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ABOUT RHIZOME21





1%

TO GO

As of 2016, the number of wild polio cases has been reduced by 99% globally since the beginning of the Global Polio Eradication Initiative in 1988. The challenges for the final push are fundamentally unlike those we have had success with so far. They are more complex and challenging, almost by definition. If they weren't, we would have already succeeded in eradicating polio.

INTRODUCTION

WHAT IS THE POLIO COMMUNICATION GLOBAL GUIDE?

The Polio Communication Global Guide is a how-to manual for planning and building effective mass media and interpersonal communication strategies with the ultimate goal of eradicating polio. This document outlines UNICEF's global approach to polio communication informed by data and on-the-ground experience with a focus on reaching the hardest-to-reach populations in the final polio reservoirs of the world. It provides a comprehensive strategic framework and identifies the key steps of planning and executing an effective and adaptive polio communication response from mass media all the way down to interpersonal communication.

WHO IS THIS FOR?

The Polio Communication Global Guide is designed for UNICEF country and regional officers, their communication counterparts, GPEI partners, or government counterparts. Whether you are reacting to the initial report of a poliovirus outbreak and need to get the word out quickly or managing a protracted outbreak and need a more nuanced communication approach that can address campaign fatigue or localised immunisation resistance, this guide provides the guidance and resources you need to reach your target audience with creative and effective communication.



HOW TO USE THIS GUIDE

First, review the [GLOBAL COMMUNICATION STRATEGY](#) section to understand the rationale behind the approach. Next, identify the polio phase of the outbreak corresponding to your country setting—[OUTBREAK](#), [ENDURING OUTBREAK](#), or [MAINTENANCE](#)—and visit that module of this guide. The guide is organised into these phases because the initial weeks and months of a new outbreak have very different communication needs than during the later stages of an outbreak, in an Enduring Outbreak area, or in a Maintenance phase.

Within the guide, planning tools, audience segmentation, and information about barriers to vaccination help clarify appropriate communication priorities. Sample creative concepts tailored to specific situations provide guidance on creating targeted mass communication, while messaging gives direction for how to connect those concepts through a comprehensive approach, ranging from mass media all the way down to interpersonal communication (IPC).

A STRATEGY ROOTED IN DATA

Previous polio communication strategies often utilised risk communication and targeted individual caregivers with facts about polio and polio vaccination. The new polio strategy is specifically designed to address the dynamic perceptions and social norms that deter caregivers in the remaining **1%** of the world from vaccinating their children.

Our shift to social norm communication is grounded in recent polling research on populations affected by polio in endemic and outbreak contexts, and their responses to polio eradication efforts. Primarily, this research shows the prevalence of destructive social norms in high-risk areas.

For instance, in the Bannu district of Khyber Pakhtunkhwa, Pakistan, **99%** of internally displaced persons from North Waziristan district supported polio vaccination, but only **60%** believed that other recent arrivals shared this belief. Similarly, in Nigeria, over **90%** of caregivers in the eight high-risk states felt that giving polio drops to children was a “very good idea;” however, when asked about how their neighbours, parents, and other community leaders felt about polio vaccination, caregiver perceptions about social support for polio vaccination dropped by half in some cases. On average, only about **56%** of caregivers felt that their own parents (the child’s grandparents) supported vaccination.

The new polio strategy is specifically designed to address the dynamic perceptions and social norms that deter caregivers from vaccinating their children in the remaining 1% of the world’s polio-affected countries.

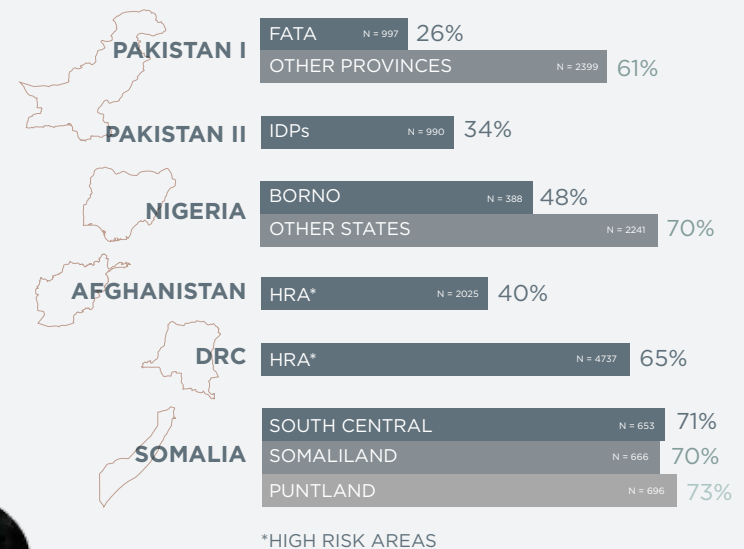
In conflict-affected areas, caregivers' perceived social support for vaccination dropped even further. In high-risk areas, caregivers also exhibit reduced trust in the polio programme and in health workers.

...in the Bannu district of Khyber Pakhtunkhwa, Pakistan, **99%** of internally displaced persons supported polio vaccination but only **60%** believed that other recent arrivals shared this belief.

In the FATA province of Pakistan, only **26%** of caregivers trusted the health worker who came to their doorstep “a great deal” compared to **61%** in the rest of the country—a proportion that is relatively higher but still lower than the programme would hope. In Afghanistan’s lowest-performing districts, only **40%** of caregivers trust their health worker “a great deal” (**Figure 1**).

The same research in high-risk areas also revealed that a caregiver’s perceptions of a health worker’s moral intentions and competence might contribute to the prevailing lack of trust. In FATA, only **27%** of caregivers felt that health workers were concerned with the well-being of children and even fewer, **19%**, felt that health workers were

FIGURE 1: Percentage of surveyed caregivers from the highest-risk areas who “trusted vaccinators a great deal”



(UNICEF/Harvard Opinion Research Polling Data, 2015).



knowledgeable (**Figure 2**).

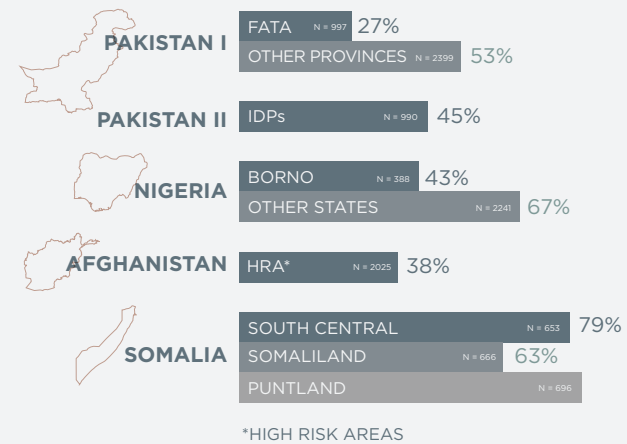
A similar observation was made in Afghanistan, where only **38%** felt that health workers were concerned about children’s well-being and **40%** felt that health workers were knowledgeable (**Figure 2**).

Furthermore, findings highlight the powerful, detrimental influence of anti-vaccinators in high-burden areas. In FATA, Pakistan, **48%** of caregivers reported exposure to a destructive rumour regarding polio vaccination, and **33%** believe these rumours as of December 2014 (**Figure 3**). Consistent with these findings, just across the boarder in Afghanistan’s low-performing districts, these figures are **60%** and **38%**, respectively (**Figure 3**).

Negative perceptions and rumours can lead to vaccine refusals and are highly detrimental in concentrated areas of unvaccinated children. These clusters pose a significant threat to eradication efforts because they can incite new outbreaks or prolong existing ones. Shifting communication to address negative health worker and programme perceptions as well as prevailing social norms around vaccination should effectively increase vaccine uptake in high-risk areas and bring the world closer to being polio-free.

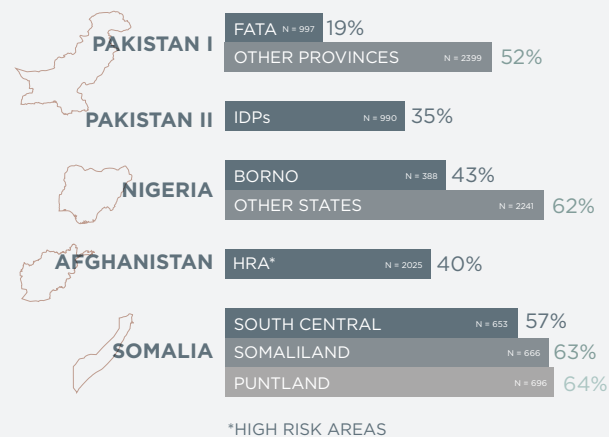
It is important to remember that communication to support positive perceptions of the health worker and programme can only be successful when complemented with qualified, properly trained, paid, and motivated health workers.

FIGURE 2: Percent of surveyed caregivers from the highest-risk areas who think vaccinators were "very knowledgeable"

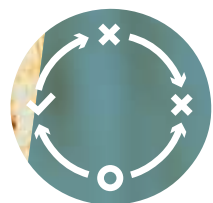


(UNICEF/Harvard Opinion Research Polling Data, 2015).

FIGURE 3: Percent of caregivers from the highest-risk areas who believe at least one destructive rumour about oral polio vaccine is at all true



(UNICEF/Harvard Opinion Research Polling Data, 2015).



GLOBAL COMMUNICATION STRATEGY

THIS SECTION CONTAINS:

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THE STRATEGY FOR POLIO COMMUNICATION

The eradication of polio depends on the success of our health workers (e.g. community health workers, social mobilisers, and vaccinators), and their success in the field revolves around a single pivotal moment: the short, interpersonal interaction between health workers and caregivers. Therefore, our strategy is twofold: to promote all vaccination, including polio, as a social norm that everyone adheres to and to build trust and goodwill for health workers by humanising them in all of our communication.

These strategic objectives should frame all topline communication, while supportive approaches and messages still provide caregivers with the information they need to make the right choice and allow their children to be vaccinated.

The normalisation of vaccination and positive perception of health workers are codependent: perception of health workers will be affected by perception of vaccination and vice versa. It's crucial that communication both redefines the impression of health workers and normalises vaccination, only then can polio be eradicated.

TWOFOLD STRATEGY



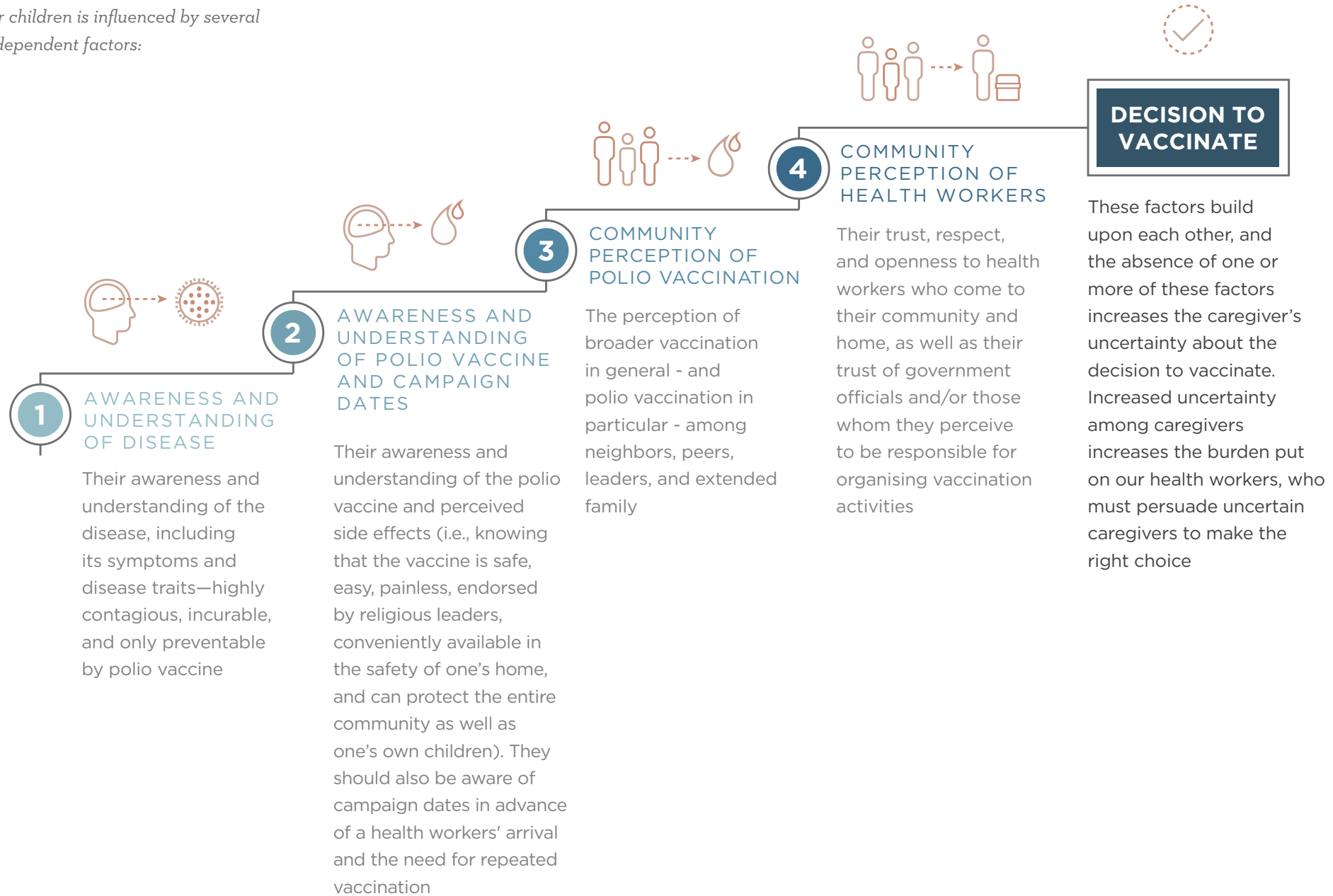
1. Promote vaccination (including polio) as a social norm



2. Build trust and goodwill for health workers by humanising them in communication



A caregiver's decision to vaccinate his or her children is influenced by several interdependent factors:



GUIDING PRINCIPLES

There are three principles that all of our polio materials and communication must adhere to:

PRINCIPLE ONE:

Understand and leverage social perceptions, norms, and beliefs related to polio and polio vaccination.

PRINCIPLE TWO:

Humanise our health workers by emphasising their social and emotional depth.

PRINCIPLE THREE:

Continuously refine communication to maintain authenticity and credibility for the target audience(s).

Health workers should be featured prominently within our communication, and they should be portrayed as:

- *Trustworthy*
- *Admirable*
- *Compassionate*
- *Helpful*
- *Professional*



PRINCIPLE ONE: UNDERSTAND AND LEVERAGE SOCIAL PERCEPTIONS, NORMS, AND BELIEFS RELATED TO POLIO AND POLIO VACCINATION.

A caregiver's decision to vaccinate takes into account more than just information and facts about polio. As research has indicated, caregivers look to the perceptions, norms, and beliefs of their neighbours and communities when they make the critical decision about whether they will give their child repeated vaccination. These beliefs and norms are often rooted in cultural, political, or historical contexts. Communication can directly address these social factors.

By communicating about beneficial behaviours as normal, we engage these perceptions directly, and, over time, can begin to change them. This kind of engagement works because it builds upon previously communicated information and facts regarding polio, and describes what action to take in response to said facts. For uncertain caregivers, engagement around social norms lets them know they are making the same choice as their peers. These techniques apply to mass communication, social mobilisation, and IPC.

USING SOCIAL NORMS TO CHANGE BEHAVIOUR

Norms are the rules of behaviour that are considered acceptable in a group or society.

There are two types of norms: descriptive or injunctive.

DESCRIPTIVE NORMS

A descriptive norm is a statement that describes a behaviour.

- Communicate a new, desired descriptive norm to the audience to change perceptions of what is normal behaviour. For example, “the majority of parents vaccinate their children” is a descriptive norm.
- Create a sense of physical proximity between the norm and the audience by tying the message to their location and situation when possible. For example, “the majority of parents in Kandahar vaccinate their children” will improve the performance of the message in Kandahar.

INJUNCTIVE NORMS

An injunctive norm is a statement that describes the social “attitude” toward a descriptive norm.

- Attach injunctive norms to the message whenever applicable to support the descriptive norms and establish social approval or disapproval. For example, “the majority of parents in Kandahar vaccinate their children because they know it is the right thing to do” combines a descriptive norm (what the majority of parents do) with a proximity creator (in Kandahar) and an injunctive norm (that these parents believe it is the right thing to do).



PRINCIPLE TWO: HUMANISE OUR HEALTH WORKERS BY EMPHASISING THEIR SOCIAL AND EMOTIONAL DEPTH.

Direct and positive contact with a health worker (i.e., at the household or a health centre) is the primary way for us to educate caregivers and communities about our polio vaccination efforts. Humanising our health workers (i.e., showing them as relatable, familiar, knowledgeable, and concerned about children's health) makes them easier to understand and trust as individuals, which makes it easier for caregivers to say yes to the polio vaccine. The best way to humanise health workers in communication is by portraying them as members of families, communities, and society as well as emphasising their emotional depth by sharing their personal stories.

BUILDING TRUST

As communication professionals, we seek to build trust between the health worker and the caregiver. There are four important values that are part of UNICEF's strategic approach and have been shown by evidence to build this trust.

- 1. GENUINE CONCERN FOR CHILDREN:** The caregivers and community need to feel that health workers and the programme demonstrate genuine empathy for the children they are serving.
- 2. MORALITY:** Those who work for the programme should be considered moral, non-discriminatory, harmless, and respectful of appropriate gender/cultural considerations for service delivery.
- 3. HONESTY:** The programme and health workers should be seen as honest, transparent, and having no ulterior motives. The vaccine and its ingredients should be presented as safe, transparent, and efficacious.
- 4. COMPETENCE:** Health workers and related programme workers should be considered knowledgeable about health and the vaccine. They should also be viewed as competent in their jobs. The vaccine should be considered an effective tool to prevent polio.



PRINCIPLE THREE: CONTINUOUSLY REFINE COMMUNICATION TO MAINTAIN AUTHENTICITY AND CREDIBILITY FOR THE TARGET AUDIENCE(S).

Communication should feel real, believable, and emotional to the target audiences. To achieve this, communication should sync with the phase of the epidemiological situation and must employ authentic cues and details that show as much as it tells. This is especially crucial if there are significant ethnic, cultural, or religious divisions within the country or region you are working within.

Good ways to pre-test for authenticity is to analyse the people and scenes depicted in your communication, and ask members of the target audience for their feedback either through focus groups or in-depth interviews. Members of the target audience should get a distinct impression of who the people are and what is happening in the scene based purely on the characteristics and setting portrayed in the communication.

AUDIENCE QUESTIONS:

Use the questions below and on the following page to understand how an audience member views communication and to help tailor materials to appear real and authentic.

GENDER ROLES

- What are men and women doing in the photos used?
- What are their roles, jobs, social classes, and ages?
- How would a member of the audience recognise this? Which elements would they point to in order to explain their answers?

ETHNICITY AND CULTURAL PRACTICES

- How are various ethnic groups represented, and does this send the intended message to the audience?
- Do the characters have a cultural significance to the target audience, and, if so, is this good or bad?
- What language and dialect do the characters use to communicate, and do they align with the audience's preferences?
- How would a member of the target audience perceive this? Which elements would they point to in order to explain their answers?

THE RELATIONSHIPS BETWEEN PEOPLE IN THE COMMUNICATION

- What kinds of relationships are on display, including romantic, professional, and familial?
- Who is portrayed most positively?
- Are individuals with polio, as well as all children, depicted and portrayed with respect and dignity?
- Who is portrayed as a decision maker?
- How would a member of the target audience perceive this? Which elements would they point to in order to explain their answers?

CONTINUED »





» AUDIENCE QUESTIONS CONTINUED

TYPES OF WORK AND PLAY

- Are the characters at work or at play?
- What kind of work are they doing?
- Where does this work position them in the social hierarchy?
- How would a member of the audience recognise this? Which elements would they point to in order to explain their answers?



RELIGION

- What religion are the characters?
- How faithful are they?
- Is that faith portrayed positively or negatively and how is this implied?
- How would a member of the audience recognise this? Which elements would they point to in order to explain their answers?



SETTINGS, COSTUMES, AND PROPS

- Are these elements harmonious or disruptive to the characters as defined by their other symbolic roles?

AUDIENCE INVOLVEMENT

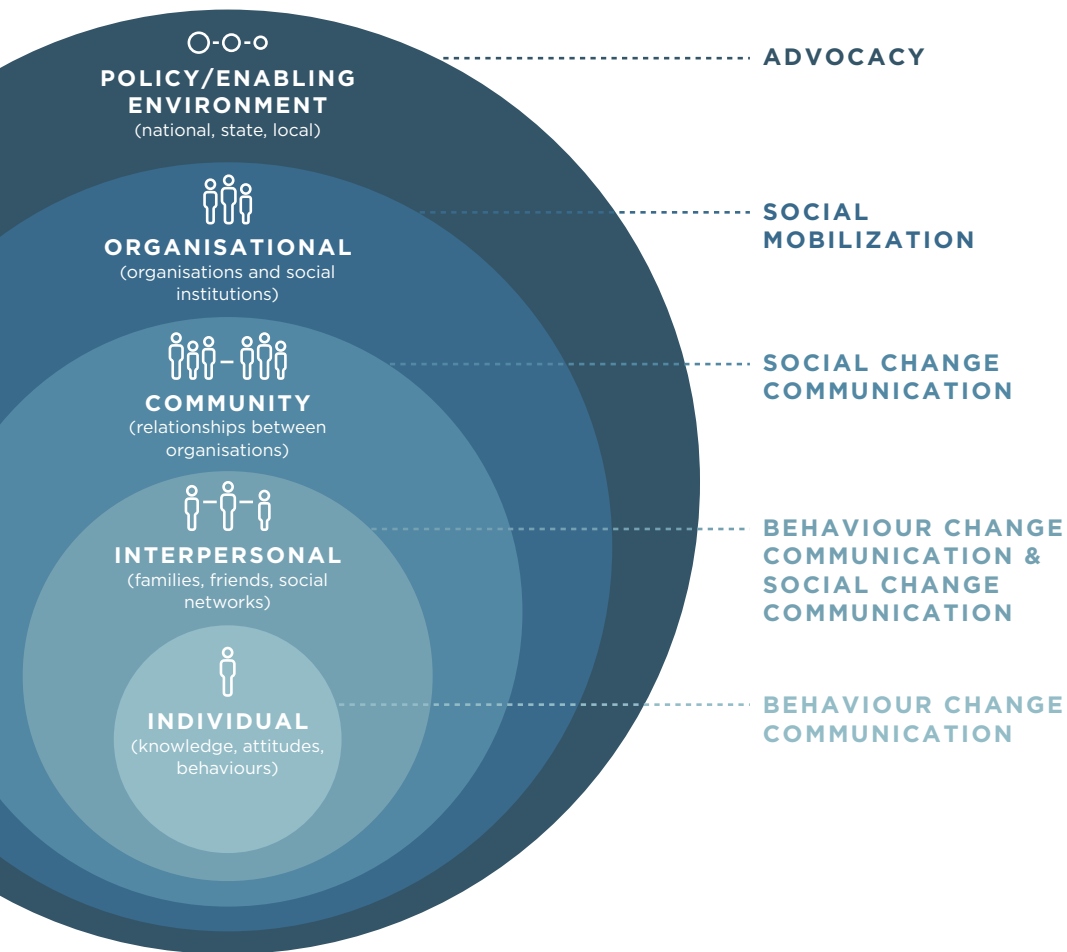
When attempting to answer questions of this nature, it is important to recognise the power of participatory design. In participatory design, members of the target audience weigh in on the creation of tactics and materials to optimise programme authenticity and efficacy. Often, consulting audience members early on in the development process can help save time and resources.

CREATE ADAPTIVE COMMUNICATION

Audiences are dynamic, with constantly changing perceptions, attitudes, and behaviours within a complex social system. Polling and other research mechanisms should be put in place to capture these constantly changing perceptions. To respond effectively to emerging data and evidence, our communication must also be dynamic and continually adapt to variances in social and audience norms.

When constructing and adapting your communication tactics, consult the Social Ecological Model (SEM). The SEM is a framework used by UNICEF to understand and address norms that influence individual, collective behaviours and societal norms, such as the acceptance or rejection of the polio vaccine. The model outlines five levels of society: individual, interpersonal, community, organisational, and policy/enabling environment. See [ELEMENTS OF SEM](#) (page 15).

During the development of norm-based behaviour change communication, consider possible interventions at all five of the framework's levels. Utilising a cohesive approach will help ensure communities and decision-makers at local, national, and regional levels are engaged in dialogue toward promoting, developing, and implementing policies and programmes that enhance the quality of life for all.



The SEM is a framework used by UNICEF to understand and address norms that influence individual, collective behaviours and societal norms.

POLICY/ENABLING ENVIRONMENT

Local, state, national, and global laws and policies, including policies regarding the allocation of resources for maternal, newborn, and child health and access to healthcare services, restrictive policies (e.g., high fees or taxes for health services), or lack of policies that require childhood immunisations.

ORGANISATIONAL

Organisations or social institutions with rules and regulations for operations that affect how, or how well, for example, mother, newborn, and child health (MNCH) services are provided to an individual or group.

COMMUNITY

Relationships among organisations, institutions, and informational networks within defined boundaries, including the built environment, village associations, community leaders, businesses, and transportation.

INTERPERSONAL

Formal (and informal) social networks and social support systems that can influence individual behaviours, including family, friends, peers, co-workers, religious networks, customs, or traditions.

INDIVIDUAL

Characteristics of an individual that influence behaviour change, including knowledge, attitudes, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic identity, sexual orientation, economic status, financial resources, values, goals, expectations, literacy, stigma, and others.

Use the guiding principles to create adaptive communication that highlight the role of the health worker.

1

REACHING THE LAST 1%

It's very different from the first 99%

GUIDING PRINCIPLES



Understand and leverage social perceptions, norms, and beliefs related to polio vaccination



Humanise health workers by emphasizing their social and emotional depth



Continuously refine communication to maintain authenticity and verisimilitude

2

FROM INDIVIDUAL TO SOCIAL

Getting community support



Every vaccination comes down to a single touch point:

THE HEALTH WORKER

When it comes to their success, TRUST IS EVERYTHING

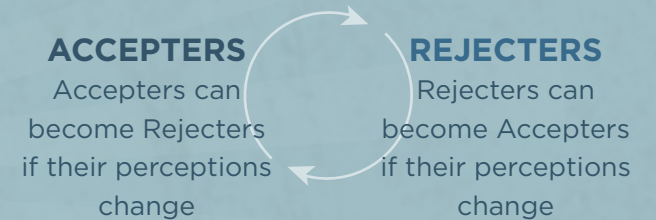
3

FROM STATIC TO DYNAMIC

Adapt communication to changing needs

ADAPTIVE COMMUNICATION

AUDIENCE



SCENARIOS



ENDEMIC



MAINTENANCE



OUTBREAK

Different scenarios have different communication needs

APPLYING THE STRATEGY

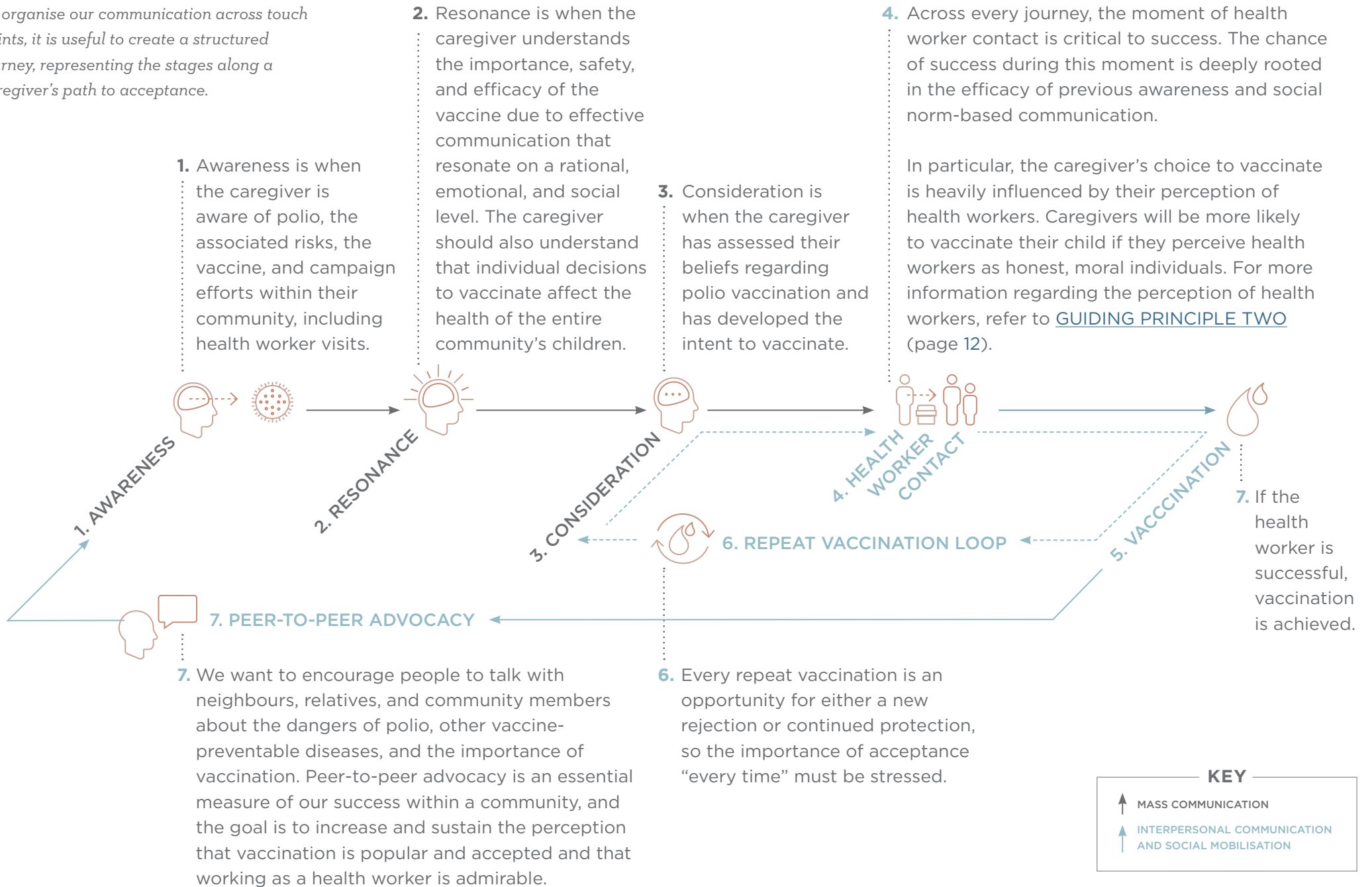
Now that you know UNICEF's communication strategy—promote all vaccination, including polio, as a social norm, and build trust and goodwill for health workers by humanising them—our goal is to use this strategy to increase the uptake of valuable, life-saving services, such as the polio vaccine. To do this, we need to build social demand for vaccination, and present the health workers as trustworthy, admirable, compassionate, helpful, and competent across all of the touch points and caregiver-targeted messages.

To organise communication across touch points, it is useful to create a structured journey. This journey was created using both empirical findings and the framework of the theory of reasoned action (TRA).

TRA focuses on an individual's intent to perform a specific behaviour, such as the intent to vaccinate, and how attitudes and societal norms contribute to this intent. The journey on the following page is composed of touch points that influence a caregiver's intent to vaccinate their child. Communicating effectively across all touch points will increase a caregiver's intent and, ultimately, increase the likelihood of success.



To organise our communication across touch points, it is useful to create a structured journey, representing the stages along a caregiver's path to acceptance.



IMPLEMENTING THE BRAND

WHAT IS A BRAND?

A brand is the unique combination of name, term, sign, symbol, or design that represents a product, service, or company and how it relates to key stakeholders: customers, staff, partners, and investors. While most are typically used in marketing to identify and differentiate consumer products, the benefits of a clear, recognisable brand extend to other categories, including public health.

At its core, a brand isn't just a logo or name. Rather, it is a promise from the branded entity to its intended audience about what to expect from every interaction or touch point.

As we go about the work of ending polio and beyond, it's important that we connect that effort with a clear, recognisable brand that can become associated with certain values over time. This association is the value, or equity, a brand carries. Apple products, for example, are "easy to use and stylish." For many organisations the brand and associated trademarks become the single most valuable asset on the balance sheet. Coca Cola's brand, for instance, is worth more than all their factories.



Coca-Cola

unicef 

Familiar trademarks are valuable because, over time, they take on the values of the products, services, and organisations they represent.

WHAT DOES A BRAND DO?

BRANDING FOSTERS RECOGNITION.

People feel more comfortable interacting with other people and entities that are familiar to them. In the case of childhood immunisation, we are asking caregivers to give us access to their children, and a strong trustworthy brand makes it easier for them to say yes at the point of contact.

A BRAND TELLS PEOPLE WHAT YOU STAND FOR.

The full brand experience—from visual elements, such as the logo, to the way our frontline workers greet caregivers at the door—works together to tell a positive narrative about immunisation and children's health.

A BRAND PROVIDES MOTIVATION AND DIRECTION FOR YOUR OWN PEOPLE.

A strong brand strategy provides the clarity of purpose that our health workers need to be successful. It gives them guidance on how to act and meet their goals.

A STRONG BRAND HELPS PEOPLE KNOW WHAT TO EXPECT.

A consistent and clear brand puts the caregivers we need to reach at ease because they know exactly what to expect each and every time they experience the brand.

A BRAND HELPS YOU CONNECT EMOTIONALLY.

Children's health is emotionally charged, and having a strong brand helps people feel good at an emotional level at the point of contact.

A consistent and clear brand puts the caregivers we need to reach at ease because they know exactly what to expect each and every time they experience the brand.



From mass communication, to the moment of contact between the health worker and caregiver, and into social mobilisation, every brand touch point builds on the next to provide a comprehensive and enduring impression.

BEFORE THE KNOCK

Mass-reach media and community engagement rebrands the effort to build trust with the health workers while expanding the conversation from polio to children's health.



THE INTERACTION

Support the moment of contact by equipping the health workers with tools to help professionalise them and build rapport with the communities they serve.



AFTER THE KNOCK

Community discussion provides feedback and input to the next campaign, while engaging leave-behinds help influence social norms about vaccination.



ABOUT THE GUARDIANS OF HEALTH BRAND



To brand the health worker effort, we've created the Guardians of Health name and logo. The diamond holding shape of the symbol contains a pair of stylised drop shapes. The larger drop seems to be cradling the smaller inverted drop in a symbolic expression of care. This mark acknowledges the heritage of oral polio vaccine while also pointing the way to the future of a post-polio health service offering.

This logo additionally signifies a new way forward and a new energy around the effort in markets that have experienced fatigue with current polio communication efforts.

Guardians of Health speaks to the role of both the health workers and the caregivers of the children we serve. It may be translated into whatever the dominant language is in your region.



If market research suggests a growing mistrust or general apathy around the current branding, then a shift to the new brand mark is recommended. When simple consumer research indicates that there are low levels of awareness, negative attributes connected to the current logo and branding, or simply fatigue with recurring visuals, that is a signal that a change needs to be made.

However, in non-fatiguing markets or markets in which the current brand has strong connectivity with an existing stakeholder (EPI, government, partnership, etc.), it's best to maintain consistency. If this is the case, the existing brand mark should be used throughout all touch points.

Implementing a new brand mark is also recommended if broader programmatic elements are changed. For example, after diagnosing and assessing gaps in service to improve your programme, shifting to the new brand mark will represent these changes and help distance the programme from any negative perceptions previously held by the audience. It is also a way to introduce new evolutions to the polio programme that may span beyond polio vaccination, such as health camps or other polio plus activities.

The logo is the most commonly visible touch point of the Guardians of Health brand and one of our most valuable assets. We must ensure proper usage. Throughout this guide, we look at the key elements that go into representing the Guardians of Health brand.

The Guardians of Health brand is used at all touch points between the health worker and caregiver. From the print ads seen around a village, to the clothing worn by health workers, to informational handouts, the brand is included seamlessly on each communication. This creates consistency and continuity across all of our touch points.

See [CONNECT ACROSS TOUCH POINTS](#) on page [24](#) for how the strategy should be applied throughout all tactics of your communication programme. See the next page for guidance around how to use the Guardians of Health logo.

Our logo is the most commonly visible touch point of the Guardians of Health brand and is one of our most valuable assets.

LOGO USAGE

SPACING

Please observe clear space around the logo to maximise visual effectiveness. Nothing should intrude into this specified clear space. The amount of required clear space is 10% of the diamond's original size.



LOGOTYPE

The logotype is positioned below (vertical layout), or to the right (horizontal layout) of the symbol, and may not be repositioned.



SYMBOL

When used together, the relationship between the diamond holding shape and the drop icons must not be altered.



**GARDIENS
DE LA SANTÉ**

*When adapting for other regions,
adapt for local relevancy.*



*Do not
disproportionately
resize*



*Do not add
stylistic
effects*



*Do not place
over image
or patterned
background*



Do not rotate

BRAND ELEMENTS

Every scenario (see page 27) and region will have unique needs in terms of how to appropriately represent the creative ideas that will translate the strategic imperatives into motivating behaviour change. While the specific details of the communication will differ, we have developed a flexible system that can help provide consistency within each area.

CONCEPT FRAME

The key visual and main message that are the emotionally resonant go in the concept frame.

BRAND BAR

The Brand Bar serves two purposes:

1. To contain the functional content necessary to communicate operational aspects of the programme, including supporting text, government endorsement, logo, and immunisation dates, and health centre locations.
2. To give visual consistency across phases of the communication campaign. While the themes, messages, content, and visual style contained in the Concept Frame may change over time, the look and feel of the Brand Bar stays the same throughout the duration of the communication effort.



The dimensions, colour, and even specific arrangement of the elements within the Brand Bar are flexible and can be tailored to your needs. To the extent possible, once you have established the Brand Bar in your region, you should try to keep it consistent, especially within phases of a communication campaign. However, if your creative concept demands a specific treatment, you should feel free to tailor. Here we show transitioning from an Outbreak concept to an Enduring Outbreak concept. The ideas and design elements are very different, but the basic architecture is consistent.

COLOUR PALETTES

One of the ways we adapt our campaigns to ensure local relevance is through colour. National flags have rich symbolism and meaning behind them intended to resonate with the people who live in the countries they represent, so we take inspiration from them in developing additional palettes.

We've included a sampling of palettes taken from a list of at-risk countries. If your country or region is not included here, you can use these examples as a guide for identifying appropriate colours.

Primary colours should serve as the basis for all creative materials, while analogous colours should be used as highlights or accents.

NIGERIA & PAKISTAN



PRIMARY COLOUR

CMYK • 90 33 95 25
RGB • 0 106 58
PANTONE • 356U
HEX • 006a3a

ANALOGOUS COLOUR 1

CMYK • 38 1 31 0
RGB • 157 210 188
PANTONE • 572U
HEX • 9dd2bc

ANALOGOUS COLOUR 2

CMYK • 69 13 36 0
RGB • 73 170 169
PANTONE • 320U
HEX • 49aaa9

CAMEROON, MALI, ETHIOPIA, & GUINEA



CMYK • 1 31 92 0
RGB • 249 181 46
PANTONE • 7549U
HEX • f9b52e

CMYK • 0 56 71 0
RGB • 245 139 87
PANTONE • 144U
HEX • f58b57

CMYK • 2 7 91 0
RGB • 254 225 45
PANTONE • Yellow U
HEX • fbd116

AFGHANISTAN, IRAQ, SYRIA, & LAOS



CMYK • 12 98 85 2
RGB • 208 40 53
PANTONE • 711U
HEX • d02835

CMYK • 1 31 92 0
RGB • 249 181 46
PANTONE • 7549U
HEX • f9b52e

CMYK • 1 73 47 0
RGB • 239 107 110
PANTONE • Red 032U
HEX • ef6b6e

EQUATORIAL GUINEA & UKRAINE



CMYK • 82 60 2 0
RGB • 59 106 175
PANTONE • 661U
HEX • 3b6aaf

CMYK • 42 0 16 0
RGB • 142 210 214
PANTONE • 7471U
HEX • 8ed2d6

CMYK • 67 1 9 0
RGB • 36 190 223
PANTONE • 311U
HEX • 24bedf

Just as our operational and vaccination strategies differ according to the epidemiological situation, our communication strategies must also differ according to a community's polio scenario and related social perceptions. Our efforts against polio take place across three potential scenarios: Outbreak, Enduring Outbreak, and Maintenance.



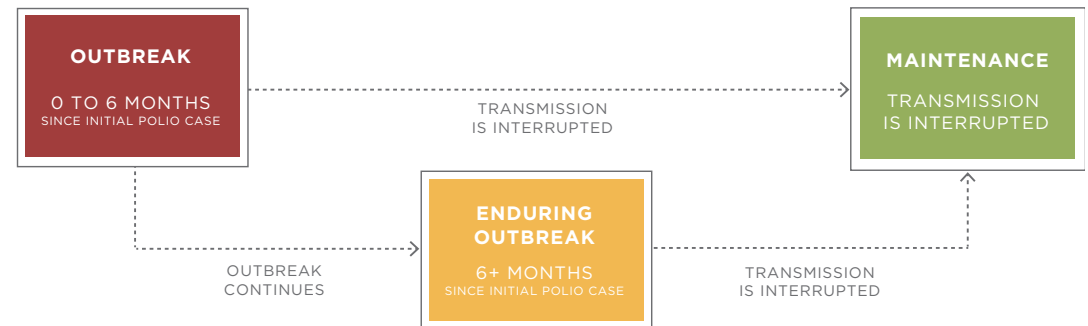
IDENTIFYING YOUR SCENARIO

THIS SECTION CONTAINS:

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OUTBREAK.....	29
ENDURING OUTBREAK	30
MAINTENANCE	31

WHICH SCENARIO DOES YOUR COUNTRY FACE?

Analyse your country setting and then visit the corresponding scenario module to tailor your communication approach.



OUTBREAK PAGE 29

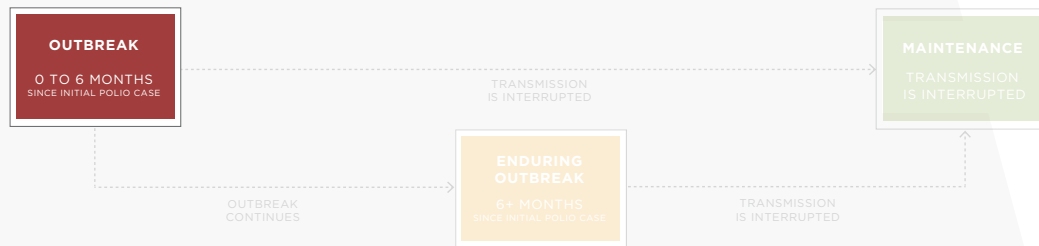
We define an outbreak as one or more cases of polio in an area that had previously been polio-free for a minimum of six months. The primary factor in an outbreak is the existence of a critical mass of vulnerable children who must be swiftly vaccinated before the virus can spread. Maximising vaccination coverage and minimising the duration of the outbreak response is the focus. The key exacerbating factors in outbreaks are the absence of strong routine immunisation practices and basic public health infrastructure.

ENDURING OUTBREAK PAGE 29

If the initial response to an outbreak fails to interrupt transmission of the virus within six months, or if a transmission has never been interrupted, we consider the outbreak to be an Enduring Outbreak. Endemic countries fall in this category. The focus for this programme is to combat barriers to polio immunisation and transition into a Maintenance Scenario.

MAINTENANCE PAGE 29

The Maintenance Scenario comes after an outbreak is closed or after an endemic country is declared polio-free. Continued monitoring and vigilance are necessary to prevent a resurgence of the disease or an increase in the population of unvaccinated children. The overall emphasis of the programme must also transition from a singular focus on polio to an overall focus on routine immunisation and health.



PHASE 1 (0-3 MONTHS)

1. Run Immediate Response Communication (IRC) to raise awareness and understanding of disease and vaccine.

PRIMARY AUDIENCE

- Accepters
- (90% of population)

SAMPLE COMMUNICATION

“UNITE” *Sound the alarm on polio outbreak*



PHASE 2 (4-6 MONTHS)

1. Analyse the root causes of missed children.
2. Make polio communication a social norm and normalise repeated doses through Adaptive Phase Communication.

PRIMARY AUDIENCE

- Rejecters
- (10% of population)

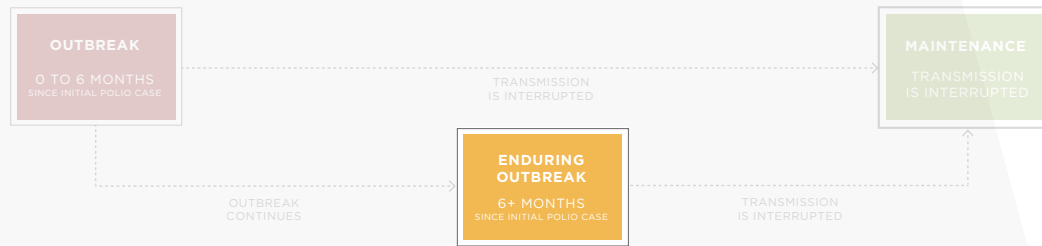
POTENTIAL BARRIERS

- Fatigue of OPV effort
- Mistrust of vaccine
- Mistrust of health worker



SAMPLE COMMUNICATION

“UNITE” *Make polio immunisation a social norm*



ENDURING OUTBREAK

After six months of an outbreak or if polio transmission has never been interrupted

1. Conduct a root-cause analysis of the failure to interrupted polio transmission (Enduring Outbreak Guide, page 7)
2. Once causes are identified, run communication to combat barriers to immunisation and communication fatigue.

PRIMARY AUDIENCE

- Rejecters
- (10% of population)

SECONDARY AUDIENCE

- Accepters experiencing OPV efforts fatigue

OTHER COMMUNICATION TACTICS

While mass communication will help in reaching and motivating Accepters experiencing OPV efforts fatigue, additional Interpersonal Communication will be needed to reach the hardcore Rejecters.

These tactics include but are not limited to:

- Use of celebrity/influencers
- Health worker training with IPC themes ([Enduring Outbreak Guide, page 24](#))
- Community meetings

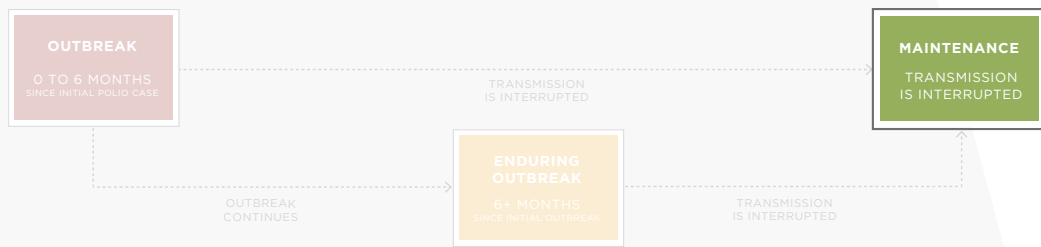
SAMPLE COMMUNICATION

“WE ARE ALL INTERTWINED”

Make polio immunisation a social norm

“STRANGERS NO MORE” Humanise health workers





MAINTENANCE

After an outbreak has closed, or after a country has been declared polio-free.

1. Run communication to maintain immunisation levels, helping to make vaccination a social norm.
2. Run communication to keep humanising health workers.

PRIMARY AUDIENCE

- Accepters

SECONDARY AUDIENCE

- Rejecters of other vaccines, not including polio

OTHER COMMUNICATION TACTICS

While mass communication will help in reaching and motivating Accepters experiencing OPV efforts fatigue, additional Interpersonal Communication might be needed to reach the hardcore Rejecters.

These tactics include but are not limited to:

- Use of celebrity/influencers
- Health worker training with IPC themes ([Enduring Outbreak Guide, page 24](#))

SAMPLE COMMUNICATION

“WE ARE ALL INTERTWINED”

Make polio immunisation a social norm

“BEST AMONGST ALL”

Celebrate the health workers



ABOUT RHIZOME



All of the material in this Global Guide can be found on [Rhizome.com](https://rhizome.com)

WHAT IS A RHIZOME?

Rhizomes are underground plant systems that produce stems and roots. By continuously establishing new connections, the whole plant system grows, thrives and regenerates both above and below ground, even in the most challenging conditions. Rhizomes are resilient, flexible and dynamic – rooted in their local environments, and primed for long-term sustainability.

WHAT CAN I FIND ON RHIZOME.COM

Inspired by this ecosystem of adaptation, innovation and sustainability, an online resource – Rhizome – has been designed to bring together data, quality guidance, tools and standards for polio Communication for Development (C4D) strategies. Rhizome hosts electronic versions of the materials and tools included in this Global Guide, as well as the latest communication campaign materials and templates which can be adapted for new country contexts. Additional guidance, best practices and tools to help countries implement high quality C4D programmes can also be found on Rhizome.

For outbreak contexts, the SOP pages digitize the Global Polio Eradication Initiative's Standard Operating Procedures for Outbreak response and includes valuable resource documents for outbreak responders.

Better strategies, better tools and access to best practices can improve results so no child is needlessly paralyzed by polio again.

Rhizome is an initiative of the GPEI and is managed and maintained by the polio team of the United Nations Children Fund (UNICEF).