus on editors and sub-editors as well as they are the final decision-makers about the content of the news.

- **Budgeting for communications** will require readjustment based on priorities. The focus needs to be based on which activities were more effective. Caregivers recalled their conversations with health workers and other community influencers to be more effective than IEC materials. Among the print IEC materials, caregivers recalled seeing posters or leaflets, but the recall was triggered by the 'school certificates' issued to the vaccinated children even after two years of the campaign. The evaluation could not get enough evidence to justify the over-investment on IEC print materials, but suggests need of prioritization during budgeting. The training of the FLWs on IPC and micro plan emerges as a key area where investments should be made depending on what suits the need of the purpose better and what proved to be more effective in the past.

- Behind the successful story of implementation of IPC and micro plan in the MR campaign was the **training of FLWs,** which was only of four hours duration and should be more elaborate and structured in the future for easier comprehension and adjustment of the FLWs. In addition to this, there were incidents of shortages of vaccinators, especially in urban areas which compromised the communication dissemination process to some extent in a few states. It has been noticed that large scale immunization programmes have always avoided investing in IPC training of FLWs in spite of realising the critical role that the front line functionaries play as communicators in all health programmes. The future health programmes need to revisit this training component not only programmatically, but also in terms of budget allocation.

- The **plan for social media message dissemination** needs to be recalibrated with regard to the target audience. The evaluation states this in light of focus group discussions conducted with caregivers in all five states, where all but one group could not recall receiving any such positive messages on social media during the evaluation. The planning can be more proactively done rather than being a reactive response to address negative message. In future, small WhatsApp videos addressing the rumours can be made for the FLWs to be shown or disseminated through WhatsApp among their community. Using local

celebrities, political leaders or faith leaders whom the community can relate to in these small messages will be more relevant and motivating.

- **Advocacy at the Local Level:** Translation of the national level IEC and creation of local materials, alongside advocacy by local administrators, faith-based leaders and celebrities was not only relatable, but were motivating and doable. Advocacy by faith leaders at the national level motivated leaders at the local level to endorse the campaign as well.

5.2.3 Policy

- This evaluation enquired into the gender sensitive approaches undertaken by the MR campaign. The study found that as neither of the two guidelines of the campaign outlined any gender-sensitive activities, it did not reflect on ground in four out of the five states. **Gender inclusive policies** and plans need to be worked out to involve the fathers more specifically. This would be one of the initial steps to remove the onus of child health placed solely on mothers or female caregivers in general and assist in improving dialogues related to decisions within households. The plans at every level should have outright programmes for men, work out ways of reaching them, design specific content explaining their role in child's immunization and suggest activities that are implemented with them. The ad hoc activities used in the programmes can be used as general strategies.

- Routine Immunization programme should take note of the implications of the shortage of vaccinators which lead to overworked staff and the impeded timelines. Adequate number of vaccinators are needed.

***

ANNEXURE

1. Composite Index Score for district selection

ASSAM					GUJARAT			
DISTRICT	Social Index	Health Index	Composite Index		DISTRICT	Social Index	Health Index	Composite Index
Dhubri	2.98	4.08	7.06		The Dangs	5.83	1.64	7.47
Karbi Anglong	2.31	4.76	7.07		Panchmahal	6.37	2.43	8.81
Hailakandi	2.52	4.91	7.43		Dohad	6.49	2.38	8.88
Chirang	2.01	5.61	7.62		Surendranagar	6.48	2.42	8.90
Kokrajhar	2.10	5.57	7.67		Banaskantha	7.10	2.06	9.16
Karimganj	3.00	5.07	8.07		Kachchh	7.26	2.18	9.45
Darrang	2.64	5.45	8.09		Patan	7.17	2.33	9.50
Barpeta	2.97	5.27	8.24		Narmada	7.72	1.98	9.70
Cachar	3.03	5.34	8.37		Amreli	7.28	2.65	9.93
Sonitpur	2.70	5.75	8.45		Bhavnagar	7.36	2.80	10.16
Dima Hasao	2.38	6.15	8.53		Sabarkantha	7.61	2.56	10.17
Goalpara	2.82	5.74	8.56		Kheda	6.99	3.26	10.25
Dhemaji	2.16	6.42	8.59		Tapi	8.25	2.15	10.40
Bongaigaon	3.22	5.51	8.72		Baruch	7.72	2.77	10.49
Morigaon	2.81	6.04	8.85		Valsad	7.03	3.48	10.51
Udalguri	2.74	6.16	8.91		Junagadh	7.86	3.02	10.88
Kamrup	3.15	5.83	8.99		Vadodara	7.78	3.55	11.33
Baksa	2.46	6.62	9.08		Jamnagar	8.67	2.67	11.34
Nagaon	3.26	5.91	9.17		Porbandar	8.45	2.97	11.42
Lakhimpur	2.82	6.64	9.46		Rajkot	8.22	3.42	11.64
Golaghat	2.88	7.34	10.21		Mehsana	8.36	3.43	11.79
Nalbari	3.70	6.60	10.30		Anand	8.40	3.68	12.08
Tinsukia	3.22	7.13	10.35		Gandhinagar	8.53	3.98	12.51
Sivasagar	3.48	7.31	10.79		Navsari	9.00	3.65	12.65
Dibrugarh	3.52	7.31	10.84		Ahmedabad	8.22	4.90	13.12
Jorhat	3.42	7.60	11.02		Surat	7.67	5.62	13.30
Kamrup Metropolitan	6.66	5.84	12.49					

MAHARASHTRA					ODISHA			
DISTRICT	**Social Index**	**Health Index**	**Composite Index**		**Dist**	**Social Index**	**Health Index**	**Composite Index**
Dhule	1.95	4.49	6.44		Gajapati	1.91	4.99	6.89
Ahmadnagar	2.23	4.53	6.76		Malkangiri	1.46	6.17	7.63
Sindhudurg	2.19	4.63	6.82		Koraput	1.88	5.84	7.72
Parbhani	1.86	5.05	6.91		Rayagada	1.89	5.96	7.84
Sangli	2.33	4.68	7.01		Nabarangapur	1.70	6.21	7.91
Osmanabad	1.80	5.23	7.03		Kendujhar	2.38	5.65	8.03
Yavatmal	1.95	5.09	7.04		Kandhamal	1.63	6.41	8.04
Buldana	2.04	5.10	7.13		Nuapada	1.85	6.24	8.09
Gadchiroli	1.51	5.63	7.14		Debagarh	1.93	6.17	8.10
Nashik	2.36	4.84	7.20		Bargarh	3.03	5.10	8.13
Akola	2.24	5.03	7.26		Anugul	2.80	5.34	8.14
Chandrapur	2.02	5.28	7.30		Kalahandi	2.04	6.20	8.24
Kolhapur	2.63	4.76	7.39		Dhenkanal	2.94	5.36	8.30
Raigarh	2.57	4.85	7.42		Baudh	1.95	6.39	8.34
Ratnagiri	2.03	5.45	7.47		Mayurbhanj	2.22	6.70	8.92
Satara	2.43	5.08	7.51		Bhadrak	4.21	4.75	8.97
Gondiya	1.98	5.53	7.51		Kendrapara	4.14	4.87	9.01
Thane	3.30	4.43	7.74		Balangir	2.49	6.59	9.07
Bhandara	2.12	5.76	7.88		Nayagarh	2.83	6.49	9.31
Wardha	2.40	5.49	7.89		Ganjam	3.76	5.60	9.36
Nandurbar	1.49	7.01	8.50		Subarnapur	2.71	6.85	9.56
Pune	3.01	5.58	8.59		Sundargarh	3.14	6.80	9.94
Jalgaon	2.20	6.52	8.72		Sambalpur	3.08	6.90	9.98
Bid	1.87	7.02	8.89		Cuttack	5.05	4.98	10.03
Latur	2.00	7.31	9.31		Jharsuguda	3.75	6.43	10.18
Solapur	2.04	7.52	9.56		Jagatsinghapur	4.76	5.59	10.35
Washim	1.96	7.86	9.82		Baleshwar	4.30	6.25	10.55
Nanded	1.81	8.35	10.16		Jajapur	4.20	6.52	10.72
Aurangabad	2.32	7.90	10.22		Puri	4.08	6.72	10.79
Amravati	2.23	8.20	10.42		Khordha	5.90	5.97	11.87
Jalna	1.87	8.58	10.45					
Hingoli	1.77	8.86	10.63					
Nagpur	2.93	9.69	12.61					
Mumbai	16.33	3.84	20.17					
Mumbai Suburban	17.23	4.85	22.08					

UTTAR PRADESH								
District	Social Index	Health Index	Composite Score		District	Social Index	Health Index	Composite Score
Bahraich	1.81	3.36	5.17		Sant Kabir Nagar	2.71	6.36	9.07
Shrawasti	1.68	4.13	5.81		Bulandshahr	3.25	5.88	9.13
Balrampur	1.75	4.24	5.99		Pilibhit	2.46	6.77	9.23
Banda	1.94	4.93	6.86		Rae Bareli	2.49	6.80	9.29
Hamirpur	2.08	5.15	7.22		Ballia	3.00	6.30	9.30
Gonda	2.25	4.98	7.23		Mahamaya Nagar	3.47	5.88	9.35
Kanshiram Nagar	2.41	4.87	7.28		Jyotiba Phule Nagar	2.86	6.49	9.35
Budaun	2.19	5.10	7.29		Allahabad	3.52	5.84	9.36
Siddharthnagar	2.28	5.16	7.44		Kushinagar	2.88	6.53	9.40
Sonbhadra	2.01	5.46	7.47		Basti	2.63	6.83	9.46
Kaushambi	2.48	5.01	7.48		Bareilly	3.32	6.17	9.50
Jalaun	2.52	5.09	7.61		Lalitpur	1.97	7.53	9.50
Hardoi	2.29	5.34	7.64		Moradabad	3.38	6.17	9.55
Auraiya	2.70	5.22	7.91		Muzaffarnagar	3.70	5.90	9.60
Fatehpur	2.35	5.59	7.94		Etawah	2.90	6.72	9.62
Kheri	2.09	5.92	8.01		Sant Ravidas Ngr (Bhadohi)	3.75	5.96	9.72
Chitrakoot	1.79	6.27	8.05		Firozabad	3.51	6.23	9.74
Farrukhabad	2.86	5.20	8.06		Aligarh	3.47	6.27	9.74
Etah	2.70	5.43	8.13		Mathura	3.59	6.16	9.75
Sultanpur	2.65	5.48	8.13		Mau	3.30	6.53	9.83
Sitapur	2.23	5.90	8.13		Chandauli	3.08	6.85	9.93
Shahjahanpur	2.45	5.71	8.16		Bijnor	3.21	6.74	9.95
Kannauj	2.67	5.50	8.17		Rampur	2.94	7.10	10.04
Mirzapur	2.73	5.48	8.21		Saharanpur	3.67	6.56	10.22
Faizabad	2.93	5.28	8.21		Deoria	3.21	7.07	10.28
Pratapgarh	2.80	5.44	8.24		Jhansi	3.04	7.47	10.51
Bara Banki	2.37	5.97	8.33		Meerut	4.54	6.18	10.72
Ghazipur	3.07	5.40	8.47		Gorakhpur	3.69	7.23	10.92
Mahoba	1.97	6.51	8.48		Baghpat	3.86	7.29	11.16
Kanpur Dehat	2.42	6.08	8.51		Agra	4.31	7.07	11.38
Mainpuri	2.65	5.98	8.63		Kanpur Nagar	4.64	6.76	11.40
Unnao	2.50	6.17	8.66		Varanasi	5.57	6.29	11.86
Ambedkar Nagar	2.73	6.03	8.76		Gautam Buddha Nagar	4.94	6.97	11.91
Azamgarh	3.06	5.73	8.79		Lucknow	5.13	7.74	12.88
Jaunpur	3.29	5.60	8.88		Ghaziabad	7.75	6.27	14.02
Mahrajganj	2.55	6.40	8.95					

2. EVALUATION MATRIX

OBJECTIVE 1. Assess what procedures and activities worked

	Evaluation Questions	Criteria	Sources of data	Methods of Data Collection
1.1	Whether followed predetermined steps & used evidence for developing a communication plan (CP).	Relevance	✓ Report, Training Reports, Communication Plans ✓ Govt., UNICEF & other stakeholders	✓DR ✓KII
1.2	Aspects of communication plan led to meeting the communication objectives	Relevance Efficiency Effectiveness	✓ Communication Plans ✓ Govt., UNICEF & other stakeholders	✓DR ✓KII
1.3	Whether gender and equity were incorporated in communication process	Relevance Effectiveness	✓ Communication Plans ✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓DR ✓KII ✓FGD
1.4	Procedures and Activities that ensured inclusion	Effectiveness	✓	✓
1.5	How was enabling environment built? What is the evidence?	Relevance Effectiveness	✓ Govt., UNICEF & other stakeholders ✓ Meeting/training reports, partnership documents	✓KII
1.6	How were prevailing myths and misconceptions addressed?	Effectiveness	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers ✓ Local communication materials	✓KII ✓FGD ✓Content Analysis (CA) of Communication materials
1.7	Which element of the process facilitated community acceptance? How?	Relevance Effectiveness	✓ Frontline workers ✓ Caregivers	✓FGD
1.8	Which elements of communication plan engaged the communities? How was the community engaged in the process?			
1.9	Were different elements of communication planned?	Relevance	✓ Local Communication materials ✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓CA of Communication materials ✓KII ✓FGD
1.10	Which elements of communication reached community? What was recalled by community members?	Effectiveness	✓ Frontline workers ✓ Caregivers	FGD
1.11	Which elements of MR campaign were accepted in the community and which ones the community did not notice?	Effectiveness	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers ✓ Caregivers	✓KII ✓FGD
1.12	Which procedure and activities were widely recalled and liked by the community?	Effectiveness	✓ Frontline workers ✓ Caregivers	✓FGD

OBJECTIVE 2: Identify the factors and reasons behind why some procedure and activities worked and why others did not?				
	Evaluation Questions	**Criteria**	**Sources of data**	**Methods of Data Collection**
2.1	Whether local context informed the communication process? Was it successful in instilling trust and confidence among the community? (Myths and misinformation versus communication messaging)	Relevance Effectiveness	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers ✓ Caregivers	✓ KII ✓ FGD
2.2	Was resource allocation planned to cater to different groups (vulnerable /non-vulnerable) and their context?	Efficiency	✓ Govt., UNICEF & other stakeholder ✓ Reports ✓ Budget breakup (percentage allotted for different groups)	✓ Review of reports & budget ✓ KII
2.3	Whether the community had accessibility to the chosen channels of communication? What is the evidence?	Effectiveness	✓ Caregivers	✓ FGD
2.4	What are the myths and misinformation that have not been addressed?	Effectiveness	✓ Teachers ✓ Frontline workers ✓ Caregivers	✓ KII ✓ FGD
2.5	Whether Caregivers are able to distinguished between myths, misinformation from campaign message	Effectiveness	✓ Frontline workers ✓ Teachers	✓ FGD ✓ KII

OBJECTIVE 3: Understand to what extent and to what effect gender element was incorporated in the procedures and activities				
3.1	How did the communication process target inclusion of male caregiver? Which part deals with gendered refusal?	Relevance Effectiveness	✓ Communication Plans & Activities ✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ DR ✓ KII ✓ FGD
3.2	What were the activities to involve men? Whether community felt that it sufficiently targeted and involved men?	Effectiveness	✓ Frontline workers ✓ Caregivers	✓ FGD

OBJECTIVE 4: Understand if, equity (to what extent, and to what effect) was incorporated in the procedures and activities				
4.1	How did the communication process consider inclusion of vulnerable communities?	Relevance Effectiveness	✓ Communication Plans & Activities ✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ DR ✓ KII ✓ FGD
4.2	What were the activities to involve the vulnerable communities? Whether they felt that it sufficiently targeted and involved them?	Effectiveness	✓ Frontline workers ✓ Caregivers	✓ FGD
4.4	Whether participation of vulnerable communities was higher than before?	Effectiveness	✓ Reports that document increase in participation (if any)	✓ DR

OBJECTIVE 5: Recommend how the procedures and activities can be further improved				
5.1	How can the reach of campaign, involvement of right holders, and uptake of vaccine be increased?	Effectiveness Sustainability	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ KII ✓ FGD
5.2	What are the different challenges faced?	Effectiveness	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ KII ✓ FGD
5.3	How were the challenges overcome?	Sustainability	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ KII ✓ FGD
5.4	How were existing community structures and systems used (strengthened or mobilised) to achieve communication objectives?	Sustainability	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ KII ✓ FGD
5.5	How can the unaddressed myths be handled in future?	Sustainability	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ KII ✓ FGD
5.6	Lessons learnt	Sustainability	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ KII ✓ FGD
5.7	Preferred channels, platforms for information dissemination and activities for increased caregivers involvement in RI	Sustainability	✓ Caregivers	✓ FGD
5.8	Recommendation towards implementing RI better in future & Role of UNICEF	Sustainability	✓ Govt., UNICEF & other stakeholders ✓ Frontline workers	✓ KII ✓ FGD

3. CONTENT ANALYSIS OF LOCALLY DEVELOPED IEC MATERIALS

STATE ASSAM

	Type	Language	Message	Audience	Producer
1	Video-Appeal by Teacher, Tahir Hussain Borbhuyan, Moin Uddin Memorial Academy	Assamese	MRV is prevention from measles and Rubella. It is for 9 months to 15 years old child. The MR vaccination should be done in every school, Madrasa. Measles causes physical disability whereas Rubella in pregnancy causes death to the child.	Parents, students	DHSFW Assam, WHO, UNICEF, NHM, UNDP
2	Video- Appeal by journalist, Samudra Gupta Kashyap	Assamese	In our country every year lots of child died due to Measles and Rubella. MR vaccine is prevention from this disease. Government has arranged free vaccination for this deadly disease in the Sub Centers and schools. Please go and get your child vaccination done either in SC or in schools.	Parents	DHSFW Assam, WHO, UNICEF, NHM, UNDP
3	Video-Appeal by Politician, Pijush Hazarika, Minister of State, Health & Family Welfare,	Assamese	Assam government will provide MR vaccination in nearby hospital and school. This will prevent from deadly measles ***'saru aai'*** disease. I request everyone to take their boy and girl child for vaccination to their nearby center. As a MOS in Health, I congratulate all the health department staff to make this three month program successful and eradicate MR from India	All	DHSFW Assam, WHO, UNICEF, NHM, UNDP
4	Video-Appeal by singer, Nahid Afrin, Indian idol Jr. winner	English	You all are 15 years of age and have you your Mr vaccination done. Get vaccinated, stay safe, strong and healthy. Go to your school or nearby health center and get vaccinated	Students	DHSFW Assam, WHO, UNICEF, NHM, UNDP
5	Video-Appeal by Actress, Barsha Rani Bishaya, Assamese Actress	Assamese	Assam government will start free Measles Rubella preventive vaccination. This vaccine is for 9 months to 15 years old child which will be given by trained health staff in the health facilities and govt./pvt. Schools. Let's protect our child from MR by giving this vaccine	Parents	DHSFW Assam, WHO, UNICEF, NHM, UNDP
6	Video-Appeal by Boxer Ankushita Boro, Gold Medallist, AIBA World Youth Women Boxing Championship	Assamese	To become a good player, good health is necessary. I am thankful to my parents that they had vaccinated me for each and every vaccine. Now, Assam govt. has started free MR vaccination from which from measles and rubella can be controlled. So everyone should take the vaccine	students	DHSFW Assam, WHO, UNICEF, NHM, UNDP
7	Video-Appeal by Actress	Assamese	Assam government has arranged free vaccination for Measles and Rubella for every child from months to under 15 years. Come, let's make Assam free from Measles and Rubella	All	DHSFW Assam, WHO, UNICEF, NHM, UNDP
8	Leaflet- Appeal	Assamese	Dibrugarh District Health Service and Family Welfare department with the help of DHSFW and Dibrugarh District Administration has taken the initiative of vaccination camp for a double vaccination to prevent Measles and Rubella disease from 17 August, 2018. Detailed on what is measles and Rubella. Who need to be vaccinated, vaccination camp sites	Parents & guardians	Dibrugarh District Health Service and Family Welfare department. Printed by Kamakhya printers
9	Folk song	Assamese	Bihu songs with key messages on Measles-Rubella campaign like children's age, campaign duration/date, disease prevented by MR vaccine etc. to increase community demand and motivate communities for enhanced uptake of MR vaccine	Parents & guardians present at Bihu function	UNICEF, Assam
10	Archbishop letter	English	To eliminate measles and control rubella and CSR, MR campaign is being carried out. Date of campaign and age group mentioned. Since two third of the targeted children are in school and CBCI has asked to extend support, so request all the heads of the catholic schools Guwahati to do the needful and to take the parents into confidence before launching the program at school	School principals	Archbishop John Moolachira

STATE ODISHA

	Type	Language	Message	Audience	Producer
1	T SHIRT	ODIYA	YODHA of MR campaign distributed among school children through quiz competition	School children	UNICEF Odisha
2	Appeal video by Ananya	Odiya	January 29th immunization against measles and rubella, one vaccine for two diseases, with your parents go and get yourselves immunized, live a healthy life.	Children in private school	UNICEF Odisha
3	Appeal video by famous music composer Jitendra Haripal	Sambalpuri dialect	Sings the famous song Rangabati, and the girl asks him for a new song. He says that instead of a song I would like to give you this important information about MR campaign. This is one vaccine for preventing two disease for all in the age group of 9 months -15 years. All boys and girls should take this vaccine and live a healthy life	Children in village	UNICEF Odisha
4	Appeal video by Actor Babushan	Odiya	More important date than my movie release is Jan 29 when Odisha govt. is launching MR vaccination campaign in the state. I appeal to all parents, sisters, brothers, uncle and aunts to get their children vaccinated in the nearest centre and stay healthy.	Community	UNICEF Odisha
5	Appeal video by child singer Satyajit	Odiya	I am Satyajit, singer, today I want to tell you a very important thing. To prevent Measles and Rubella it is important to give your child of 9 months -15 years MR Vaccine because one vaccine protects us from two diseases. I will myself take this vaccine and I appeal you take it too	Community	UNICEF Odisha

4. TERMS OF REFERENCE

1. Background

Measles is a highly infectious disease that continues to kill many of India's infants and young children. Rubella Infection in pregnant women disables a child for life with congenital rubella syndrome (CRS) that may result in deafness, blindness, and heart defects. Measles-Rubella (MR) can, however, be prevented with a safe and effective MR vaccine that gives long-term immunity. Measles immunisation directly contributes to the reduction of under-five child deaths and the combination of rubella vaccine controls rubella and prevents CRS in country population, thereby reducing disabilities. Globally, an estimated 1,34,200 deaths were caused from measles in 2015. Measles has killed an estimated 49,200 children in 2015 in India, contributing nearly 36% to the global figures.

According to the National Health Mission, India has attained impressive milestones through immunization and continues with its efforts to achieve comprehensive immunization coverage for a birth cohort of 27 million children through the Universal Immunization Programme (UIP). Immunization is one of the most effective public health interventions for protection of children, especially under 5 years of age, from life-threatening conditions which are preventable. Despite high vaccination coverage levels for individual vaccines, India's full immunization coverage has plateaued around 65% (RSOC 2013-14) in the last few years with slow progress, thus contributing to continued high burden of morbidity and mortality in children from vaccine-preventable diseases (VPDs).

Measles is one of the most common vaccine-preventable diseases among the under-five children in India, for which the country has been providing vaccination under UIP, since 1985 across all states.

Following the South-East Asia (SEA) Regional Committee resolution in September 2013, setting the goal for measles elimination and rubella / congenital rubella syndrome (CRS) control by 2020, India geared up and accelerated its key elimination strategies. The National Technical Advisory Group on Immunization (NTAGI) in June, 2014, recommended the introduction of measles-rubella vaccine in routine immunization program, following a nationwide MR campaign.

State-wise MR vaccine coverage across India after the 2018 MR campaign is annexed to the terms of reference (see Annexure A).

Effective communication is important in achieving the MR campaign's coverage and equity goals. A well-coordinated communication strategy was therefore developed to ensure that the MR vaccination is well accepted by the communities and achieves a wider coverage of target groups.

1.1 The communication objectives of the MR campaign were:

a. Positive positioning of the MR campaign among the stakeholders, development partners, schools, communities and media thereby ensuring strong commitment among partners.
b. Facilitate community acceptance of MR vaccination during the campaign through specific social mobilisation interventions
c. Build an enabling environment through positive media reporting and involvement of key stakeholders and influencers.
d. Combat and counter negative responses, myths amongst all stakeholders. Details on negative responses and myths associated with the MR vaccine may be found in this National Health Mission Report.

1.2 The components of the communication strategy (as outlined in the MR Communication Guideline) included:

a. Pre-Campaign – building an enabling environment for Measles-Rubella (MR) vaccine
   i. Media engagement – organising media sensitisation workshop two-three weeks before launch
   ii. Social/digital media mapping and plan with an identified focal person/lead coordinator
   iii. WhatsApp plan with an identified focal person/lead coordinator
   iv. Influencer mapping and engagement plan with an identified focal person/lead coordinator
b. Media and social media monitoring plan, and WhatsApp reporting and monitoring plan (please refer to the pre-campaign section)
c. Adverse event following immunisation (AEFI) - Crisis Communication planning and preparedness
d. Advocacy with key stakeholders such as schools, public representatives, government, private medical networks, and private medical practitioners, religious leaders, media, etc.
e. Social mobilisation to create demand for MR vaccination required the following:
   i. Identifying a nodal person at state, district and sub- district levels for communication, and training them as master trainers on MR Communication – organise ToTs at state/district levels.
   ii. Carrying out cascade training of frontline workers on joint microplanning including communication and information related to MR vaccine and campaign. Conducting BRIDGE IPC skills training for FLWs (ANMS and ASHA + AWW) of 4 hours duration.
   iii. Developing communication plans at state, district, sub-district, and community level with components of social mobilisation, mass media, and mid media.
   iv. Organising sensitisation of school principals/nodal officer/teachers to facilitate cascade training to school principals and nodal persons on their roles and responsibilities referring to the teacher's handbook.

v. For urban areas, identify all reputed and elite private schools and mobilise the children and their parents through parent-teachers meetings, school website, and new media platforms.
vi. Identification of institutions such as Panchayats, religious leaders, social and community groups, women's groups, self- help groups, milk cooperatives, agriculture produce committees, youth clubs, NGOs, community-based organisations (CBOs), and other network of polio influencers to support social mobilisation activities.
vii. Sensitisation of influencers and engaging influencers.
viii. Identify religious institutions and key religious leaders who can support the campaign in different aspects as mentioned in religious leaders' leaflets.
ix. Coordinate announcements from religious institutions.
x. Conducting community/mothers' meetings.
xi. Use VHSNC platform to disseminate messages among community members on MR.
xii. Organising mobilisation events in schools like painting competitions, debates, group discussions, talks by doctors etc.

f. Maximising the reach through mass media and IEC material: Maximise the reach of MR campaign using different mass media channels and ensure visibility through the IEC materials provided. Develop a communication plan including mass media and mid media activities and monitor its implementation. Some suggested activities include the following:
   i. Celebrity engagements
   ii. Newspaper advertisement
   iii. TV/Radio spots on MR campaign
   iv. Mic/announcements on MR campaign
   v. Posters for MR introduction
   vi. Banners/hoardings
   vii. Leaflets for caregivers, religious leaders, influencers, teachers, and health workforce including, ASHA, AWW etc.
   viii. Specially customised WhatsApp messages and videos

1.3 Timeframe of Communication Processes

Communication processes and activities mentioned in the section 1.2 often precede the launch date of the MR campaign (see Annexure B). Naturally, pre-campaign activities (point a in section 1.2) commence before the MR campaign. In addition, planning activities (points b, c, d, and e in section 1.2) often start before the campaign launch and continue till after. Details on timelines for each of the key procedures and activities are mentioned on pages 46 to 48 of the 'Communication Guidelines for Measles Rubella Vaccination Campaign' which may be accessed here.

1.4 Role of the Government

The Ministry of Health and Family Welfare (henceforth, MoHFW) in collaboration with WHO and other development partners planned activities for the MR campaign. The following were the main responsibilities of MoHFW:

a. Provide sufficient planning time for a well-coordinated MR campaign across the country in line with the WHO MR campaign guidelines,
b. Be responsible for the overall implementation of MR strategy in all the states,
c. Organise periodical national and state level technical and communication core group meetings,
d. Review the campaign under Joint Secretary at the national level and by Principal Secretaries and Mission Directors (NHM) at state level,
e. Designate Principal Secretaries to be responsible authorities to spearhead and provide oversight at state level inter-sectoral coordination mechanisms,
f. Designate State Immunisation Officers to track state task force meetings and organise state planning workshops.

1.5 Role of UNICEF

As designated by MoHFW, UNICEF provided strategic communication support to foster community ownership and demand for immunisation, to increase coverage and help achieve desired MR campaign goals. The National Core Group on Communications led by UNICEF aligned with the India Expert Advisory Group (IEAG) recommendations, revised the existing comprehensive national level communications and social mobilisation plan to reflect advocacy with decision-makers, including political leaders, health-care professionals, teachers and other educators, religious and traditional leaders, and professional associations and other influential groups — to explain the benefits of immunisation, address community concerns and invite their active participation.

UNICEF facilitated the development and testing of a robust communication package including media strategy and social media management. Special emphasis was given to effective communication and public engagement with parents and schools, health professionals, community leaders and the media, to 1. gain their trust, 2. understand and address vaccine concerns and 3. support vaccine acceptance. Some of UNICEF's major responsibilities were as follows,

a. Developing communication planning tools along with Standard Operating Procedures (SOPs) and getting them approved from MoHFW,
b. Facilitating all MR state ToTs (particularly the social and behaviour change communication – SBCC – section of trainings),
c. Developing and pre-testing all training and communication materials,
d. Providing prototypes of all communication materials to states through MoHFW,
e. Developing pre-assessment tools and checklists for communication preparedness along with technical indicators,

f. Developing social media content,

g. Organising media sensitisation workshops at the national and state level,

h. and tracking social media news and content (and developing messages countering rumours with the help of MoHFW and other development partners).

2. Rationale & Objectives

The MR vaccine campaign in most states in India (please refer to table 1 on MR coverage as given in Annexure A) has been completed. Furthermore, the Government of India has now decided to introduce the MR vaccine into the routine immunisation schedule. This decision makes this evaluation relevant and its findings, recommendations and lessons learnt useful, not only for UNICEF but also for the Government of India.

The overall purpose of the assessment is to determine if, and to what extent, the communication processes for the measles and rubella campaign have been relevant, effective, efficient, and sustainable. The evaluation will not seek to assess UNICEF's support specifically; however, where findings can be relevant for UNICEF's work, these will be considered.

This formative evaluation will, therefore, highlight critical issues and challenges, provide essential lessons from implementation, document any local innovations, and submit a set of recommendations. Through this evaluation we are not going to measure impact but understand 'what' worked and what did not – and more importantly, 'why'. It will also assist in identifying and understanding the characteristics – interests, behaviours and needs – of communities that influence decisions and actions related to immunisation.

It may be noted that the human rights-based approach to evaluation will be mandatory in this evaluation, especially during primary data collection. This has been further explained in section 6 on 'Ethical Considerations'.

UNICEF desires to now conduct a formative evaluation of these communication processes. The evaluation will be conducted on four of the five 'OECD-DAC Criteria for Evaluating Development Assistance' (relevance, effectiveness, efficiency, impact, and sustainability). Since this is a formative evaluation, and since the MR campaign began only a year ago (refer to the dates of launch in Annexure B of the Terms of Reference), it is difficult to capture impact.

Evaluation objectives:

The objectives are:

a) Assess what procedures and activities (mentioned in section 1.2) worked*,
b) Identify the factors and reasons behind why some procedures and activities (mentioned in section 1.2) worked and why others did not,
c) Understand to what extent, and to what effect gender element was incorporated in the procedures and activities,
d) Understand if, equity (to what extent, and to what effect) was incorporated in the procedures and activities.
e) Recommend how the procedures and activities can be further improved.

*Note: 'Worked' entails if the communication processes 1. followed predetermined steps and use of evidence for developing a communication plan; 2. The different elements of the communication plan that reached communities, were recalled by the community members; 3. Elements of the communication plan engaged the communities; 4. Aspects of the communication plan led to meeting the communication objectives (in section 1.1); 5. Helped ward off MR-vaccine related myths and miscommunication; and 6. Helped address inequities (especially relating to gender and marginalised - caste-based, poverty-based and tribal populations).

3. Use of Findings

As stated in section 2 of the Terms of Reference, the findings will be used to learn from the successes and shortfalls of the communication processes within the MR campaign. They will influence the communication planning processes that are being followed in ongoing immunization programmes as well as inform the development of those that are being planned in the future. UNICEF continues to support social and behaviour change communication for Government of India's health programmes. This evaluation will provide results that are not only MR-specific but may influence other communication work as well, such as that for routine immunisation. Lessons learnt from the evaluation would also inform UNICEF's communication for programmes in nutrition, WASH, child protection, and education. An example of one such usage is the documentation of 'if and how the MR communication plan and tools countered negative messaging (myths and misinformation) being circulated through new media platforms such as WhatsApp'.

In addition, the findings from this formative evaluation will inform the inclusion of the MR vaccine into the routine immunisation programme. For the government, such an evaluation would provide key lessons and recommendations, i.e. What processes are necessary for a successful communication campaign and what aspects may be reduced or dropped from the planning and implementation. Further, it would help the government identify relevant, efficient, effective, and sustainable communication platforms that may be then used in other government programmes and campaigns, such as the routine immunisation programme.

The appetite for the results of such an assessment is immense. Not only would such a report be shared within UNICEF, but also externally with the larger C4D and SBCC networks. To that end, the result of this assessment will be published by UNICEF after the satisfactory completion of the assessment. The findings will be disseminated to UNICEF C4D staff in India, other UN organisations (UNDP, UNFPA, UN Women, WHO), donors, relevant government parties (Ministry of Health and Family Welfare, Ministry of Women and Child Development), key development partners, and NGO parties (implementing partners and other NGOs working in the realm of SBCC and healthcare) through PowerPoint presentations, a full report, and an executive summary report.

4. Publication Plan

The results of this formative evaluation will be published by UNICEF. The final publication will adhere to the guidelines under UNICEF's publications policies and guidelines (mentioned in detail in Section 9). Credit for the formative evaluation, its results, and forms of publications will be shared between UNICEF and the agency. At this stage there is no intention to publish the results academically; however, if this intention changes, this will be discussed with the agency before the contract ends.

5. Methodology

5.1 Scope

In addition to answering the evaluation questions, the hired agency is expected to derive lessons learned, document any local innovations, and submit a set of recommendations that are firmly based on evidence and analysis. The agency should apply an appropriate set of methodologies (involving key informant interviews and participatory focus group discussions) in deriving answers, keeping in mind that the end objective is to learn. It may be noted that the evaluation will focus on all the 'communication processes' used for the national MR vaccine campaign and evaluate whether the communication objectives (as outlined in Section 1.1) were met. 'Communication processes' include all components of the communication strategy – from pre-campaign planning steps to outreach activities (mentioned in Section 1.2 of the Terms of Reference). Each of these will be covered by the evaluation. Simply examining the success or failure of a procedure or activity is not the primary objective of this assessment. The objective is more granular, it is to understand the 'why' and the 'how'.

Furthermore, within the above-mentioned scope of assessment, bidders are encouraged to propose other innovative approaches to data collection. In the event of the usage of innovative data collection techniques, the local context of the various states must be considered. The local context must determine the use of innovative methods and techniques, rather than a uniform implementation of an innovative technique that is innocent of local contexts.

Timeframe

As stated in section 1.3 of the Terms of Reference, details on timelines for each of the key procedures and activities are mentioned in the 'Communication Guidelines for Measles Rubella Vaccination Campaign'. Therefore, the timeframe covered by the evaluation is from four months before the start date of the MR Campaign (please refer to Annexure B) till the date of commencement of this evaluation. All procedures and activities between the two dates will be evaluated.

Geographical Coverage

The best method to gather this useful information is by conducting the evaluation across various states. The assessment will, therefore, be conducted across five states in India – Assam (and with the North East States' representatives), Gujarat, Maharashtra, Odisha, and Uttar Pradesh. With the objective of gathering rich evidence, states have been selected due to – a. their involvement in various phases of the MR campaign and b. the context that they offer (urban-rural, high-burden, good governance, and tribal population). It is worth noting that these five states have UNICEF presence at the state level.

Within each of these five states, only two districts will be covered. This will provide critical programmatic insights into what worked and what did not work across the ten districts and within each of these individual states. As additional information that may help the evaluating agency, dates of commencement of the MR campaign in these states have been annexed to this document (see Annexure B).

Availability of Data

For a desk review, the agency will need access to multiple data sets. Administrative data on MR vaccine coverage is available at the national and state-level (this may be used to assist sampling). UNICEF will provide this data to the selected agency. However, block-wise data on MR vaccine coverage will only be available at the state-level with the state government. Relevant UNICEF reports will also be made available to the selected agency by the UNICEF India Country Office.

Data on planning and implementation will be available at the state-level. However, it is possible that such data may not be available for each of the steps/procedures or activities. The evaluating agency will need to rely on key-informant interviews to gain access to some of this data. UNICEF State Offices will facilitate this process, wherever possible. All official data (government or UNICEF) will be considered as reliable and fit for analysis.

Desk Review

At the onset of the evaluation, a review of existing literature is encouraged. Some of the pre-identified key sources are,

a. IAG meeting minutes (from August 2017)
b. Progress report from UNICEF on MR campaign Phase 2, which includes the challenges of phase 1 and actions required to overcome the challenges
c. Brief/Summary of the MR campaign qualitative study conducted by Centre for Communication & Change- India
d. District-level MR communication plans (or municipal plans)

Wherever possible, access to this literature will be provided to the agency by UNICEF.

In addition, the agency will be expected to review the content of the communication material before collecting any primary data.

Primary Data Collection

The Primary data collection will consist of:

a. qualitative data from key informant interviews to understand what key government officials (at state, district, block level) and integral stakeholders (such as local leaders, influencers, religious leaders, teachers, frontline health workers (3As) think about the communication processes, their planning, and implications.

b. and from participatory focus group discussions with community members (fathers, mothers and caregivers) to gather opinions of community members and understand how the communications process reached them and what were its implications.

5.2 Evaluation Questions

The specific questions and areas of inquiry under each of the 'OECD-DAC Criteria for Evaluating Development Assistance' (except impact) are provided below. Note that the evaluation questions will be further refined during the inception phase.
Note: It must be noted that 'communication processes' is a broad label when we are 'Evaluating the Communication Processes Used for the National Measles Rubella Vaccination Campaign'. The evaluating agency will have to detail out all their areas of inquiry (in accordance to section 1.1 and 1.2 of the Terms of Reference) before proceeding to collect primary data. Therefore, each of the questions asked will not only inquire about the overall communication strategy, but also about specific processes, procedures and activities. This will ensure findings that include explanations for individual procedures and activities as much as about the overall communication strategy.
5.2.1 Relevance:

a. To what extent were the communication procedures and activities consistent with the overall goal of the MR campaign and its objectives?
b. To what extent were the communication processes relevant to the local needs of the stakeholders?
c. Were the communication processes informed by the local context?
d. Were the processes designed to counter some of the contextual challenges (such as misinformation)?
e. Were the communication processes designed to be gender sensitive?
f. Were they inclusive and did they attempt to target vulnerable groups?

Suggested areas of inquiry: Were the communication processes well contextualised (according to local language and needs)? If not, then why? What media was irrelevant? How relevant was the communication material? Any recommendations to make it more relevant? What (specific messages and media) do they find more relevant? Did the procedure/activity target male caregivers and other male stakeholders? Which procedure/activity (implicitly and explicitly) only targeted females? Were any vulnerable groups identified? Did the campaign attempt to target these vulnerable groups? Was appropriate media selected to target vulnerable groups (who may not have access to traditional media)? Did the communication processes and actions address the underlying reasons for vaccine resistance in the communities? How do caregivers situate campaign messaging within the myth-and-misinformation context? How did the communication processes use vulnerable groups as agents of age? What was their participation like in the communication process?
5.2.2 Effectiveness:

a. What evidence exists to support that the communication procedures/activities (i.e. the communication planning and implementation processes) meet their objectives?
b. How have each of the communication procedures/activities - directly or indirectly - influenced caregivers?
c. How acceptable were the communication processes to people?
d. Did the processes effectively tackle local challenges?
e. Did the processes effectively involve both genders and vulnerable groups?
f. How can the communication processes be made more inclusive for vulnerable communities and how can they be made gender sensitive and transformative?
g. What are the major factors influencing whether objectives are achieved, and specifically how effective and acceptable the communication processes are?

Suggested areas of inquiry: Could the communication processes create more trust and confidence in the MR vaccine? Did the different communication methods help in reducing resistance towards the vaccine? What further information would caregivers want? Are the caregivers more aware now? Can caregivers recall key messages from the campaign? What was the one message or medium that stood out for the caregiver? The conscious sharing or organic spreading of myths and misinformation around MR is detrimental to a child's wellbeing, and poses a substantial challenge to the success of the campaign. Do they find myths and misinformation more compelling? Why? Can caregivers distinguish between campaign communication and misinformation and myth? What convinced them more and why? How much has misinformation around MR effected their understanding of MR? Could the communication processes mitigate the effect of myths and misinformation? Could the frontline workers answer the doubts related to AEFI adequately? Did specific procedures/activities have a positive effect on male relatives/fathers (by encouraging their participation in immunisation activities)? Could some of these procedures/activities mobilise men? Were there any specific vulnerable groups that could not be reached? Did as many girls get vaccinated as boys? Was vaccine denial a gendered issue? Were there any explicit gender-based or vulnerable-group-based observations that frontline workers would like to report?
5.2.3 Efficiency:

a. What role do allocated resources (comprising of processes, mechanisms, logistics, finances, human resources and time) play to ensure good delivery of key messages?
b. Were the resources allocated adequate to meet communication objectives?
c. Were the resources allocated used optimally to deliver messages?
d. What were some of the implementation challenges (process based, logistical etc.) that led to inefficiency, loss of information, or misinformation?
e. Was efficiency of resource use to deliver messages different for vulnerable groups vs non-vulnerable groups?

Suggested areas of inquiry: Do district or municipal communication plans exist? If not, why? What were some of the processes and logistics that were missing? What could be some of the media channels and approaches that could be used for future messaging?

Were measures taken during the planning, designing, and implementing stages to include male relatives/fathers in MR communications? What were some of the barriers (social, political etc.) in including men into the conversations? Were there any barriers (social, political etc.) in including vulnerable groups in the campaign?

5.2.4 Impact: Since this is a formative evaluation and the campaign began only a year ago, it is difficult to capture impact. This assessment will not aim to establish causality or attribution, but only aim to provide learnings and recommendations for course-correction and future amendments.

5.2.5 Sustainability:

a. What support would the government (at the state and district-level) require implementing a similar communication strategy in the future?
b. How were existing community structures and systems used (strengthened or mobilised) to achieve communication objectives?
c. What are the implications of moving from a campaign mode to routine immunisation?
d. For a sustained and strong understanding of the MR vaccine, what needs to be done in the future? What lessons have been learnt regarding actions need to ensure that operational immunization strategies/plans integrate communication planning and implementation.
e. Are there any dormant challenges that have not been addressed yet?
f. How can gender sensitive and transformative communication processes be made sustainable?

Suggested areas of inquiry: Considering that the MR vaccine will now be included under routine immunisations, is there a need for other support mechanisms to ensure success? If no, then what kind of additional support would such campaigns require from UNICEF in the future? What are some of the anticipated roadblocks in the future for such a communications campaign? Are there any dormant challenges that have not been addressed yet? What are some of the recommendations from key informants for future communication campaigns? How can men be involved in all immunisation campaigns? How can the involvement of vulnerable groups be ensured in similar campaigns? Were there any attempts to de-stigmatise these vulnerable groups? MR is being planned to move to routine immunisation programming. It is therefore important to understand how sustainability of such an effort can be ensured, how uptake can remain consistent or even improve when a vaccine like MR shifts from campaign mode to RI programming.

5.3 Methodology

The objective of this formative evaluation is to learn and not to establish causality. Therefore, the evaluation does not require a counterfactual and an appropriate methodology is sought. Moreover, while innovative approaches to data collection are encouraged, field-appropriate data collection instruments must be chosen.

The proposed methodology is based on the experience of designing similar evaluations, but should be enhanced based on the bidder's understanding of UNICEF's requirements. Therefore, the agency could either utilise a similar methodological approach to what is being proposed below, or further suggest improvements/modifications to the proposed methodology in their technical proposals.

Along with a literature review of all existing district MR communication plans (or municipal plans), the study will involve,

a. key informant interviews with state and district level officials (government, partner, and other key stakeholders)
b. focus group discussions with community members – parents and frontline workers using community based participatory research (henceforth, CBPR) techniques

Note: Techniques such as narrative, visual (aids, diagrams, maps), numeric, sorting-and-ranking, and of word association will be employed during the focus group discussion. Once developed, these tools will need to be reviewed by the Evaluation Reference Group before being employed.

Key Stakeholders for Data Collection

Within each of the five states, two districts will be selected for this evaluation. The selection will be purposeful, we would like to cover districts that faced various challenges – logistical, administrative, demographic, socio-cultural etc. The selection may be done based on inputs from key government officials. The subjects of this study will be the key informants at the state, district, and block level. A key informant in this evaluation is a government or non-government stakeholder who actively participated in the Measles Rubella campaign (specifically on communication). This would not only include those directly involved in the campaign (such as state and district immunisation officers, block development officers) but also the more unlikely but integral stakeholders (such as local leaders, influencers, religious leaders, and teachers). While districts normally have only one district or state immunisation officer, local religious leaders can be many. While a comprehensive list of stakeholders will be detailed during the inception phase, it is assumed that at the district level there would be at least 30 key informants being interviewed. Some of the stakeholders include the Ministry of Health and Family Welfare (for child health, immunisation, and social media), the Ministry of Human Resource Development, WHO, UNDP, the Immunisation Technical Support Unit (ITSU), media representatives, the Indian Academy of Pediatrics (IAP), the Indian Medical Association (IMA), the Lions Club, the Rotary Club, boards of schools, and local celebrities.

At least 10 focus group discussions will be organised at the district level. In order to capture the varied perspectives of local community, it is suggested that each identified district would be divided into four parts (geographies), i.e. North, South, East and West. From each part, one block would be selected purposively. In each selected block, two focus group discussions would be held among the local community (parents, caregivers) based on lists that the frontline workers maintain. It is suggested that two different villages be selected for this and the village should have households belonging to various socio-economic groups. In addition, it is important for the FGDs to recruit based on – gender, religion, and caste groups. While this may be automatically done based on the selection of blocks, the agency must review the final list to ensure that all social groups have been reached. Thus, a total of eight FGDs will be held among the local community, two FGDs from one block. It is advised that at least one focus group discussion (per district) should have men (male caregivers, fathers, village leaders etc.). If the need arises, specific focus group discussions must be organised specifically for vulnerable communities. The size of the group, composition, and nature of any of these interactions would depend entirely on the

questions and CBPR tools prepared by the evaluation agency. In each district, two FGDs will be conducted among the frontline workers. The venue and location of these two FGDs should be decided in consultation with the ICDS/health department.

6. Ethical Considerations

No IRB clearance is needed for this evaluation. The assignment does not require the involvement of children and does not aim to study sensitive issues. However, the agency is required to adhere to UNICEF's Ethical Guidelines for research, studies, and evaluations. It is the responsibility of independent evaluators to ensure there is no conflict of interest when carrying out this activity.

In compliance with the human rights-based approach, it is imperative that the agency lay out their plan to ensure ethics of conducting research with human subjects is maintained during the evaluation. It is worth noting that the communication messaging may have various underlying social messages. While dealing with community members who have denied vaccine administration, their involvement in such an evaluation may provoke fear or shame. It may also be possible that caregivers participating in focus group discussions may have lost a child earlier in their life, and discussing immunisation and infant death may be saddening, distressing, or even traumatic for them. The agency must outline how such risks will be addressed.

Both the assessment team and the Evaluation Reference Group are expected to follow the ethical principles and considerations outlined in the UNEG Ethical Guidelines for Evaluation. In addition, the UNEG norms and standards will be observed.

Standard consent procedures will be followed throughout the evaluation. Data collectors will emphasise the voluntary nature of participation in the evaluation activities. In addition, participants who wish to withdraw from the study after providing consent will be free to do so. All results will be reported at aggregate level and no identifying information will be disclosed. Overall, the evaluation does not involve more than minimal risk to subjects and has more benefits than risks. UNICEF expects the agency to adhere to strict standards even when local settings permit looser standards. Furthermore, the agency must detail all data protection and data storing (for primary data) measures taken.

7. Schedule of Tasks & Timeline

The timeline has been detailed in section 9 of the Terms of Reference and Annexure C.

7.1 Develop Methodology and Study Design: The inception document must include details on – desk review, primary data collection and analysis, stakeholder participation, building consensus, feedback, and reporting. UNICEF seeks a design that fits all five states (and specifically the ten districts), keeping in mind the geographical and demographic variations. It is anticipated that the design may need to vary depending on geography. The study needs to be purely qualitative in nature based on a literature review, key informant interviews (functionaries of the system), and focus group discussion with community members —parents and frontline workers. While developing the study design, the agency is advised to adhere to the four 'OECD-DAC Criteria for Evaluating Development Assistance'.

It is expected that the agency selected for the evaluation, in consultation with UNICEF, will provide the final design specifying data collection and analysis methods taking into consideration key evaluation questions and the context of the programme. There will be a need to agree on the detailed design, analytical methods, and tools between the selected agency and the UNICEF Evaluation Reference Group. A draft study protocol and all data collection tools are expected to be submitted to the Evaluation Reference Group for a review.

7.2 Obtain Study Approvals: Detailed in section 6 of the Terms of Reference.

7.3 Develop Work Plan: A work plan must be submitted to UNICEF detailing the data collection protocol, with all data collection activities listed against a timeline, and with details of work allocated to team members. In addition, all data collection tools must be tested in Hindi.

7.4 Train Local Evaluation Teams: The agency's local evaluation teams must be fully prepared and supported by the agency. This will include training workshops, the adaptation and translation of data collection instruments, and on-line technical support whenever needed.

7.5 Collect Data: Accuracy of data collection and management is of paramount importance, including coding, setting up of data entry, data screening, and data clean-up protocols.

All data collection will be conducted in the local language and subsequently translated into English. Verification and triangulation of collected information will be conducted to ensure the quality of data.

7.6 On-Field Reporting: Once the evaluation has begun, the agency will be required to update UNICEF with data collection and field activity updates, in an agreed upon format (which may be digital). This Progress Report or Dashboard will have daily/weekly activity logs along with updated field plans. This will be followed by a brief implementation report.

7.7 Analyse Data: Analytical plans will address how analysis will be conducted. Since data collected will be stratified and categorised at times (as per state, district, gender etc.), data harmonisation for ease of analysis must be ensured. A plan must be submitted by the evaluating agency as part of the technical proposal, outlining the data analysis plan.

7.8 Draft Report: The agency will be required to present preliminary findings in a meeting before the draft report is shared. A draft report, professionally edited and copy edited, will include an executive summary, methods, limitations, findings, discussion, learning, any innovative processes followed in any of the states, and recommendations. This will be presented to the Evaluation Reference Group which will then provide feedback to the evaluating agency. In addition, please note that the report must conform to the UNICEF-Adapted UNEG Evaluation Reports Standards. The 'Draft Report' will have two components, the first component will be the technically detailed report of the evaluation and the second will be a non-technical executive summary (within the report), designed keeping in mind that it will be shared with non-experts.

The first revised draft report will be based on feedback received from the Evaluation Reference Group. This revised draft report will be externally assessed by an independent agency managed by the Regional Office for South Asia with the view to help improve its quality.

A second revised draft report incorporating feedback from the independent agency will be submitted to UNICEF. It may be noted that there may be more than one version of these draft documents, based on feedback from UNICEF and based on the satisfactory revision of reports.

7.9 Final Report and Presentation: Professionally edited and copy-edited final versions of the report with all feedback incorporated will be submitted to UNICEF. The report (including the executive summary) should be no more than 40 pages. The agency will also draft a separate 8-12 page 'mini-report' on an analysis of the gender and equity component of the MR communication process. The timeline for this deliverable will be the same as that of the evaluation report (which is why it has not been detailed in the chart on Section 9).

Along with these reports, a stand-alone PowerPoint presentation of up to 20 minutes with complete speaking notes with evaluation details will also be submitted to UNICEF. The PowerPoint presentation will be succinct and engaging with the goal of providing audience members with an overview of the communication processes, brief note on the methodology, key findings from the evaluation, lessons learned, and recommendations.

Cutting, pasting, and touching up bullet points, charts, and other information from the PowerPoint presentation into a Word Document does not equal a report and will be rejected.

Electronic copies of all data sets, including all materials required to permit additional analysis is to be submitted as well. This will include de-identified, clean, and labelled final datasets, with codebook variable names, data cleaning notes, and error logs.

8. Estimated duration of contract

Total Number of Months: 5 months

9. Deliverables

Each of the tasks and corresponding deliverables have been represented below against their delivery date/deadline for completion of deliverable. Note that the length, structure and content of the final report will be as per UNICEF Evaluation Report Standards (GEROS) and the main sections of report will be further discussed after inception report. The inception and the final report will be reviewed by the technical and evaluation managers. An Executive Summary is mandatory, and will be approved by an internal steering committee before the report can be finalised.

10. Qualifications & Experience Required

A qualified evaluation agency or research organisation (5-7 years old) with proven expertise in healthcare (specifically routine immunisation) is required for this evaluation. The organisation should have performed evaluations of similar scale and scope, have a track record of producing reliable data, linked to an effective system for internal quality assistance and ethical review. The organisation should be able to have or organise field presence in the five states (preferably in the ten selected districts) mentioned in section 2 of the Terms of Reference. The evaluation team should have knowledge of the local language of the 5 states. The composition of the evaluation team should ensure gender balance and cultural diversity.

The bidding agency should identify an evaluation team leader who should be available to work on the evaluation throughout the evaluation process. Change of the evaluation team leader or members during the course of the evaluation will not be accepted without prior approval of UNICEF.

It is for the bidding agency to pre-empt and explicitly mention any possible or potential conflicts of interest while submitting their proposal. This may include details on their involvement with the MR campaign, past or ongoing work, individual team member involvement etc.

The evaluation team leader should have the following,

- At least 10 to 15 years of extensive experience in designing, planning, organising, and conducting participatory and qualitative evaluations in rural India. Experience in the states of Assam (or the North East States), Gujarat, Maharashtra, Odisha, and Uttar Pradesh would be advantageous.
- Proven experience of leading an evaluation in the last three years.
- Demonstrated ability to produce high quality evaluation reports.

The team members must show the mix of skills adequate to meet the following requirements. While individual members of the team may possess several of the required competencies, the team together must possess all. The number of team members is for the bidding organisation to decide, subject to the competencies listed in section 10 of the Terms of Reference.

- Expertise in healthcare/immunisation, SBCC, and gender are essential.
- Expertise in conducting SBCC evaluations including programme evaluation research, sampling, data collection, instrument development, and data analysis.
- Expertise with both qualitative and quantitative research tools will be required. Especially with literature reviews, key informant interviews, and focus group discussion.
- Proficiency in English-language writing and presentation.
- Ability to travel and provide on-field technical assistance.
- Ability to collect data on field.
- Professional level skill in the working languages of the five states mentioned in section 2 of the Terms of Reference.

Note: If required, two or more agencies may join to make a consortium bid. However, the consortium will need to nominate one agency and individual as the clear point of contact with UNICEF.

11. Duty Station

Data collectors from the evaluating agency will need to be present in the five states where the evaluation is to be conducted. These are – Assam, Gujarat, Maharashtra, Odisha, and Uttar Pradesh. UNICEF has local presence in their state offices in each of these states.

12. Management and Supervision

Evaluation Management: Research & Evaluation Specialist, SPME, UNICEF
Technical Support: Alka Malhotra, Communication for Development Specialist & Elnur Aliyev, Communication for Development Specialist
Overall Technical Oversight: Siddartha Shrestha, Chief, Communication for Development

12.1 Management Arrangement: It must be noted that an Evaluation Reference Group will be formed to oversee the evaluation process and ensure compliance to United Nations Evaluation Group (UNEG) Norms and Standards. It is an independent group of UNICEF and non-UNICEF experts (consisting of technical experts, government representatives) constituted for a specific evaluation by UNICEF India. From the government, UNICEF envisions the empanelment of various officials, especially members of the national steering committee, state NHM mission directors etc. In addition, state C4D Specialists from each of the states being evaluated will be a part of the Evaluation Reference Group. This group will serve as an advisory body which will support the evaluation by 1. providing strategic direction and technical inputs, 2. monitoring progress and quality, 3. supporting dissemination of finding, as applicable, and 4. brining critical issues to the notice of the Monitoring and Evaluation Specialist.

12.2 UNICEF Responsibility: Management of this evaluation will be done by the evaluation manager appointed by the SPME section with technical support from C4D specialists. UNICEF India's C4D section will be responsible for providing the evaluation team with the necessary background information to carry out the evaluation as well as technical inputs throughout. UNICEF India will also keep the evaluation team updated on any changes or development that may affect the evaluation.

For local logistics, the UNICEF State offices will provide necessary support to the evaluation team, such as making introductions to key informants and stakeholders. However, the agency will ensure 'independent selection' of respondents in order to ensure that the responses received are not biased toward or against UNICEF.

The Supply and Procurement Section will remain the focal point for all administrative, financial, and commercial queries and correspondence, including contract amendments, if required.

12.3 Responsibility of the Evaluating Agency: The evaluation agency will be required to satisfactorily complete all the tasks mentioned in section 7 and all deliverables mentioned in section 9 as per the framework detailed in section 2, 5, and 6 of the Terms of Reference. The "satisfactory completion" of each of these tasks, is subject to Evaluation Reference Group's approval.

13. Official travel involved

The formative evaluation will be conducted in five states across India (as stated in section 2 of the Terms of Reference). These are; Assam, Gujarat, Maharashtra, Odisha, and Uttar Pradesh. The agency should preferably, have presence in the states. In addition, core team members from the selected agency will need to travel to UNICEF ICO for a kick-off meeting during the inception phase.

It is assumed that on-field data collectors will be locally recruited by the agency. Therefore, their training will be conducted by the agency individually in each state.

It must be clarified that travel cost shall be calculated based on economy class travel, regardless of the length of travel.

14. Deliverables / Payment Schedule

Payments will be made against the competition of each of the below mentioned milestones and deliverables. It must be noted that the completion of each of these tasks is subject to the Evaluation Reference Group's approval.

Milestone/Deliverable
Submission of Approved Inception Report (with Design Methodology and Study Design), including Workplan, Pre-Tested tools
Report of the completion of field work (Implementation Report) and the Analysis Plan Presentation
Presentation on top-line findings and submission of draft 1 of report
Submission of Final Evaluation Report (Technical and Non-Technical) and Presentation

Annexure A

Table 1: State-Wise MR Coverage in India (as of May 2019) *

States	%
Andaman & Nicobar	93.53
Andhra Pradesh	96.67
Arunachal Pradesh	101.06
Assam	98.04
Bihar	101.74
Chandigarh	97.01
Chhattisgarh	100.19
Dadra & Nagar Haveli	101.39
Daman & Diu	107.4
Goa	97.3
Gujarat	96.06
Haryana	99.04
Himachal Pradesh	101.88
Jammu & Kashmir	99.87
Jharkhand	96.77
Karnataka	98.83
Kerala	84.76
Lakshadweep	76.25
Madhya Pradesh	97.72
Maharashtra	95.92
Manipur	97.03
Meghalaya	94.73
Mizoram	99.92
Nagaland	97.8
Odisha	98.32
Puducherry	87.46
Punjab	95.98
Tamil Nadu	96.3
Telangana	101.63
Tripura	93.57
Uttar Pradesh	99.11
Uttarakhand	101.43

*Please note that this is administrative data provided by the Government of India. Coverage is calculated on the basis of planned target-population versus actual reach. Due to unforeseen population movement or inaccurate denominator estimates the recorded coverage may be above 100%

Annexure B

State	Date of Commencement of MR Campaign
Assam (and the North East States)	18 August 2018 (for NE states, started from Feb 2018 in Arunachal, Meghalaya last to start in Sept 2018. Sikkim planned in mid-2019)
Gujarat	16 July 2018
Maharashtra	27 November 2018
Odisha	29 January 2018
Uttar Pradesh	26 November 2018

Annexure C

PHASES AND TASKS	DELIVERABLES	W1	W2	W3	W4	W5	W6	W7	W8	W9	W10	W11	W12	W13	W14	W15	W16
PHASE 1: INCEPTION																	
Kick-Off Meeting		■															
Development of Inception Report		■	■														
Development of Evaluation Methodology	Inception Report			■													
Development of Study Design (Data Collection Tools)				■													
ERG Review and Feedback on Inception Report				■													
Ethics and Data Approvals	Submit Approvals (if any)			■													
Develop Work Plan	Work Plan Presentation				■												
Reporting Format	Submit Reporting Format				■												
Pre-Test Tools (including CBPR Techniques)	Submit Tools				■												
Local Evaluator Training	Conduct Training					■	■										
PHASE 2: DATA COLLECTION AND ANALYSIS																	
Weekly Progress Reporting	Reflected on the Field Reporting Dashboard						■	■	■								
Updated Field Plans and Reporting	Implementation Report							■									
Analysis Plan	Analysys Plan Presentation								■								
All Raw Data	Original, in Electronic Format									■							
PHASE 3: REPORT WRITING AND DISSEMINATION																	
Preliminary Findings	Preliminary Findings Presentation									■							
ERG Review and Feedback										■							
Draft 1 of Analysis Report	Report										■						
ERG Review and Feedback												■					
Draft 2 of Analysis Report	Report												■				
ERG Review and Feedback														■			
Draft 3 of Analysis Report	Report														■		
ERG Review and Feedback																■	
Final Evaluation Report	Final Report																■
Final Presentation	Final Presentation																■
All Data Collected & Analysed	In Electronic Format (Hard Drive)																■

5. EVALUATION TOOLS

Participant Information Sheet

Study Title:	**Formative evaluation of communication processes used for the National Measles Rubella vaccination campaign, for inclusion in Routine Immunization**
Evaluation Site(s):	5 States-Assam, Gujarat, Maharashtra, Odisha, Uttar Pradesh,
Study Duration:	6 months
Start of Data Collection:	February 2020

Reason for the Research Study
Namaskar, my name is ______________________. I am from a research organization named CMS (Centre for Media Studies). We are carrying out an evaluation for UNICEF on child health and Immunization. We are undertaking this research study to identify people's opinion about child health and vaccination you are your exposure to communication on vaccination. We are talking to parents and caregivers of children of 9 months -15 years age / the service providers like you in five states. The information obtained from this study will be useful to improve the government's work to reach out to the communities more effectively in the future.

How You Were Identified
We got your name from the AWW/ASHA/neighbour and you are eligible to participate in this discussion. This discussion will take about 60 minutes to complete and we will have participation of 7-9 more eligible individuals from your community.

Your Role in the Evaluation
Your role in this discussion is very important. During this discussion, you are encouraged to talk freely about your awareness, exposure to information and practices related to vaccination. You will be telling us about the current sources of information on MR Campaign and identify the preferred communication person and channel for you to receive information about immunization in future .You can also share the barriers that you face in accessing immunization information and services.

Confidentiality
The information that you share with us will not be viewed by any of your peers or anybody else. This discussion will be audio recorded so that we can revisit the information while writing the report. It is possible that others will learn of your participation in the study, which may make you feel embarrassed or uncomfortable, but measures will be taken to protect your confidentiality. No personally identifying information will be collected, and recordings will be kept in secure locations in locked cabinets and on password-protected computers with limited access to study personnel only.

Possible Risks
During the survey, you may share with me, who are strangers, some information that is of a personal nature. Some questions may embarrass you, and you do not have to answer any question that you do not want to. We do not expect extra risk during the study. However, in case of any discussion related risk, injury, or any discomfort you feel, you will be referred to suitable facility and counselling services.

Potential Benefits
You may or may not directly benefit from the study. However, by participating in this study, you will be able to share with us valuable information and opinion, which will assist us in planning for better communication content and channels, which addresses the needs identified by you and your community.

Compensation
We cannot pay you for the time you will spend on the discussion but we hope you will agree to take part because your experience and opinion will help to address anything that makes immunization more effective.

Voluntary Participation &Right to Refuse or Withdraw from Research Study
The participation in this research study is voluntary, and you are free to refuse to participate. If you agree to participate, you can decide not to answer certain questions or even decide to withdraw from the discussion at any time. If you choose not to participate, or withdraw, this decision will not affect you or your family in any way. If you have any questions or concerns about taking part in this research study, please feel free to talk to me and I will be happy to answer your questions to the best of my abilities. You can also ask questions at any time of the interview/discussion. You can take this consent form back if you want to review it further.

Persons to Contact
If you have any questions now or later about this study in general, please talk to the interviewer who is available with you now. If you are not satisfied with their answers, you can also request the interviewer/researcher to put you in contact with Ms. Paramita Dasgupta, at Centre for Media Studies, New Delhi; Tel: 011- 26864020.

Informed Consent Form (TO BE READ BY THE PARTICIPANT)

I have read this consent form completely/ this consent form has been read out to me completely.

I/we understand that I have been asked by CMS (*Centre For Media Studies)* to participate in a study to investigate the awareness about immunization information and services, and I willingly agree to respond to the questions based on my level of comfort.

I/we understand that during this study I/we will be enquired about my/our awareness, exposure to information and practices related to immunization, current and preferred communication sources to receive information about immunization and that the responses will be recorded. My participation in the study will be kept confidential, and my identity will be available only to those the researchers for the study.

I understand that there may be some questions asked during the interview that may make me uncomfortable. I realize that I do not have to answer any question that I do not want to answer. I am aware that I am free to withdraw my consent and discontinue participation in this research project at any time for any reason and that would not affect me or my family in any way.

I realize that I may or may not benefit directly from this study. However, my participation and opinion will help better planning of immunization program in future. All my questions related to the study have been answered to my satisfaction.

I have read this consent form or have had explained to me to my satisfaction the information relating to this study. I understand what my participation will involve and agree to take part in this interview under the terms of this agreement. I have had the opportunity to ask questions about it, and my questions have been answered to my satisfaction. I consent voluntarily to participate in this study and I understand that I have the right to withdraw at any time, without it in any way affecting my family or me.

Date ___________________

Signature or thumbprint ________________________

Investigator Name ___________________________

Date ____________________________Signature ________________________

Guideline for Key Informant Interviews: STATE/DISTRICT
(Govt. Representatives from Dept of Health, HRD, WCD, & UNICEF)

Hello, I am___________, and I will be conducting your interview today. I would like to thank you for sparing your time. We are part of CMS (Centre for Media Studies). As you are aware that we have been assigned by UNICEF to carry out a formative evaluation of Measles Rubella Vaccination Campaign. We seek to understand the communication processes adopted in this campaign and how effective they were in reaching out to people to get their children vaccinated. These discussions would be free flowing and there are no wrong answers. I am interested in hearing your opinions and different points-of-view. Your opinions and points-of-view are very important to us – so please feel free to share them with us. I will be recording this discussion so that we do not miss out anything while documenting. First please give us a brief about yourself and your background.

Name	
Designation/ Organisation/Dept	
State/District	
Roles/Responsibilities	
Years in the position	

1. Tell us about how MR campaign was implemented in your state? What was your role in the MR campaign?
2. How was an **enabling environment** built? Who all were involved? What **role** did each of them play? Who and when did you **partner** with for the campaign? What were their roles in communication processes? What was unique in the partnership? Why do you say so? What is the evidence?
3. How effective was the **preparedness assessments** conducted before the launch of the campaign? What kind of changes were made after the preparedness assessment was conducted?
4. Please tell us about the **different elements** of communication that you planned for your state? Can you please share the **communication plan** of your state (UNICEF/State IO).
5. What **gaps i**n communication was identified in the state? How did the **local context** inform the communication plan and processes?
6. Which part of the communication plan **targeted men**? What all activities were planned to involve men in your state/district? What were key elements that were kept in mind **while involving men** or incorporating gender in the plan? How do you know that they were sufficiently involved and all were reached? Kindly share any data on this.
7. Which part of the communication plan targeted **vulnerable population**? What all activities were planned to involve vulnerable population in your state/district? How do you know that they were sufficiently involved and all were reached? Can you share any data on this?
8. How was social media activity managed and monitored in your region?
9. Which elements of the communication plan **engaged the communities**? How were they engaged? How did you ensure that the parents understand that the vaccine is for both boys and girls and that both the child are brought for vaccination? What evidence do you have to share on increased participation of vulnerable/minority community than before?
10. While designing the plan at various levels what were the **challenges** that were brought on table? The challenges that you had foreseen? How were they addressed? What were some of the **unforeseen challenges** that affected implementation and how did you overcome them? Are there any dormant challenges that have not been addressed yet? (Probe if not mentioned by respondent: myths, involvement of men, vulnerable communities, tribal community, religious community, urban schools, negative media reporting, negative social media etc.)
11. Now let us talk about the communication materials that were used in your state. How **relevant were the national IEC** materials to your state? What all did you use and adapt? What kind of **new materials** were developed at the state level/district? Who were they meant for? Why? How were they disseminated? Can you please share copies of these?
12. Out of all the **strategies** that you applied in your state to achieve 100% coverage which strategies were most successful and which ones were ineffective?
13. Was **resource allocation** planned to cater to different groups and their contexts? Please give us some examples. Also share the percentage of budget that were allocated for different formats and channels and groups.
14. What role did the allocated resources play to ensure good delivery of messages (because fund was sufficient you could think of expansion, or you compromised on process/logistics, design, human resource, media channels etc. because it was insufficient) Give us examples of how **optimally** was the allocated resources used to deliver messages? (piggy ride) Why do you think that the fund was sufficient/not sufficient to meet the communication objectives you set for the state?
15. How have the different community based institutions (both social & political- VHSNC, PRI, SHGs, Youth Clubs etc.) being involved in the MR campaign? In future which of these would you collaborate with for improved coverage of RI? Which of these need strengthening? Which community based institutions were left out that you would like to collaborate with?
16. What **support** would the government/UNICEF require for implementing a similar campaign in future to ensure better coverage of immunization?
17. What are the **lessons learnt** that can be considered, adopted in future for better implementation of RI in future? Anything else you want to tell us?

Thank you so much

Guideline for Key Informant Interviews: Partners

(WHO, UNDP, Immunization Technical Support Unit (ITSU), Media, IAP, IMA, Local Lion & Rotary Clubs, local celebrities)

Hello, I am___________, and I will be conducting your interview today. I would like to thank you for sparing your time. We are part of CMS (Centre for Media Studies). As you are aware that we have been assigned by UNICEF to carry out a formative evaluation of Measles Rubella Vaccination Campaign. We seek to understand the communication processes adopted in this campaign and how effective they were in reaching out to people to get their children vaccinated. These discussions would be free flowing and there are no wrong answers. I am interested in hearing your opinions and different points-of-view. Your opinions and points-of-view are very important to us – so please feel free to share them with us. I will be recording this discussion so that we do not miss out anything while documenting. First please give us a brief about yourself and your background

Name	
Designation/ Organisation/Dept	
State/District	
Roles/Responsibilities	
Years in the position	

1. Tell us about how MR campaign was implemented in your state? What was your organization's role in the MR campaign?
2. How was the **partnership** planned and implemented? What was unique in the partnership? Why do you say so? What were the challenges faced? How did you overcome them?
3. How was an **enabling environment** built? Who all were involved? What **role** did each of them play? What were their roles in communication processes? What was unique in the partnership? Why do you say so? What is the evidence?
   How effective was the **preparedness assessments** conducted before the launch of the campaign? What kind of changes were made after the preparedness assessment was conducted?
4. Please tell us about the **different elements** of communication that you planned for your state? Can you please share the **communication plan** of your state?
5. What **gaps i**n communication was identified in the state? How did the **local context** inform the communication plan and processes?
6. What **resources** did your organization apply in this campaign? How they were optimally used to achieve the objectives of the campaign?
7. How was social media activity managed and monitored in your region?
8. Which part of the communication plan targeted **vulnerable population**? What all activities were planned to involve vulnerable population in your state/district? What are the evidence regarding the **extent of outreach** among vulnerable communities? Can you share any data on this?
9. Which elements of the communication plan **engaged the communities**? How were they engaged? What evidence do you have to share on increased participation of vulnerable/minority community than before?
10. How was **gender and equity** incorporated in the communication process? What were the key elements that were kept in mind while incorporating gender and equity?
11. Which part of the communication plan **targeted men**? What all activities were planned to involve men in your state/district? What were key elements that were kept in mind **while involving men** or incorporating gender in the plan? How do you know that they were sufficiently involved and all were reached? Kindly share any data on this.
12. How did you ensure that the parents understand that the vaccine is for both boys and girls and that both the child are brought for vaccination?
13. How were married adolescents and first time mothers reached out to by the campaign?
14. During implementation, what were the challenges faced? What were some of the challenges that you had foreseen? How were they addressed? What were some of the unforeseen challenges that affected implementation? How did you overcome them? Are there any dormant challenges that have not been addressed yet?
15. What were the different kinds of media formats used for various stakeholders? How were they modified in the local context? Which form of media was most relevant? Which form of media was ineffective? What were the alternate forms of media adopted in places where mainstream media is unavailable?
16. Which part of the communication process considered inclusion of vulnerable community? What were the activities conducted to involve the vulnerable communities? What kind of IEC materials were developed for vulnerable communities? What were the unique challenges faced while communicating to the vulnerable/minority communities?
17. How have the different community based institutions (both social & political- VHSNC, PRI, SHGs, Youth Clubs etc.) being involved in the MR campaign? In future which of these would you collaborate with for improved coverage of RI? Which of these need strengthening? Which community based institutions were left out that you would like to collaborate with?
18. What support would the government/UNICEF require for implementing a similar campaign in future to ensure better coverage of immunization?
19. What are the lessons learnt that can be considered, adopted in future for better implementation of RI in future? Anything else you want to tell us?

Thank you so much

Guideline for Focus Group Discussion with ASHA, ANM and AWWs

Hello, I am___________, and I will be conducting your interview today. I would like to thank you for sparing your time. We are part of CMS (Centre for Media Studies). As you are aware that we have been assigned by UNICEF to carry out a formative evaluation of Measles Rubella Vaccination Campaign. We seek to understand the communication processes adopted in this campaign and how effective they were in reaching out to people to get their children vaccinated. These discussions would be free flowing and there are no wrong answers. I am interested in hearing your opinions and different points-of-view. Your opinions and points-of-view are very important to us – so please feel free to share them with us. I will be recording this discussion so that we do not miss out anything while documenting. First please give us a brief about yourself and your background

Name	
Designation	
District	
State	
Years in the position	
Date of Interview	

1. Can you please tell us about how MR campaign was **implemented** in your region? How were you involved in it? What role did each of you play?

2. How did you **plan** for the campaign at the **sub-centre level**? What were some of the factors you kept in mind while creating the plan? What were some of the issues faced while planning the campaign?

3. Now tell us about the training that you received. What were the areas covered in the training? What was the most important part in your training? Which elements were new for you all? How relevant was the crisis communication planning and preparedness (Adverse event following immunization)? Why do you say so?

4. What were some of the **expected challenges** related to MR Vaccine in your region? How did you plan to tackle them? What were some of the **unforeseen challenges** that affected implementation? What kind of myths and misinformation with regard to MR vaccine existed in the community that you work? And how did you overcome them? Are there some pockets in your area who resisted MR Vaccine? What are the reasons for doing so?

5. Which are the vulnerable population/communities in your area? How did you plan to reach them? What were the **communication strategies** used to reach out to them? How were married adolescents and first time mothers reached out to by the campaign? (Any specific strategies that you worked out for reaching them?)

6. Which elements of communication plan **engaged the communities**? How were the community engaged in the process? What were the activities conducted to involve the vulnerable communities? Which strategies were most successful and which ones were ineffective? How do you know that these activities resulted in increased participation of the vulnerable communities in getting their child MR vaccinated? What was the proportion of boys and girls who got vaccinated? Who got vaccinated? More girls or more boys? Why do you think this happened?

7. How were **men involved** in the campaign? What strategies were used to reach out to them? What kind of response did you receive? How did you ensure that the **parents understand** that the vaccine is **for both boys and girls** and that both the child are brought for vaccination?

8. What kind of **IEC materials** were used to reach out the various communities? Which form of media was most relevant? Among all these what reached to majority of the community members? How do you say so? Which form of media was ineffective? What were the alternate forms of media used in places where mainstream media is unavailable?

9. How have the different community based institutions (both social & political- VHSNC, PRI, SHGs, Youth Clubs etc.) being involved in the MR campaign? In future which of these would you collaborate with for improved coverage of RI? Which of these need strengthening? Which community based institutions were left out that you would like to collaborate with?

10. What are the **lessons learnt** that can be considered, adopted in future for better implementation of RI in future? Anything else you want to tell us?

Thank you so much

Guideline for Focus Group Discussion with Communities
(Parents and caregivers)

Hello, I am___________ from CMS (Centre for Media Studies) conducting a study in 5 states on health. Thank you for sparing your time. We have been conducting discussions with mothers and fathers of children of 9 months 15 years of age. We are here to talk about health of children and your exposure to information on vaccination. There is no right or wrong in what you say. Please respond one by one as each of your opinion is important to us. I will be recording this discussion so that we do not miss out anything while documenting. First please give us a brief about yourself and your background. (Table later)

1. We have a stack of message cards and a chart paper. We would like you to discuss amongst yourself and **arrange the cards on the basis of the topic that you know most about (high knowledge) to what you know least about (low knowledge)**. (CARDS WITH VACCINE NAME ON THEM)

Chart paper for activity

	Arrange - HIGH to LOW knowledge	Get where?	Disease prevented	Information Source	Preferred source
1					
2					
3					
4					
5					
6					
7					

CARDS of Vaccine: BCG (TB) , Hepatitis B (Hep B), Oral and Inactive Polio Vaccine (OPV & IPV), Rotavirus, Pentavalent, Pneumococcal Conjugate Vaccine (PCV), Measles Rubella, Japanese Encephalitis, Vitamin A, Tetanus Toxoid (TT)
Name of Diseases : Tuberculosis, Hepatitis B, Polio, Rotavirus Diarrhoea, Diptheria, Pertusiss, Tetanus, Influenza type B , Hep B, Pneumonia (one of many diseases), Measles and Rubella, Japanese Encephalitis, Night blindness, Tetanus

Probe and explore:

a) Where do you get your child's vaccinations done? When?

b) Can you now tell us what diseases are prevented by each of these? (Repeat for each vaccine they identified)

c) Source of information: Where did you get the information from? (Media channels -TV, Radio, WhatsApp, pamphlet, FLWs- ANM, AWW, AHSA, School teacher, Children in school, PRI members, Leaders, Hospital, friend, spouse, etc.)

d) What are the barriers and challenges -
   - in accessing immunization services
   - in accessing information on immunization

2. Why is it important to prevent Measles and rubella? What can happen to your child if you do not give this vaccine? How do you think you can you prevent your child from getting measles and rubella?

3. In the past 1 year which are the ones that you have been exposed to- among the one that you all listed? Where? (Flipbook, pamphlet, poster, radio, video, etc.).

4. **Content & recall**: What information was shared? Can each of you recall and tell us about the messages that you got on MR?

5. **Crisis communication & misinformation**: How many of you know about what may happen as an after effect of the MR Vaccine? What do you know about it? Where did you come to know about this? What should one do in such cases?

6. **Believability:** Did you believe this message on MR vaccine that was told, shared, or shown to you? Who all believed in what was told, shared, shown to you on MR Vaccine? If yes, please raise your hands. Why do you say so? Why did you **believe what was told to you? Why did you have doubts or not believe** what was told to you? (prevailing myths if any versus messages)

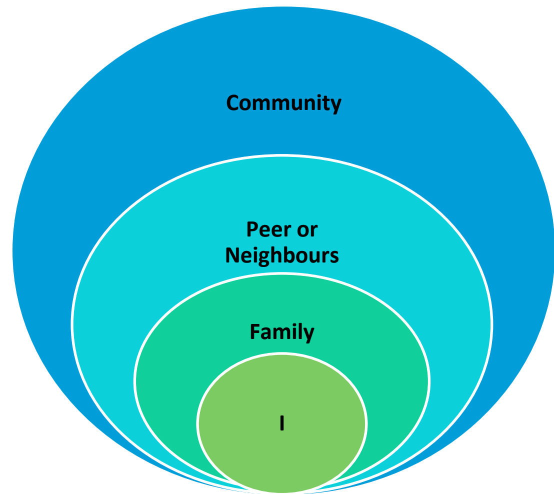
7. **Involvement & activities**: What all activities happened in your village/colony/basti before the vaccination camp? Who were the activities meant for? *Mothers, fathers, only vulnerable groups?* How were you involved? What role did you play? Who all in the community did not participate in the campaign? Can you tell us what all were they thinking? *Why do you say so?*

CBPR

Note to Facilitator: *You will lead the participants of the FGD through the creation of "maps" of concentric circles (see example below) depicting the people they talk to about immunizing their children and more specifically about the Measles-Rubella Campaign. The smallest circle will be marked as "I". Subsequent circles will be marked as family (people residing in the immediate household), peers (extended family relations and neighbours) and community members (Health workers, PRI members, religious leaders, school teachers, etc.) Using the questions below, you will ask the respondents to reflect upon the people who provide them with information (such as helping or advising) related to topic.*

Materials needed: *Chart paper, coloured pens*

8. Take a couple of minutes and think about who all you speak to about your child's health in general? Since we are talking about measles and rubella and vaccination, please try to recall and answer the questions accordingly



   - **a.** Who in the household decides whether the child gets vaccinated or not? Who else? Who else? What are the reasons put forth for vaccination or avoiding vaccination? What were the apprehensions? How did these affect the decision of getting the child vaccinated?
   - **b.** Who in your family did you talk to when you got to know about the measles rubella vaccination campaign? What did you talk about? What activities did you do with them to make them understand about MR vaccine? How were you related to the people you talked to about the vaccine?
   - **c.** Who among the neighbours did you interact regarding the MR campaign/vaccine? What did you discuss?
   - **d.** Who among the village/community did you interact regarding the MR campaign/vaccine? What did you discuss?
   - **e.** Who were the other people in the community who discussed MR vaccine? *(If not taken the name of Teacher, AWW, ASHA, NGO worker, Doctor etc) then Ask)*
     - Can you tell us anything about your interaction or meeting with school teachers on MR vaccine? What did you talk about?
     - Can you tell us something about your interaction with ASHAs and AWWs? What did you talk about?
     - Who are the people you were not comfortable talking with about vaccination of child?
     - Who were the people you were comfortable talking to?
     - Among all the sources of information, which was your most preferred one and why?
     - Who is the person whom mothers and fathers listen to when it comes to your child's health and future?

9. **Vaccinated or not**: How many of you took your child for vaccination please raise your hand? Why? Beside your concern for your child's health, what else motivated you to get your child vaccinated? Mention any key message/ information from the activities that encouraged you to get the child immunized?

10. **Those who did not go for vaccination:** please tell us why did you not take your child for MR vaccination? What stopped you from doing it? What would have motivated you to get your child vaccinated?

11. Why did some people in your community/school resist this MR vaccine?

Thank you so much for your time