

FRAMEWORK FOR DEVELOPING AN

Integrated Communication Strategy for the Introduction of Oral Cholera Vaccine in Cholera Prevention and Control Programmes



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ACRONYMS

BCC	Behaviour Change Communication
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
C4D	Communication for Development
CFSC	Communication for Social Change
CSO	Civil Society Organization
FAQ	Frequently Asked Questions
FGD	Focus Group Discussion
GSM	grams per square meter (measure of paper thickness)
HH	Household Head
HW	Health Worker
IPC	Interpersonal Communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IRC	International Rescue Committee
ITN	Insecticide Treated Bednet
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interview
LLIN	Long Lasting Insecticide Treated Bednet
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
NYHQ	New York Headquarters

OCV	Oral Cholera Vaccine
ORS	Oral Rehydration Salts
PRCA	Participatory Rural/Urban Communication Appraisal
PAR	Participatory Action Research
PLA	Participatory Learning in Action
PSA	Public Service Announcement
Q&A	Question and Answer
ROSA	Regional Office for South Asia
SEM	Socio-Ecological Model
SMART	Specific, Measurable, Attainable, Relevant and Time-bound
SMS	Short Message Service
STD	Sexually Transmitted Disease
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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This document is a product of ongoing collaboration among UNICEF, Johns Hopkins University (JHU), International Rescue Committee (IRC) and International Medical Corps (IMC) to develop communication guidance and tools on oral cholera vaccine (OCV) for governments, implementing agencies, communities and media.

This document was prepared by Teresa Stuart with guidance and support from the Communication for Development team at UNICEF headquarters. Drafts of the document were reviewed by staff from UNICEF country, regional and headquarters offices, the Centers for Disease Control and Prevention, the International Federation of Red Cross and Red Crescent Societies, the International Medical Corps and the International Rescue Committee.

NOTE

This document is designed for use in the field. While this version is complete, it has not yet been field tested and is therefore considered interim. Suggestions for improvements from teams using this guide in the field will be integrated into a final version.

Comments should be sent to: choleratoolkit@unicef.org



Background

Cholera is an intestinal infection caused by the ingestion of the bacterium *Vibrio cholerae* (*toxigenic strains of serogroup O1 and O139*). It spreads through contaminated water or food. Outbreaks are linked to crowded living conditions, inadequate or unprotected water supply, poor sanitation and hygiene, conditions that are rampant in many developing countries. The risk of cholera outbreaks intensifies during crises where essential services may be destroyed or disrupted, e.g., in the aftermath of an earthquake, and transmission exacerbated displacement, crowding and weather related spread due to floods or storms. Measures for preventing cholera are based mainly on provision of clean water, proper sanitation and education on proper water, sanitation and hygiene practices. But once an outbreak occurs, timely and sustainable control, treatment and management measures to mitigate further spread of the disease become a challenge among all partners, involving different sectors.¹

¹ WHO (2010). Oral Cholera Vaccines in Mass Communication Campaigns: Guidance for planning and use. Geneva, Switzerland, p. 3

Oral Cholera Vaccine (OCV) presents an [additional approach](#) for cholera prevention and control to supplement but not to replace existing priority cholera control measures.² Two OCVs are currently prequalified by WHO: Dukoral® and Shanchol™. As Shanchol™ is less expensive, is easier to use in the field and provides longer protection it is more commonly used in emergency setting than Dukoral® and this document will focus on Shanchol™. While the main communication strategies are the same for Shanchol™ and Dukoral® some technical details differ. If Dukoral® is to be used in the OCV campaign in your area, please contact your headquarters technical specialist for further information.

Shanchol™ has a two-dose regimen with a minimum 2 weeks between doses. It provides at least 5 years of protection for the general population. It is currently licenced for use in the population over 1 year of age.

This OCV Communication Framework aims to support cholera-prone and outbreak countries to develop their national and sub-national communication strategy for OCV uptake and cholera prevention, control and management.

It is intended for use in both development and emergency contexts as a pre-emptive/ preparedness measure in cholera endemic countries as well as for immediate response (reactive) when an outbreak occurs. Based on a risk assessment, an integrated approach that includes OCV vaccination will target geographic areas and communities that are particularly vulnerable, especially marginalized populations, crowded and unhygienic settings, urban slums, refugee and displaced sites, and communities that lack access to safe water, sanitation and hygiene, and health services. In endemic contexts, WHO recommends prioritizing young children eligible for vaccination (over 1 year of age) because they have the greatest risk of dying, followed by other at-risk groups, e.g., individuals with HIV, those with moderate or severe malnutrition and older populations. However, during epidemics all eligible age groups are targeted.

² UNICEF (2012). Guidance Note on the Use of Oral Cholera Vaccines. New York, USA, p. 1

This Framework is based on recommendations from the UNICEF and WHO Communication [Framework](#) for New Vaccines and Child Survival, the [UNICEF Guidance Note](#) on the use of Oral Cholera Vaccines, the WHO Guidance for [Planning OCV Mass Immunization Campaigns](#), with addendum³ and the [UNICEF Cholera Toolkit](#) particularly Chapter 7 on Communicating for Cholera Preparedness and Response.

Intended users

This resource aims to strengthen national capacity to proactively plan and implement a communication strategy to introduce oral cholera vaccine as an additional approach to more effectively prevent endemic cholera cases (pre-emptive) as well as to be prepared to respond to (reactive) seasonal cholera outbreaks.

The intended users of this resource are:

- Programme managers of national immunization programmes
- Members of the national and sub-national communication technical working group,
- National communication and immunization officers, managers and consultants
- Partners implementing of communication, health, WASH, nutrition and education
- Communication officers from UN and other international development agencies
- Media partners

The Framework is designed to supplement traditional communication tools and guidelines for cholera prevention and control available for governments. This resource offers additional practical guides and tools for effectively planning and managing communication activities to integrate oral cholera vaccine in different settings.

3 WHO Addendum to OCV in mass immunization campaigns (2013): Addendum Guide: Vaccination for Shanchol.



Goal and Objective of OCV Communication

The goal of OCV communication is to achieve broad and sustained uptake among cholera-prone populations of oral cholera vaccine as integral to other cholera preventive, treatment and management actions.

The specific behaviour objective of OCV communication is to increase the number of children, women and men from the most at risk, vulnerable and hard to reach populations to complete the required two doses of cholera vaccinations as an additional preventive measure against cholera.



Part 1 features steps and guidelines that can help you and your team to develop the communication strategy and action plan.

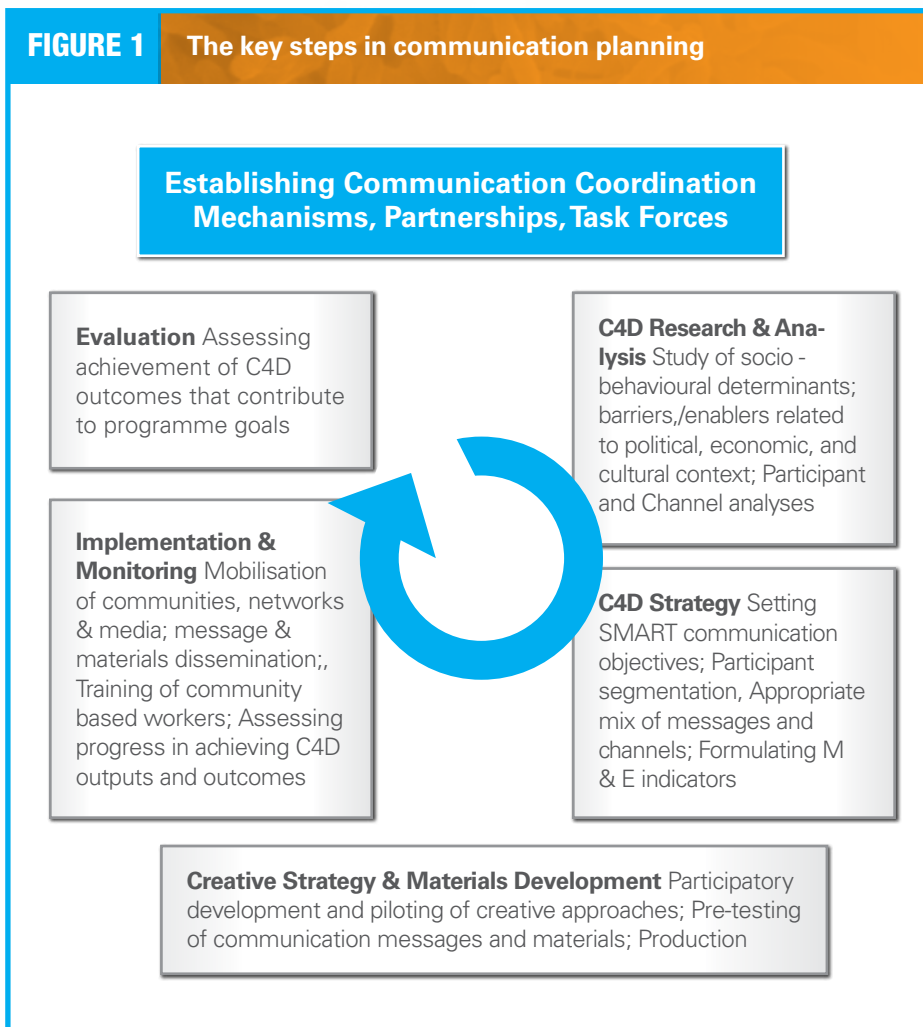
Part 2 offers some tools and resources such as examples of communication materials, how-to guides, suggested templates and sample formats for planning.

The hyperlinks, footnotes and the reference list can also help you, as the communication planner/manager, to effectively advise and oversee specific communication tasks in the strategy that are usually subcontracted to individual consultants and institutional contractors.

The communication planning process

In developing interventions, communication practitioners typically follow a series of steps based on common elements from well-established communication models and planning frameworks. This is summarized in the following steps as illustrated in [Figure 1](#). This may be used as basis for an outline of a communication strategy document. Ideally, the initial analytical steps should be undertaken prior to an emergency as they can be time consuming.

FIGURE 1 The key steps in communication planning





STEP 1: Establish a communication team and coordination mechanism

The success of communication efforts for cholera prevention and OCV introduction depends on the effective coordination of a working group responsible for its assessment, planning, implementation and monitoring. Before initiating any assessment (or research) and planning steps, map and assess communication partners and allies including media organizations. Based on set criteria, it is also suggested to have in place a Communication Sub-committee for Cholera at the national level working as part of the National Cholera Coordinating Committee, or the Immunization Coordinating Group (ICG), or National Immunization Technical Advisory Group (NITAG), whichever exists in a country.

The Ministry of Health and the ministry responsible for WASH usually have equal representation in the National Cholera Coordinating Committee. Whichever agency serves as national coordinator for public health related programmes usually appoints the head of its health education, hygiene promotion and communication division as members of the inter-agency cholera communication sub-committee. Member agencies also appoint the person responsible for health education and communication to the sub-committee.

At the provincial or district level, establish communication teams that will plan, manage, implement, monitor and report on the communication intervention.

For each mechanism, there should be a clear understanding of terms of reference, roles and responsibilities. To integrate OCV into cholera communication, the National Cholera Communication Sub-Committee and the Provincial/District Cholera Communication Teams should be:

1. Functional and active
2. Able to coordinate and work quickly to assess and advise on communication needs of intended audiences
3. Familiar with the communication plan and its implementation
4. Prepared with key messages in the form of ready-to-go press statements, FAQs, Q&As and fact sheets for media and spokespersons and IPC tools for health workers and community groups
5. Able to engage, orient and mobilize spokespersons and champions, media partners, other partners and allies.

Member agencies of the national level communication sub-committee and the communication teams at each administrative level should be strategically selected based on their institutional capacity to undertake and manage advocacy, social mobilization, community engagement, media relations and resource mobilization. Individual members should possess technical knowledge and management skills in the communication strategy development process - assessment, strategy formulation for advocacy, social mobilization and community engagement, media relations, and monitoring and evaluation - and with experience in applying these competencies in the health, immunization and WASH sectors.

STEP 2: Conduct a rapid communication assessment

Before you start planning, conduct a cholera situation assessment. In many settings the team will conduct this assessment, in some settings it may be possible to hire a research agency to do the assessment. The objectives of an assessment should include gathering and analysis of secondary and primary data to describe the scope and status of the cholera problem: who are affected, where they are located, the programmes and resources that are/ or should be in place to prevent and control cholera among affected communities, including political will to use OCV.

Continue the assessment by determining the potentially problematic behaviour/s to address. Describe the participant or audience groups, their existing behaviours and practices, the channels that are available, accessible and preferred by each audience or participant group. Try to identify how these might change during an emergency.

What are the social, cultural and other determinants to sustained adoption of OCV and other cholera preventive and control measures? List the barriers and motivators to desired behaviours that will need to be addressed by the communication intervention.

- Who are the primary audience groups or those directly affected? Who are the secondary audience groups whose actions can support the primary group to adopt desired actions? Who are the tertiary audience groups who need to be addressed through advocacy?
- What are people doing or not doing that lead to the problem or make them prone to cholera?
- Who suffers most from the problem?



Follow this with a channel assessment:

- What channels and media are available and preferred by different participant groups? In which format – print, radio, TV, internet, mobile phones, interpersonal, group?
- Which mix of channels is best suited to participant groups' engagement in the cholera programme that could best lead to adoption of OCV? Of other cholera preventive and control practices?
- What key messages are preferred and culturally appropriate for which mix of channels? In which languages?
- What kinds of communication skills among health care providers, vaccinators and community groups need strengthening? In which areas?
- Determine the institutional capacity and capacity gaps in undertaking communication activities and media relations - of your team, government implementers, and NGO/CSO/CBO partners, including members of the coordinating group.

Table 1 Sample behaviour and participant analysis:
Identifying barriers and motivators to adoption of
OCV and cholera prevention and control practices

	Audience/ Participant Group	Motivating Factors
1	Primary - Individual and family level: Heads of households, Mothers, Fathers and Guardians (includes grandparents, mothers-in-law, children, adolescents and youth, and extended family members.	<ul style="list-style-type: none"> • Desire to maintain good health, freedom from cholera and other diseases
2	Secondary - Community level: Community leaders, Health workers, vaccinators, NGOs, CSOs and other community-based groups, religious leaders/groups	<ul style="list-style-type: none"> • Community pride in being free from the disease • Playing a role in saving lives
3	Tertiary, subnational Provincial/district government leaders, local health authorities, health professionals, clinicians, academics, business leaders, local media	<ul style="list-style-type: none"> • Political pride in disease-free status • Key role in agenda-setting and resource mobilization
4	Tertiary, national - Public policy/societal: Policy makers, parliamentarians, government officials, national media	<ul style="list-style-type: none"> • Key role in policy making, resource allocation • Key role of media in public awareness about disease prevention

Behaviour Barriers (Can be addressed by communication)	Non-Behaviour Barriers (Can be addressed by programme)
<ul style="list-style-type: none"> • Resistance to vaccination • Poor knowledge of vaccines and their benefits • Negative attitude toward health worker • Negative past experience with health workers or vaccinators 	<ul style="list-style-type: none"> • Lost time and income from economic activities • Long distance to vaccination site • Costs in travel time and expenses • Other competing priorities
<ul style="list-style-type: none"> • Low capacity to facilitate social mobilization • Careless attitude towards clients • Low self-esteem • Poor interpersonal communication and counselling skills 	<ul style="list-style-type: none"> • Lack of leadership / initiative • Weak supervision and monitoring structures • Lack of resources
<ul style="list-style-type: none"> • Lack of political commitment • Not clear about the issues 	<ul style="list-style-type: none"> • Competing programmes for limited resources; • Desire for political image building/ conflict of interest
<ul style="list-style-type: none"> • Lack of political commitment to allocate funds for OCV and promote integrated cholera programme • Not clear about issues and data 	<ul style="list-style-type: none"> • Lack of country-level data



Participant groups and key behaviour objectives/results

Based on your rapid assessment of determinants (barriers and motivators) to behaviour change, plot the communication objectives stated in terms of desired actions or behaviour results. The following table (Table 2) shows the desired actions by different levels of participant groups that may result from the interplay of communication approaches, a supportive environment from the community and health delivery system, and an enabling environment from the government, civil society and the media.

What we ultimately seek or the goal of our communication strategy in the national cholera prevention and control programme is to prevent the transmission of cholera through appropriate hygiene practices and the creation demand and maximize uptake of OCV among families and communities.

Table 2 Key behaviour objectives to create/increase demand/uptake of OCV

Participant Group A. Mothers and Fathers, Guardians, Grandparents, Mothers-in-law, Siblings, Extended Family members

Desired Behaviour Results/ Expected Actions

- Heads of household or parents bring family members for cholera vaccination including children aged one year and older to vaccination site at scheduled times.
- Complete two doses.
- Bring cholera immunization card (if appropriate)
- Allocate money for transportation expenses.
- Convey importance of OCV immunization and to continue practising good hygiene and sanitation and drinking safe water to all members of the family.
- Understand that cholera causes severe diarrhoea and dehydration and that it can quickly cause death if not treated early.
- Cholera can transmit rapidly through the fecal-oral route.
- Understand the main methods of transmission in a community to know how to prevent it from spreading.
- Properly treat themselves and family members suffering from diarrhoea with ORS and other safe liquids; bring to a health center as soon as possible once symptoms begin.
- Communities know about the vaccines, that it is safe and effective but not fully protective against cholera and other diarrheal diseases;
- Continue with other prevention and treatment practices.

Participant Group B. Frontline Health Workers

Desired Behaviour Results/ Expected Actions

- Demonstrate good interpersonal communication and social mobilization skills and to deliver OCV immunization tasks as per OCV immunization policy and guidelines.
- Treat all persons/clients coming for OCV immunization with respect and professionally; answer their questions and address their concerns and show active interest in their opinions.
- Provide clients information regarding the cholera vaccine, the disease it protects against, the necessity of a second dose and when it is due, any possible side effects and reasons it is important for the person to be vaccinated.
- Provide information on hygiene, use of safe water and food and sanitation and how to treat cholera with ORS
- Consider the views and needs of the communities in planning OCV vaccination schedule and venue, times and other aspects of the programme as conveniently as possible for the client.

Table 2 Key behaviour objectives to create/increase demand/uptake of OCV (cont'd)

Participant Group C. Religious leaders, CSOs, local NGOs, Local government authorities, business sector, school officials, Youth Groups, School Children, Community groups

Desired Behaviour Results/ Expected Actions

- Help at-risk communities understand cholera; know how to treat and prevent; explain added prevention value of OCV.
- Motivate cholera-prone communities to adopt OCV as an added measure against cholera.
- Provide information on OCV and where and when to get it if available.
- Discuss in gatherings the importance of OCV as added prevention measure but hygiene, safe water and sanitation and treatment when ill still important

Participant Group D. Media

Desired Behaviour Results/ Expected Actions

- Become familiar with OCV and its role in providing additional protection against cholera. Crosscheck facts before putting out publications.
- Provide clear and accurate facts about OCV to the public as part of a comprehensive approach to cholera control.
- Handle allegations and rumours regarding any adverse events following OCV immunization or other issues may serve as disincentive to parents and guardians.
- Contact relevant health officials for their advice and guidance immediately after any allegation is made and preferably before the allegation is publicized.
- Where allegations are made in live programmes, insist on having a spokesperson or a health official to meet with the person making the allegation for an immediate credible response.

Desired Behaviour Results/ Expected Actions

- Support orientation workshops for health workers, vaccinators and implementing partners so they can explain: that:
 - OCV is safe, effective, feasible and acceptable to communities that have received them so far
 - They can integrate OCV into cholera prevention and control activities
 - There are limitations in implementing traditional interventions in some settings, and
 - OCV helps mitigate disease transmission.
- Strengthen capacity and skills of agencies and institutions responsible for cholera prevention and control with OCV immunization
- In endemic countries:
 - Add OCV to the national cholera strategy
 - Provide the technical guidance and tools to do it
 - Access OCV through the global stockpile when appropriate (outbreaks, humanitarian emergencies and areas of seasonal peaks)
 - Get the necessary resources, OCV, vaccine supplies, funding, trained human resources..
 - Implement OCV with other cholera interventions
 - Monitor and evaluate OCV use
- In countries with cholera outbreaks and in complex emergencies:
 - Information about OCV should be shared and OCV included in national cholera contingency plans
 - Rapidly integrate OCV into a response strategy.
 - Access OCV through the global stockpile.
 - Ensure that if OCV is used, that it is integrated with traditional control measures.
 - Frame persuasive and balanced messages to ensure sustainability and acceptance of OCV by the population.
 - Help communities understand cholera, how to prevent and treat it including using OCV.
 - Motivate cholera-prone communities to adopt OCV as an added measure against cholera.
 - Support frontline health workers with interpersonal communication skills training and equip them with appropriate IPC tools like flipcharts, leaflets, and audio-visuals.

Table 2 Key behaviour objectives to create/increase demand/uptake of OCV (cont'd)

Participant Group F. Policy Makers

Desired Behaviour Results/ Expected Actions

- Issue a policy that integrates oral cholera vaccination in the national cholera programme
- Give political commitment and manifest political will through public pronouncements and participation in OCV and cholera prevention and control programme activities.
- Understand the limitations of implementing traditional interventions in some settings and how OCV may help mitigate disease transmission.
- Include OCV immunization for at risk populations in financing comprehensive cholera prevention plans for water, sanitation and hygiene improvements.
- Include in public statements the importance of OCV as an additional approach to cholera prevention.

Step 3: Plan your communication strategy

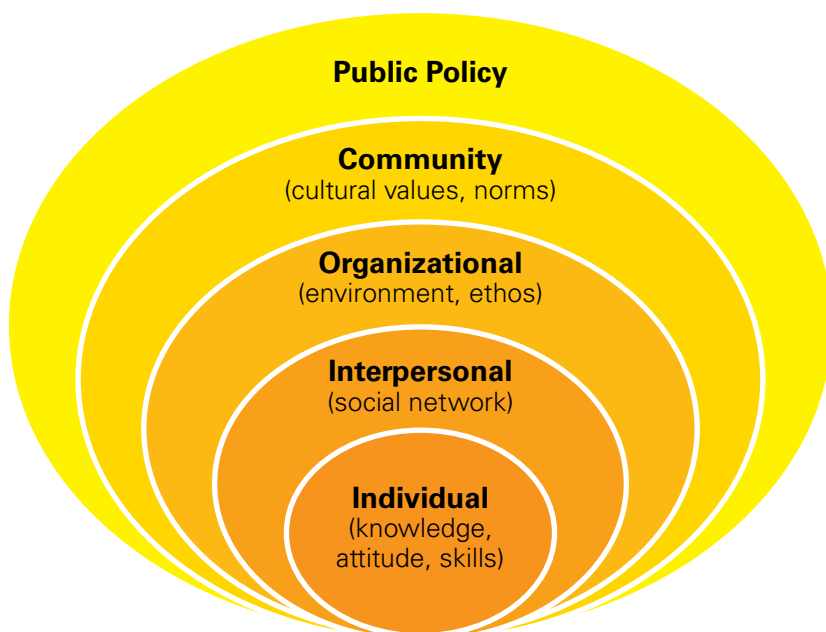
Communication for Development (C4D) plays a central role in the successful introduction of oral cholera vaccine as an additional tool in cholera prevention and control, both in endemic and epidemic settings. C4D is a research-driven systematic process that operates through four interrelated, interdependent and interacting approaches with respective audiences or participant groups:

- advocacy,
- social mobilization
- communication for social change
- behaviour change communication

Theoretical framework

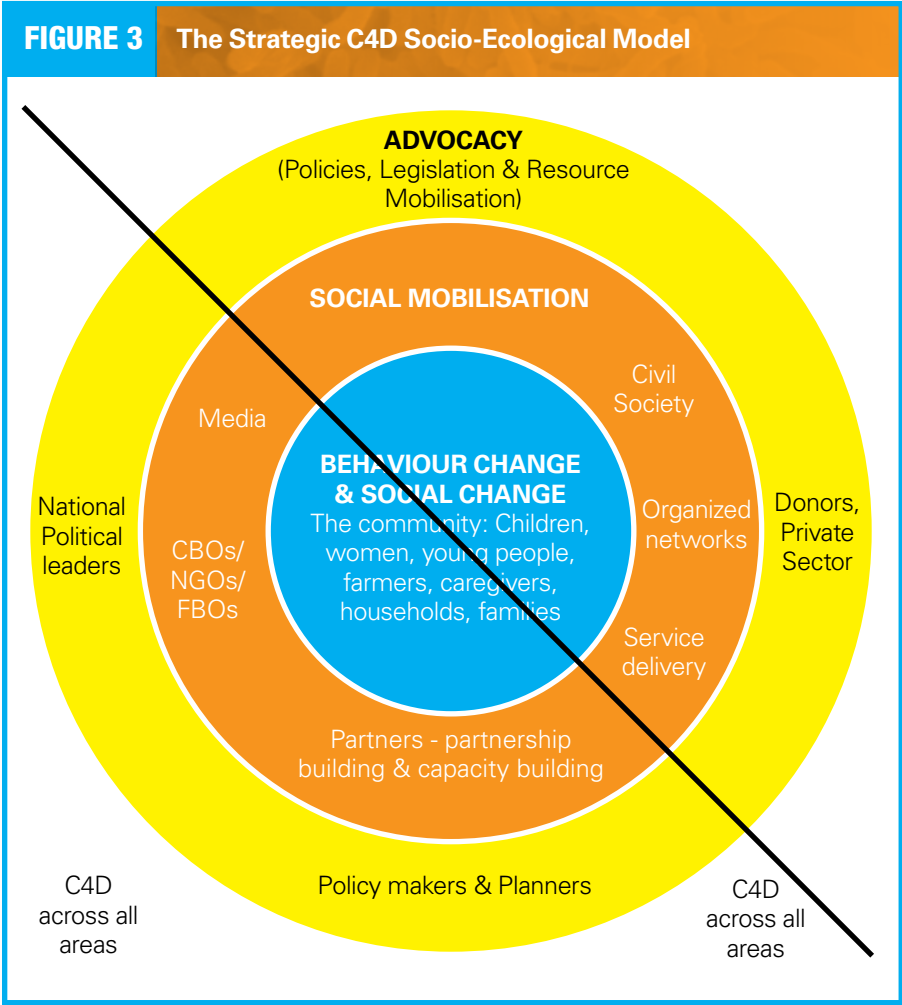
C4D is one of the many applications of an overarching Socio-Ecological Theory of Human Development⁴ (see Figure 1). The theory posits that in order to understand individual behaviour development and social transformation, the entire ecological system - the interconnected influences of an individual's social environment: family, peers, community, institutions and society need to be taken into account. This theory clearly has direct and practical implications for communication planning and programming for it underpins the logic of behaviour and social change decisions and communication strategy development based on levels of influence (Figure 1).

FIGURE 2 Model of Socio-ecological Theory of Human Development



⁴ Bronfenbrenner, U. (2005). Making human beings human: Bioecological perspectives on human development. Thousand Oaks, CA: Sage Publications.

Levels or orbits of influence include *intrapersonal* (individual's present knowledge, attitudes, values, skills, self-esteem, demographics), *interpersonal* (families and kinship network, social networks, social supports, friends, neighbors), *organizational* (workplace norms, incentives, organizational culture, management styles, communication networks), *community* (social norms, resources, informal and formal leadership norms, communication patterns), and *policy* level (legislation, policies, laws, governance, resource allocation).



Planning Strategic Communication: applying the socio-ecological model (SEM)

The C4D socio-ecological model or SEM (Figure 2) looks at behaviour and social change as a function of a person's multiple levels or orbits of influence from his or her social environment. Every individual is part of other larger units: a family, a neighbourhood, a community, a religion, the workplace, and the larger society. Each of these units directly or indirectly influences how people behave. Based on evidence from formative research, C4D uses a mix of multi-level interventions that can be most effective as in the case of health promotion, e.g., OCV introduction for cholera prevention and control.

The inner circle represents the core or primary participant group - the children and adolescents, their parents and guardians, their families and communities. Communication addressing this level seeks to bring about positive individual **behaviour change** and **social change** with collective groups at community and societal level

The middle circle represents the group of key influencers, the secondary participant group (duty bearers) who can provide a supportive environment and engage those in the inner circle toward the desired change through **social mobilization**.

The outer circle represents the participant audiences for policy and structural change and resource allocation – leaders and decision makers who have the power to effect such change. To effect long term change and for impact and sustainability of development programmes and service delivery, policies, political will and resources need to be mobilized through **advocacy** with leaders and decision-makers who have the power to create policies, programmes and structures and to allocate resources.

As illustrated in **Figure 2**, the four key communication approaches are **behaviour change communication**, **communication for social change**, **social mobilization** and **advocacy**. **Media engagement comes as a fifth approach**. The pervasive nature of the mass media makes it a fifth approach that cuts across the first four communication approaches. When planning strategic communication, develop a media plan to **engage media** organizations, media managers, editors and journalists.

Key communication approaches

1. Behaviour change communication (BCC)⁵ is the process of applying participatory communication techniques and tools to inform, influence, inspire & involve individuals and families in adopting new attitudes and practices or in sustaining existing recommended behaviours that lead toward improving and sustaining their well-being. BCC focuses on the *individual* as the unit of change.

2. Communication for social change (CFSC) focuses on groups or collectives as the unit of change. CFSC seeks to collectively engage & empower families, communities and social networks to positively influence and/or reinforce social norms and practices of the community and the larger society.

BCC and CFSC approaches, as well as social mobilization and advocacy, apply a mix of three types of interventions:

- Interpersonal communication (client-provider interaction, family/ community dialogue, group activities reinforced by the use of IPC tools and materials)
- Community mobilization (community meetings, annual commemorations and events, skills enhancement trainings, encouraging participation, e.g., in media programming and monitoring quality and uptake of services, etc.),
- Mass media (print, radio, television, Internet)

3. Social mobilization is the process of engaging a wide network of partners, stakeholders and allies around a common cause. It provides a supportive environment for individuals and families to change or reinforce desired practices. Social mobilization partners include communities (community mobilization); civil society organizations, organized networks and associations, the media, religious groups and individuals who can influence change.

⁵ See also definitions of C4D strategies in: C4D Basics (2011). UNICEF C4D Webinar Series for Programme and Communication Specialists, p. 13-15; UNICEF ROSA (2006). Behaviour Change Communication in Emergencies: A Toolkit, p. 40 and UNICEF Cholera Toolkit (2013), Chapter 7, Annex 7A.

Social mobilization at all levels is primarily based on effective interpersonal communication among participants. It is the tried and tested approach to mobilize partners, allies and communities to influence others to learn and know about, understand, and adopt preventive behaviours against cholera including vaccination. The social/community mobilizer as facilitator of the process becomes more effective when the interaction with community members is supported by well planned, engaging and stimulating communication/ IPC resources and IPC tools.

Develop the action plan for social mobilization at provincial level and community mobilization plan at community level using the suggested steps below.

Steps in planning for social mobilization⁶

1. Develop a Social/Community Mobilization Action Plan as a major part of the Provincial/State and District Communication Action Plan.
2. Identify mobilizers (community volunteers, youth groups, theatre groups). The mobilizer must be aware of and sensitive to community values, social norms and practices and understand the barriers to the recommended behaviours. The mobilizer will need to train community groups in participatory techniques.
3. Orient/train mobilizers especially on IPC skills, facilitating group meeting, delivering key messages and using lively, interactive methods.
4. Be creative and work locally in developing and using communication materials, IPC tools and media products:– FAQs, leaflets, brochures; audio-visuals – posters, video documentaries, PSAs; and group media such as local story telling, role playing and songs, etc.

⁶ Adapted from: *The Intensification of Routine Immunization in India: Strategic Communication Guideline* (2012). Prepared by Bhawani Shankar Tripathy, Communication Consultant for UNICEF India and Ministry of Health and Family Welfare, Government of India (Immunization Division).

- 5.** Enlist champions and role models: Set your criteria for role models and invite their testimonials, i.e., from those who have been OCV vaccinated and who practice recommended cholera preventive behaviours. Use positive deviance as message appeals for known OCV or general immunization resisters.
- 6.** Ensure that cholera vaccination sessions use plenty of visual aids, other communication resources and effective IPC tools to remind and encourage people to return for the second dose and to reinforce other cholera preventive behaviours.
- 7.** Put in place mechanisms to get daily feedback on social mobilization activities, focusing on challenges. Make immediate adjustments based on feedback.
- 8.** Ensure that visits to vaccination sites for OCV immunization sessions are positive and memorable. Health workers and vaccinators should see to it that community members receiving OCV return as satisfied and happy as possible with their experience. Any bad experience arising from vaccinators' behavior can prevent revisits and a negative impression about immunization.
- 9.** Conduct IPC skills training with proper use of IPC tools for vaccinators. Supervise practice of these skills.
- 10.** Plan OCV vaccination sessions according to the convenience of the community and with their support and participation in decision-making. The objective should be to create a comfortable, reassuring and enabling environment where OCV immunization is welcomed.
- 11.** Develop communication materials and IPC tools to support social/community mobilization.

Some social mobilization strategies that can influence family demand for OCV and uptake of cholera prevention behaviours:

Mobilization through community influencers

Identify and approach prominent people from the area – community leaders, religious leaders, and opinion leaders, other charismatic and highly regarded members of the community. Engage and educate them on the risks and benefits of OCV immunization along with other key messages. Motivate them to help in reaching out to the community. Support them with communication tools to enable them to organize meetings in comfortable venues.

Mobilization by involving community groups

Community leaders, schools, places of worship, mothers' clubs, children's clubs, youth groups and other community groups are critical to get communities involved. They can help increase demand for OCV immunization and practice of cholera preventive behaviours particularly in high-risk areas. Support community dialogues and meetings led by these groups and influentials. Define and roll out a local media strategy that gives community members voice and visibility. For example, community radio programmes, radio dramas, theatre troupes, banners, local media outreach. Engage national and local celebrities and local "heroes" and role models.

Mobilization through NGOs/CBOs/networks

Identify and list out all potential NGOs and CBOs like women groups, school clubs, children's clubs, youth groups, and self-help groups. Prepare interactive presentation and group dynamics tools for training and orientations. Conduct a training needs assessment, focusing especially on basic knowledge, IPC skills, understanding and interpretation of key messages on OCV and cholera prevention tools. Develop training agenda, session plans and materials, or customize existing modules with involvement of partners. Organize training, and document. Monitor community mobilization efforts through community volunteers and using monitoring formats.

Mobilization through frontline health workers

Hold meetings with health workers/vaccinators/community mobilisers to share their knowledge, views and work experience. Create opportunities for different levels of health workers. Offer training in IPC and counseling skills at mutually convenient times. Remember to take care of logistics; offer small incentives and rewards for good performance. Ensure that health workers/vaccinators/community mobilizers are equipped in advance with the necessary resources – IPC tools and techniques, , presentation equipment, etc.

4. Advocacy is communication that is addressed to leaders and the powers that be – to political, economic and social decision-makers at national and local levels. An advocacy strategy should inform and motivate appropriate leaders to take actions supportive of cholera programme objectives.

The results of advocacy – a legislative framework, policies, resources and structures - provide the enabling environment for behaviour and social change.

For the cholera programme, advocacy aims to provide an enabling environment for the following results:

- Commitment and political will for cholera prevention and control programme
- National policy on an integrated cholera prevention and control programme
- Administrative directives and public pronouncements
- Allocation of resources
- Cholera programme with OCV as a high national priority to prepare for and respond to cholera outbreaks

Participant groups and behaviour objectives of OCV advocacy.

Based on data from your communication assessment of the cholera situation - the political, social and communication environment in your country - you can identify groups with whom, you should address your advocacy. The same data would also help guide why these are key groups and when they should be approached. See [Table 1](#) for

specific behaviour objectives for OCV advocacy addressed to policy makers and programme managers.

5. Media engagement. National and local media – print, radio, television, the Internet and telecommunications are valuable allies in your communication strategy. Nurture partnerships with media executives, managers, journalists and reporters including from local radio and TV, cable TV stations and local newspapers, social media sites and mobile phone companies. Establish internal capacity to manage media relations⁷ particularly your ability to:

- Prepare and execute a media plan;
- Organize and conduct media briefings and media conferences;
- Produce and distribute timely press statements, press releases and other media materials;
- Coordinate responses to media enquiries and respond promptly;
- Support spokespersons with accurate messages and materials.

The Media Plan. Prepare a good media plan at national and subnational level. Keep in mind that local media are closer to the ground in involving community perspectives and voices – community radio, local newspapers, cable television stations, mobile phone companies and social networking platforms.

The media plan should include the following:

- **A database of journalists:** Keep a regularly updated list of print, broadcast and online journalists and other media practitioners covering health (local, national, international) with contact information. Always use a computer-based database that allows immediate updating.

⁷ For more on media relations, refer to: Hyer, R N and VT Covello (2005). Effective Communication during public health emergencies: WHO Media Handbook. Geneva, Switzerland.

- **Media kit:** Keep media informed of the cholera programme and OCV campaign through email or hardcopy by sending regular updates on any plans, programmes, decisions, etc. Sensitize media about health aspects like benefits of OCV immunization and its impact nationally and globally on cholera prevention and control. A media kit may contain the following documents with clear and concise key messages in both hard and soft copy (stored in computer or on a CD):
 - Frequently Asked Questions (FAQs) on OCV immunization and traditional cholera prevention and control methods
 - Fact Sheet or a Technical Brief on OCV with other cholera prevention tools;
 - Recent updates – progress made in country, specific outbreak or at risk areas – and a few case studies;
 - Graphs and charts;
 - Photographs and illustrations;
 - Contact addresses of spokespersons and or relevant experts that media can contact. Remember to check and permanently remove all old and outdated material from the information package.
- **Media release:** The media release must specifically answer the 5 W's and H: who, what, when, where, why, and how.

Table 3 Suggested checklist of activities for media engagement

The Communication Sub-Committee, working with the National Cholera Coordinating Committee shall perform the following actions:

- 1.** Establish partnership with media organizations. Nurture sound professional relationships with their managers, editors and reporters.
- 2.** Prepare a database with latest contact numbers, email addresses, websites and social media accounts (Skype, Face Time, Facebook, Twitter, LinkedIn, etc.) of:
 - 2.1.** National, state and district media executives and staff covering health issues,
 - 2.2.** Editors of major newspapers, television and radio channels
 - 2.3.** Local cable operators at district level
 - 2.4.** Telecommunications executives
 - 2.5.** Print and broadcast journalists
- 3.** Identify, appoint and train spokespersons at national, state and district levels.
 - 3.1.** Ensure that spokespersons possess the requisite media skills, are respected and authoritative about immunization and vaccines.
 - 3.2.** Organize media skills training for spokespersons as necessary.
 - 3.3.** Prepare key message sheets and sample scripts on OCV and cholera prevention for spokespersons
- 4.** Prepare a list of relevant health, WASH and immunization experts at state and district level, with their contacts and mailing address as per the hierarchy and share this list with key communication staff at corresponding level.
- 5.** Keep media informed periodically about progress on the cholera situation and OCV immunization by sharing data, progress on the OCV vaccination campaigns, events, and key policy decisions made.
- 6.** Prepare a standard press release format, using the cholera/OCV immunization brand or logo (if agreed and developed) along with the state logo on official letterhead for effective branding.
- 7.** Provide latest data on cholera disease burden of state/district/block. Also provide national and global data.
- 8.** Organize media collaboration meetings with state-level; district level journalists.
- 9.** Seek the help of development partners, media and communication agencies to hold media orientation seminars on OCV and other cholera prevention and control efforts, updates, latest data, challenges, successes.
- 10.** Produce and update a standard media kit with key messages given in the form of frequently asked questions (FAQ) or Q&As, progress reports, case studies with action photos, graphs and illustrations on OCV and cholera prevention and control measures.
- 11.** Keep media regularly informed of all cholera/OCV- related developments through email, the Ministry website and other commonly used Internet and social media platforms.

Step 4: Design the creative strategy: key messages, channels and tools

Effective communication entails tailoring your messages according to the level of your audience/ participant group. To create acceptance and demand for OCV, clearly explain the benefits as well as the potential risks and side-effects of vaccination.

Designing the creative strategy involves collaboration with representatives of participant groups, designers and media developers, researchers, printers and producers in developing and pre-testing messages, communication tools and creative materials prior to production and dissemination. Determine the appropriate mix of channels and the kinds of communication materials/tools that will be used to support participatory approaches. This also involves developing the appropriate mix of interpersonal approaches and IPC tools, use of group or mid-media, mass media and social media based on information from the communication assessment.

The creative strategy includes the following actions:

- Formulating key messages on OCV and cholera prevention for different stakeholders/participant groups (Table 4);
- Preparing Interpersonal communication tools for health workers, vaccinators and community leaders to support IPC with families and community dialogues to explain the benefits of OCV immunization and any side effects; and other approaches to cholera prevention and control;
- Pretesting, production and use of IPC tools and media materials (e.g., Q&As, FAQs, flipcharts, flash cards, brochures, leaflets, posters, audio and video formats, logo designs, graphics and illustrations) to support IPC, social/community mobilization and media engagement;
- Organizing community dialogues and meetings involving parents, guardians, schoolchildren, youth groups, religious communities, CBOs, CSOs, etc.;
- Engaging mass media (culturally appropriate and preferred print, radio, TV formats) to reinforce and support interpersonal communication, community engagement, social mobilization and advocacy

- Using social media and social networking with digital technologies and platforms
- Managing any adverse events following immunization (AEFI) and counteracting rumours and misperceptions about OCV.

Pre-testing key messages and materials for OCV and cholera prevention

Pretesting aims to determine the reaction of a sample of your audience to your communication prior to production and dissemination. The aim is to identify any elements that need to be improved to make your material more effective. Pretest to ensure that your messages and materials have the five elements of effectiveness:

- 1. Understandable** – Is the message clearly explained and easy to understand?
- 2. Attractive** – Is the message attractive enough to hold attention and be remembered?
- 3. Acceptable** – Does the message contain anything that is culturally offensive, annoying or false?
- 4. Involving** – Does the audience feel that the message/material speaks to them and is about them?
- 5. Persuasive** – Does the message convince the audience to take the recommended action?

Table 4 Key messages for different audience groups/ participants in oral cholera vaccination and cholera prevention, control and treatment measures

1. Government Policy Makers and Donors (Advocacy)	
QUESTIONS	KEY MESSAGES
What is Oral Cholera Vaccine?	<ul style="list-style-type: none"> • It is a vaccine that can protect persons from getting sick from cholera. • The cholera vaccine is given by mouth, two doses are required. • Shanchol™ was prequalified by WHO in 2011.
Why use oral cholera vaccine?	<ul style="list-style-type: none"> • It can help to reduce the transmission of cholera. • It will help protect our communities from cholera.
Is it safe?	<ul style="list-style-type: none"> • It is safe and has very few (mostly minor) side effects.
Does it work? Is it effective?	<ul style="list-style-type: none"> • It offers good protection from cholera for up to 2/3 of those vaccinated. • Shanchol™ is protective for at least 5 years. It is not perfect and does not cover other causes of diarrhoea. People still need to practice good hygiene, treat the water, practice good sanitation and get treatment if they are sick.
How is it used?	<ul style="list-style-type: none"> • Shanchol™ is given in 2 doses a minimum of 14 days apart to adults and children older than 1 year. • Shanchol™ is distributed in individual glass vials (1.5ml) with doses given directly to the individual from the vial. • OCV is not a sole solution to stop cholera; it can be used along with clean water, adequate sanitation and good personal hygiene for prevention and early and appropriate treatment to reduce illness and death as part of a multi-sectoral integrated approach.
Has it been used before?	<ul style="list-style-type: none"> • It has been used in number of countries with good results. Over 1 million doses of Shanchol™ have been delivered in the past few years. • People that have received it so far have welcomed it in their communities.

How can the OCVs be accessed? Where can they be purchased?	<ul style="list-style-type: none"> • The International Coordination Group has developed an OCV stockpile for rapid use in epidemics and emergencies. This stockpile can be accessed through the International Coordination Group (ICG). • OCVs can also be purchased directly from the manufacturer.
How much does it cost?	<ul style="list-style-type: none"> • Shanchol™ costs US \$1.85 per dose. • GAVI started to support the ICG Stockpile in 2014, as a result, GAVI eligible countries will receive the vaccine from the ICG Stockpile free of charge. Non-GAVI eligible countries and non-government agencies will have to reimburse the cost of the vaccine to the ICG Stockpile.
What about washing hands and drinking clean water?	<ul style="list-style-type: none"> • People still need to practice good hygiene, treat the water, practice good sanitation and get treatment if they are sick.
Should we use the money instead to improve the water and sanitation systems?	<ul style="list-style-type: none"> • Long term infrastructure changes – building safe water systems and sanitation facilities are indispensable for cholera (and other waterborne) disease prevention and control. These changes will have longer-term impact on not just cholera, but also other food- and waterborne disease prevention; however, these changes take time and will require more resources and cholera is a problem now.
Why should we use it in our country?	<ul style="list-style-type: none"> • OCVs can be used as a bridging tool for cholera prevention and control while these longer-term interventions are put into place. Ideally, there should be a plan for OCV and longer-term interventions to occur hand in hand. OCVs can be phased out as infrastructure improves.

2. Mass Media (Media Engagement)

QUESTIONS	THEMES
What is Oral Cholera Vaccine?	<ul style="list-style-type: none"> • It is a vaccine that can protect persons from getting sick from cholera. • The cholera vaccine is given by mouth, two doses are required. • Shanchol™ was prequalified by WHO in 2011.
Is it safe?	<ul style="list-style-type: none"> • It is safe and has very few (mostly minor) side effects.

Table 4 Key messages for different audience groups/ participants in oral cholera vaccination and cholera prevention, control and treatment measures (cont'd)

Does it work? Is it effective?	<ul style="list-style-type: none"> • Shanchol™ is effective and offers good protection from cholera, up to 2/3 of those vaccinated for at least 5 years • It is not perfect and does not cover other causes of diarrhoea. People still need to practice good hygiene treat the water, practice good sanitation and get treatment if they are sick.
How is it used?	<ul style="list-style-type: none"> • Shanchol™ is given in 2 doses a minimum of 14 days apart to adults and children older than 1 year. • Shanchol™ is distributed in individual glass vials (1.5ml) with doses given directly to the individual from the vial. • OCV is not a sole solution to stop cholera; it can be used along with clean water, adequate sanitation and good personal hygiene for prevention and early and appropriate treatment to reduce illness and death as part of a multi-sectoral integrated approach. It is given in 2 doses 14 days apart for adults and children older than 1 year.
Why should we use the vaccine in our country?	<ul style="list-style-type: none"> • It will help protect our communities from cholera. • OCV can help to reduce the transmission of cholera in communities.
Has it been used before?	<ul style="list-style-type: none"> • More than 1 million doses of Shanchol™ have been given over the past few years. • People that have received it so far have welcomed it in their communities.
What about washing hands and drinking clean water?	<ul style="list-style-type: none"> • OCV is not a sole solution to stop cholera; it should be used along with clean water, adequate sanitation and good personal hygiene for prevention and early and appropriate treatment to reduce illness and death. • All of these approaches need to be used together.

<p>How can the OCV be accessed? Where can they be purchased?</p>	<ul style="list-style-type: none"> • The International Coordination Group has developed an OCV stockpile for rapid use in epidemics and emergencies. This stockpile can be accessed through the International Coordination Group (ICG). • OCVs can also be purchased directly from the manufacturer.
<p>How much does it cost?</p>	<ul style="list-style-type: none"> • Shanchol™ costs US \$1.85 per dose. • GAVI started to support the ICG Stockpile in 2014, as a result, GAVI eligible countries will receive the vaccine from the ICG Stockpile free of charge. Non-GAVI eligible countries and non-government agencies will have to reimburse the cost of the vaccine to the ICG Stockpile.
<p>Should we use the money to improve the water and sanitation systems?</p>	<ul style="list-style-type: none"> • Long term infrastructure changes – building safe water systems and sanitation facilities are indispensable for cholera (and other waterborne) disease prevention and control. • These changes will have longer-term impact on not just cholera, but also other food- and waterborne disease prevention • However, these changes take time and will require more resources and cholera is a problem now. • OCVs can be used as a bridging tool for cholera prevention and control while these longer-term interventions are put into place. Ideally, there should be a plan for OCV and longer-term interventions to occur hand in hand. OCVs can be phased out as infrastructure improves.

Table 4 Key messages for different audience groups/ participants in oral cholera vaccination and cholera prevention, control and treatment measures (cont'd)

3. Programme Managers and Development Partners: Ministry of Health, UN, NGOs, IO, Cholera Coordinating Committee (Advocacy)	
QUESTIONS	THEMES
What is Oral Cholera Vaccine?	<ul style="list-style-type: none"> • It is a vaccine that can protect persons from getting sick from cholera. • The cholera vaccine is given by mouth, two doses are required. • Shanchol™ was prequalified by WHO in 2011.
How is it used?	<ul style="list-style-type: none"> • Shanchol™ is given in 2 doses a minimum of 14 days apart to adults and children older than 1 year. • Shanchol™ is distributed in individual glass vials (1.5ml) with doses given directly to the individual from the vial. • OCV is not a sole solution to stop cholera; it can be used along with clean water, adequate sanitation and good personal hygiene for prevention and early and appropriate treatment to reduce illness and death as part of a multi-sectoral integrated approach.
Is it safe?	<ul style="list-style-type: none"> • It is safe and has very few (mostly minor) side effects.
Does it work? Is it effective?	<ul style="list-style-type: none"> • It is effective. It offers good protection from cholera for up to 2/3 of those vaccinated for at least 5 years. • It is not perfect and does not cover other causes of diarrhoea. People still need to practice good hygiene treat the water, practice good sanitation and get treatment if they are sick.
Who can take the vaccine?	<ul style="list-style-type: none"> • If your country is cholera-prone, it may be appropriate to give at-risk populations aged one year and older OCV vaccination at the beginning of an epidemic or in areas adjacent to those experiencing an epidemic. • It is also safe for the elderly and people living with HIV/AIDS to take the vaccine. • In more stable endemic settings, it may be appropriate to target specific populations and/or age groups.

Why use the vaccine?	<ul style="list-style-type: none"> • OCV can help protect cholera prone communities from the disease. • It can help to reduce the transmission of cholera in communities.
What about washing hands and drinking clean water?	<ul style="list-style-type: none"> • OCV is not a perfect solution to stop cholera; it should be used along with clean water, adequate sanitation and good personal hygiene for prevention and early and appropriate treatment to reduce illness and death. • All of these approaches need to be used together.
Why should we use it in our country? Has it been used before?	<ul style="list-style-type: none"> • More than 1 million doses of Shanchol™ have been given over the past few years. • People that have received it so far have welcomed it in their communities.
How is it used?	<ul style="list-style-type: none"> • OCV is usually given through a mass vaccination campaign along with other cholera control measures.
How can the OCV be included into the existing programs for cholera?	<ul style="list-style-type: none"> • WHO⁸ recommends that OCV should be used with cholera control measures such as use of safe water and sanitation facilities, good hygiene practices and adequate case management.
How about the existing expanded program on immunization (EPI), will there be any conflict, or can it be integrated?	<ul style="list-style-type: none"> • The WHO has guidelines on how to conduct an OCV campaign. • In most countries, it is currently given as a mass vaccination campaign, and not yet integrated into the routine EPI schedule. It should be given 2 weeks apart from Oral Polio Vaccine but it is ok to give at the same time as other injectable vaccines.
How are the vaccines accessed?	<ul style="list-style-type: none"> • The International Coordination Group has developed an OCV stockpile for rapid use in epidemics and emergencies. This stockpile can be accessed through the International Coordination Group (ICG). • OCVs can also be purchased directly from the manufacturer.

⁸ See: WHO (2010). OCV in mass immunization campaigns: guidance for planning and use, Annex 1.

Table 4 Key messages for different audience groups/ participants in oral cholera vaccination and cholera prevention, control and treatment measures (cont'd)

4. Religious groups, CSO, local NGOs, CBOs, Local government authorities, business sector, school officials (Social Mobilization)	
QUESTIONS	THEMES
What is cholera?	<ul style="list-style-type: none"> • It is acute watery diarrhoea, sometimes with vomiting. • Bacteria called <i>Vibrio cholerae</i> cause it. Cholera germs are found in the faeces of infected people. • If not treated, it can cause death from dehydration (or loss of water and salts from the body) within hours.
How does cholera spread?	<ul style="list-style-type: none"> • Cholera spreads very easily if hygiene is not good. • Cholera spreads when feces from infected persons gets into the water people drink or the food they eat.
How can community members protect themselves from cholera?	<p>If community members have cholera there are 3 things they can do to protect themselves:</p> <p>1) Treat the sick person:</p> <ul style="list-style-type: none"> • The greatest danger of cholera (and other diarrhoeal diseases) is loss of water from the body. • Give oral rehydration therapy (ORT) or a mixture of oral rehydration salts (ORS) and safe (boiled or chlorinated) water to replace the lost fluid. If given early, ORT saves lives. • Rapid action is essential! • Community members should go to a health center immediately if sick while continuing to drink fluids. <p>2) Prevent the spread in families and the community:</p> <ul style="list-style-type: none"> • Community members should practice good hygiene, keep water safe to drink and use latrines. • Wash hands during critical times: after using latrine, after cleaning the child's bottom, before preparing food and before feeding child. <p>3) Get vaccinated with the oral cholera vaccine</p>

What is Oral Cholera Vaccine?	<ul style="list-style-type: none"> • It is a vaccine that can protect persons from getting sick from cholera. • It can save lives in the community. • It is safe and has very few side effects. • But it is not perfect. It does not protect against other types of diarrhoea. • Oral cholera vaccine (OCV) is taken by mouth. • Two doses are required. The vaccine is only effective after the second dose. Taking 1 dose is not enough. • The 2 doses are taken 2 weeks apart. • Good hygiene remains very important. People still need to treat the water, practice good sanitation and get treatment if they are sick.
Who can receive OCV?	<ul style="list-style-type: none"> • In cholera-prone communities, entire families except children under one year of age should get the cholera vaccine if available or according to protocol.
Who should not receive OCV?	<ul style="list-style-type: none"> • It can be given to the elderly and those with HIV/AIDS.
What to advise the community on Who, Where, and When to get OCV vaccination?	<ul style="list-style-type: none"> • Inform communities on who is eligible for the vaccine (see above). • If there is a campaign let communities know where and when to get it. • Remind community members: Keep your vaccination card and to bring it when you go for your second dose of the vaccine.

5. Community Health Workers and OCV Vaccinators (Community Mobilization)

QUESTIONS	THEMES
What is cholera?	<ul style="list-style-type: none"> • It is acute watery diarrhoea, sometimes with vomiting. • Bacteria called <i>Vibrio cholerae</i> cause it. Cholera germs are found in the faeces of infected people. • If not treated, it can cause death from dehydration (or loss of water and salts from the body) within hours.

Table 4 Key messages for different audience groups/ participants in oral cholera vaccination and cholera prevention, control and treatment measures (cont'd)

<p>How does cholera spread?</p>	<ul style="list-style-type: none"> • Cholera spreads very easily and quickly if hygiene is not good. • Cholera spreads when faeces from infected persons gets into the water people drink or the food they eat.
<p>How can community members protect themselves from cholera?</p>	<p>If community members have cholera there are three actions they can do to protect themselves:</p> <p>1) Treat the sick person:</p> <ul style="list-style-type: none"> • The greatest danger of cholera (and other diarrhoeal diseases) is loss of water from the body. • Give sick person clean, safe (boiled or chlorinated) water mixed with oral rehydration salts (ORS) to replace the lost fluid. The ORS solution can save his/ her life if given early. • Rapid action is essential. Use existing national protocols to treat patients with cholera. • Community members should go to a health center immediately if sick while continuing to drink fluids. • Refer ill patients to a health facility. <p>2) Prevent the spread in families and the community:</p> <ul style="list-style-type: none"> • Wash hands during critical times: after using latrine, after cleaning the child's bottom, before preparing food and before feeding child. • Remind community members to continue to practice the key hygiene and sanitation practices as described above <p>3) Get vaccinated with the cholera vaccine:</p> <ul style="list-style-type: none"> • Entire families except children under one year of age should get the cholera vaccine if available (or according to protocol).

What is Oral Cholera Vaccine?

- It is a vaccine that can protect persons from getting sick from cholera.
- It is called Shanchol™, it is in vials; one vial is good for one dose and is given to one person.
- Oral cholera vaccine (OCV) is taken by mouth.
- Two doses are required. The vaccine is only effective after the second dose. Taking 1 dose is not enough.
- The 2 doses are taken 2 weeks apart.
- Each dose is 1.5 ml. The full vial needs to be consumed.
- OCV can save lives in the community.
- It is safe and has very few side effects. Very rarely people have abdominal discomfort or diarrhoea.
- But it is not perfect and it does not protect against other diarrhoea. Good hygiene remains very important. People still need to treat the water, practice good sanitation and get treatment if they are sick.
- Inform people receiving the vaccine to come back with any health complaints.
- Inform people receiving the vaccine to keep the vaccination card they receive and to bring it back when they come for their second dose.

Table 4 Key messages for different audience groups/ participants in oral cholera vaccination and cholera prevention, control and treatment measures (cont'd)

<p>How can you prevent cholera?</p>	<p>Remind community members and persons coming for OCV vaccination that they should continue to:</p> <ul style="list-style-type: none"> • Wash hands often with soap and rinse with safe water (or use ash, lime or sand, where soap is not available) <ul style="list-style-type: none"> – After every defecation; – Before handling food (cooking, eating, feeding children); – After cleaning child's bottom; – After cleaning a patient with diarrhoea. • Use the latrine for defecation or bury faeces. <ul style="list-style-type: none"> – Do not defecate in any body of water; – Clean latrines and surfaces contaminated by faeces. • Use clean drinking water and food: <p>WATER:</p> <ul style="list-style-type: none"> • Boil the water before drinking (or use chlorinated water if possible). Always pour the water from water containers; do not dip a cup. <p>FOOD:</p> <ul style="list-style-type: none"> • Cook raw food thoroughly; • Eat cooked food immediately; • Store cooked food carefully in refrigerator; • Reheat cooked food thoroughly; • Avoid contact between uncooked/raw food and cooked food; • Eat fruits and vegetables you have washed and peeled yourself. <p>UTENSILS:</p> <ul style="list-style-type: none"> • Keep all food preparation and/or kitchen surfaces clean; • Wash cutting boards especially well with soap and water; • Wash utensils and dishes with soap and water.
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6. Families, Parents, Guardians, Children, Community Members, Cholera at-Risk Populations, General Public (Interpersonal/Group Communication)

QUESTIONS	THEMES
What is Cholera?	<ul style="list-style-type: none"> • It is acute watery diarrhoea, sometimes with vomiting. • If not treated early it can lead to death within a few hours. • It can affect adults and children. • It is caused by a germ that is in the stool of a person sick from cholera that can contaminate many others.
How do you get it?	<p>By poor hygiene from:</p> <ul style="list-style-type: none"> • Not washing hands after latrine use or after cleaning a child's bottom • Not washing hands before preparing or eating food • Not cleaning/preparing food well • Shaking hands with someone who did not wash his/her hands • Drinking contaminated water or food.
What do you do if you get cholera?	<p>If you or a family member has diarrhoea:</p> <p>1) Treat the sick person. Remember:</p> <ul style="list-style-type: none"> • The greatest danger of cholera (and other diarrhoeal diseases) is loss of water from the body; • Do not panic, but act quickly; • Give a solution of oral rehydration salt (ORS) prepared with safe (boiled or chlorinated) water, a recommended sugar salt solution if not ORS and continue breastfeeding babies; • Go immediately to the health center; • Continue giving clean liquids to drink. <p>2) Prevent spread of cholera in your family and community:</p> <ul style="list-style-type: none"> • Practice good hygiene, keep your water safe to drink and use latrines. <p>3) Get vaccinated with the cholera vaccine:</p> <ul style="list-style-type: none"> • Get yourself and your entire family, except children under one year of age, vaccinated with the cholera vaccine if available (or according to protocol).

Table 4 Key messages for different audience groups/ participants in oral cholera vaccination and cholera prevention, control and treatment measures (cont'd)

How do you prevent it?

- Wash your hands often with soap and rinse with safe water (or use ash, lime or sand, when soap is not available)
 - After every defecation;
 - Before handling food (cooking, eating, feeding children);
 - After cleaning a child's bottom;
 - After cleaning a patient with diarrhoea.
- Use the latrine for defecation or bury faeces.
 - Do not defecate in any body of water;
 - Clean latrines and surfaces contaminated by faeces

WATER:

- Boil the water before drinking (or use chlorinated water if possible). Always pour the water from water containers; do not dip a cup.

FOOD:

- Cook raw food thoroughly;
- Eat cooked food immediately (while still hot);
- Store cooked food carefully in cool place or refrigerator;
- Reheat cooked food thoroughly and eat it while still hot;
- Avoid contact between uncooked/raw food and cooked food;
- Eat fruits and vegetables you have washed and peeled yourself.

UTENSILS:

- Keep all food preparation and/or kitchen surfaces clean;
- Wash your cutting board well with soap and water;
 - Wash your utensils and dishes with soap and water.

What is Oral Cholera Vaccine?	<ul style="list-style-type: none"> • It is a vaccine that can protect you from getting sick from cholera. It saves lives! • It is safe and has very few side effects. • But it is not perfect and it does not protect against other diarrhoea. Good hygiene, drinking safe water, practicing good sanitation and getting help when sick remain very important!
How do you take it?	<ul style="list-style-type: none"> • Oral cholera vaccine (OCV) is taken by mouth – you drink it • You need to take 2 doses. <ul style="list-style-type: none"> – The vaccine is only effective after the second dose. – Taking 1 dose is not enough. • The 2 doses are taken 2 weeks apart. • You need to fast one hour before and one hour after taking the vaccine.
Who can receive OCV?	<ul style="list-style-type: none"> • Everyone at risk of cholera over the age of 1 year (or according to protocol⁹); • Do not give OCV to persons who are ill or have cholera.
Where/When can I get OCV vaccination?	<p>Venue: _____</p> <p>Date: _____</p> <p>Time: _____</p> <p>Look for: _____</p> <p>_____</p> <p>_____</p>

⁹ During an outbreak, pregnant women may receive OCV according to protocol.

Choose the appropriate mix of channels and media

An appropriately selected mix of channels creates synergy and enhances effectiveness. Choose culturally appropriate and available channels. Combine channels and media to offset the weaknesses of one channel with the strengths of the others. A channel analysis at the assessment stage will help you decide on the appropriate mix of channels that would actively involve your audience groups in discussion and decision-making. See Table 3.

We should not be tempted to use a communication channel simply because it is popular with the development community but may not be affordable to or used by the intended audiences. (See also: [UNICEF Cholera Toolkit Chapter 7; Annex 7D](#) for a description of the different types of communication activities and channels used in cholera response.

Manage rumours and misperceptions

The spread of rumours and misperceptions about a new vaccine like OCV can derail any immunization programme and create a crisis. Lack of information and mistrust of the programme can create unanswered questions that may lead to fear, apprehension and people's refusal to be vaccinated. People deal with their fear and anxiety by trying to explain the unknown with a rumour.

This is why it is essential to plan for managing rumours as part of your communication plan; in this case, a crisis communication plan. You will need to identify key staff that will manage rumours. Select spokespersons who will serve as the Ministry of Health's face for the media. Identify spokespersons who are regarded as authoritative on the subject and are respected and trusted by communities.

The factors that can help a rumour lead to a boycott of services can also be turned around to help make the programme succeed¹⁰:

- Community discussion at various levels

10 Understanding Rumours: Lessons Learned from immunization in West Central Africa. Power point presentation by Jon Shadid, Mika Kuneida and Guy Scandlen, 2012.

- Trusted local opinion leaders
- Public statements by influential leaders
- Strengthened identity and values
- Resistance perceived as a moral norm and religious imperative
- Peer-to-peer pressure
- Comprehensive media coverage

WHO, UNICEF and USAID offer some tips to communication managers in counteracting and managing rumours about immunization.¹¹ The communication plan should therefore prepare for the following:

Ways to counteract rumours

- Move quickly to respond to a rumour.
- Analyze the situation.
- Clarify the extent of the rumour or misinformation (type of messages circulating, source, persons or organizations spreading the rumour).
- Determine the motivation behind the rumour (lack of information, questioning of authority, religious opposition, desire for publicity or other).
- Turn the rumour around. Go to the source and ask what the solution is.
- Acknowledge existing shortcomings if necessary. Offer the source an opportunity to be part of the solution.
- Invite key opinion/charismatic leaders for advocacy meetings (politicians, traditional and religious leaders, community leaders, celebrities, health workers).

¹¹ Adapted from: WHO, UNICEF and USAID. *Dealing with rumours*. In: Communication for polio eradication and routine immunization: Checklists and easy reference guides. Polio Eradication Initiative, March 2002. p. 30-32.

- Launch a corrective campaign at the highest level, e.g. the Minister of Health, the Governor, District Health Chief, local health administrators, etc.
- Meet with local leaders at sites where the concerned groups are comfortable and can feel at ease to ask questions and have peers present.
- Invite partners, allies and the media. Strengthen alliances. Involve all immunization partners through social mobilization committees, communication coordinating groups, etc. Alert and collaborate with relevant ministries and NGOs.
- Encourage onward briefings to stimulate a cascade effect.
- Conduct orientations and training sessions. Train volunteers and health workers to handle rumours.
- Disseminate tailored information on common misconceptions and guidelines on response. Promote positive key messages.
- Mobilize communities. Empower local people to address and take responsibility for the issue through local channels such as health workers, school events, community seminars, community radio, discussion groups and social media.
- Invite support from the health community. Seek collaboration from health professionals in the public and private sectors, including doctors, nurses and vaccinators, volunteers and members of partner organizations.
- Mount a mass media campaign. Involve all appropriate media (TV, radio, newspapers, and social media.) and traditional media commonly used in the community.
- Seek out and involve media that have already misinformed the public. Call on previously established relationships with the media.
 - Delegate one spokesperson to handle the media questions. Display confidence and credibility.
 - Invite celebrities to help explain the truth.
 - Use the print and broadcast media where appropriate to provide answers to common questions, to correct common misconceptions and to deliver positive messages.

Ways to prevent rumours

- Be “proactive” – before launching the OCV campaign, research and anticipate any potential occurrence of rumours and act accordingly.
- Implement continuing communication activities to prevent and limit rumours.
- Build on-going relationships with local NGOs, religious organizations, community groups and media that have the respect of primary participant groups/individuals as mobilizers and educators.
- Involve community leaders in planning and implementing communication activities for OCV vaccination.
- Approach communities early, and make frequent contact.
- Present health issues as national social, economic and security issues.
- Discuss FAQs on OCV vaccination with public and private practitioners in advance to obtain their support.
- Design communication and social mobilization strategies that establish continuity between NIDs and routine immunization.

Step 5: Plan to monitor and evaluate

Monitoring is used to determine if a communication intervention is progressing as planned, and to make adjustments or changes if necessary. It provides insight as to how well your planned communication activities are being implemented and whether strategies are achieving the intended behaviour outcomes among participant groups. In **behaviour monitoring**, we use carefully selected communication indicators assessed against the “baseline” and data collection methods while the programme is underway to determine “how we are doing”.

There are **two types of monitoring** that need to be addressed:

1. **Behaviour monitoring** refers to tracking the process, outputs and outcomes related to the communication objectives
2. **Implementation monitoring** refers to tracking operations and management of the communication intervention.

Designing a behaviour monitoring plan

The first step in designing a behaviour monitoring plan is defining behaviour outcomes and indicators based on SMART communication objectives (see Table 1). The Communication Coordinating Team should appoint a Communication M&E Task Force within its ranks. Invite an M&E specialist from your agency or from an academic institution.

Three types of indicators:

- **Process indicators:** What processes have been followed in the communication strategy?
- **Output indicators:** In communication activities, are the outputs (such as number of health workers trained on IPC; number of communication tools, mass-media products, etc. developed, pretested and produced) produced as planned?
- **Outcome indicators:** As a result of the process followed and outputs used – what behaviour outcomes are we expecting (actions on the part of participant groups)?

Your indicators should include process measures (number of cholera prone individuals/families and communities vaccinated over a given period); outputs (number of OCV orientations conducted; IPC training with HWs conducted; number trained, types, number and distribution of IPC materials, etc.); and outcomes (level of participation, satisfaction, improved hygiene practices, changes in social norms, etc.)

The following table (Table 5) presents some illustrative indicators on OCV uptake and other cholera prevention measures.

Table 5 Illustrative behaviour monitoring and evaluation indicators for adoption of OCV and other cholera prevention

Knowledge	<ul style="list-style-type: none"> • % of households who can correctly identify cholera illness • % of heads of households who consider immunization to be very important to prevent diseases • % of heads of households who are aware of the benefits of OCV immunization as a preventive measure against cholera • % of heads of households who are aware that two doses of OCV are necessary • % households who mention at least 3 other cholera preventive measures (WASH related).
Attitudes	<ul style="list-style-type: none"> • % of household heads who intend to be vaccinated and have their families vaccinated • % of household heads who are resistant to immunization
Practices	<ul style="list-style-type: none"> • % of cholera prone families (in location) who went for OCV vaccinations and were fully immunized (completed the 2 doses) against cholera in (year) • % of households with (safe drinking water) improved water sources/safe water storage containers • % of individuals who claim to wash their hands with soap at critical times • % households with visible hand washing stations

Table 5 Illustrative behaviour monitoring and evaluation indicators for adoption of OCV and other cholera prevention (cont'd)

Social change	<ul style="list-style-type: none"> • % of families that participate in community programmes to prevent cholera and other diarrhoeal diseases • % of communities with zero open defecation (over a given time) • Case studies that document good practices, innovations and lessons learned from uptake of OCV and other cholera prevention approaches • Improved community system for garbage disposal and sewerage
Advocacy	<ul style="list-style-type: none"> • In a cholera endemic country, national policy and programme exists that integrates OCV in cholera programme as part of cholera prevention • Financial resources allocated to OCV vaccination • # of communities engaging in public declarations supporting OCV vaccination • Case studies that document political will, public policy, resource allocation and programme coordination in OCV integration into cholera programme

Once the M&E Task Force approves the behaviour monitoring matrix, the next step would be the development of guidelines for the specific tools and methods. Both quantitative and qualitative methods as appropriate and feasible can be used to ensure suitable data collection and analysis.

Evaluation is done after a pre-determined period of time has elapsed, known as an “endline” to ask, “how did we do?” i.e., to measure the expected outcomes from a communication intervention assessed also against the “baseline” data and indicators. Therefore, at the early stage of writing the communication and behaviour objectives, you need to identify the indicators.

Indicators are evidence-based signals that help to measure the progress (monitoring) of communication or achievement (evaluation) of a certain behaviour or social change objective.

Examples of M&E Tools

Please refer to: *Behaviour Change Communication in Emergencies: A [Toolkit](#)* for more practical tools that you can adapt for OCV and cholera communication. These tools can guide you in your behaviour monitoring and evaluation (M&E) tasks. In particular, see:

- Tool 2, How to develop indicators based on behaviour results;
- Tool 9, Monitoring chart; Tool 13, Tools to monitor the milestones, and
- Tool 8, How to facilitate a participatory exercise.

From the same Toolkit you can find tools that involve your primary participants/stakeholders in generating in-depth, qualitative M&E data, for example:

- Tool 3, Most significant change technique
- Tool 5, How to conduct a key informant interview
- Tool 6, How to use a pocket voting chart
- Tool 7, How to do a ranking exercise
- Tool 10, Structured observation checklist for health workers' communication skills



Step 6: Document good practices and lessons learned

Invest time and effort to write high quality progress reports, power point presentations, case studies, human-interest stories and vignettes on OCV and cholera prevention communication for different audience groups. These will pay off by helping you:

- Critically analyze reports from the monitoring process and/or the evaluation results as the case may be;
- Adjust or enhance your interventions and fine tune the next iteration of strategic communication action plan;
- Provide material for sharing and networking, allowing active discussion and feedback on progress, challenges and opportunities and where improvements or adjustments in the operations work plan need to be made. These are usually presented during coordination meetings with partners, media, stakeholders and beneficiaries.

Depending on the focus and use of your documentation, those interested will likely be the members of the national or community

coordinating groups, the implementing partners and allies, the funding sponsor, the media, and the intended primary participants who stand to gain healthy, cholera-free status from their participation and feedback.

Documentation allows you to identify and validate innovations, lessons learned and good practices that in turn allow partners, allies, donors, stakeholders and direct beneficiaries to learn from experience and to pursue the better approaches in the context of helping to free at risk children and their families from the threat of cholera. Case studies that use photos and charts and graphs are often developed to document a particular practice; with the categories as defined below.¹²

Lessons learned are more detailed reflections on positive (successes) or negative (failures) lessons from implementing certain strategies with specific participants over a longer time frame.

Good Practices are well documented and assessed programming practices that provide evidence of success/impact and which are valuable for replication, scaling up and further study. They are generally based on similar experiences from different countries and contexts.

Innovations are summaries of new programmatic or operational approaches that are being piloted over the short term into standard programming that can demonstrate effectiveness and efficiency in achieving intended results.

Some good examples can be gleaned from the Reports^{13, 14, 15} on [good practices, innovations and lessons learned](#) in C4D experiences. These are useful [resources](#) that showcase innovative approaches to water, sanitation and hygiene for diarrhoea and cholera prevention and other healthy family practices.

¹² See relevant UNICEF webpage: www.unicef.org/innovations/

¹³ UNICEF WCARO (2012). Report on good practices and lessons learned in UNICEF C4D experiences in the West and Central African Region.

¹⁴ UNICEF New York (2011). Developing capacities to realize the rights of children and women: selected innovations and lessons learned from UNICEF-assisted programmes.

¹⁵ UNICEF Report (2010). Community Approaches to Total Sanitation: India, Nepal, Sierra Leone and Zambia.



RESOURCE 1. Examples of IPC tools/ communication materials

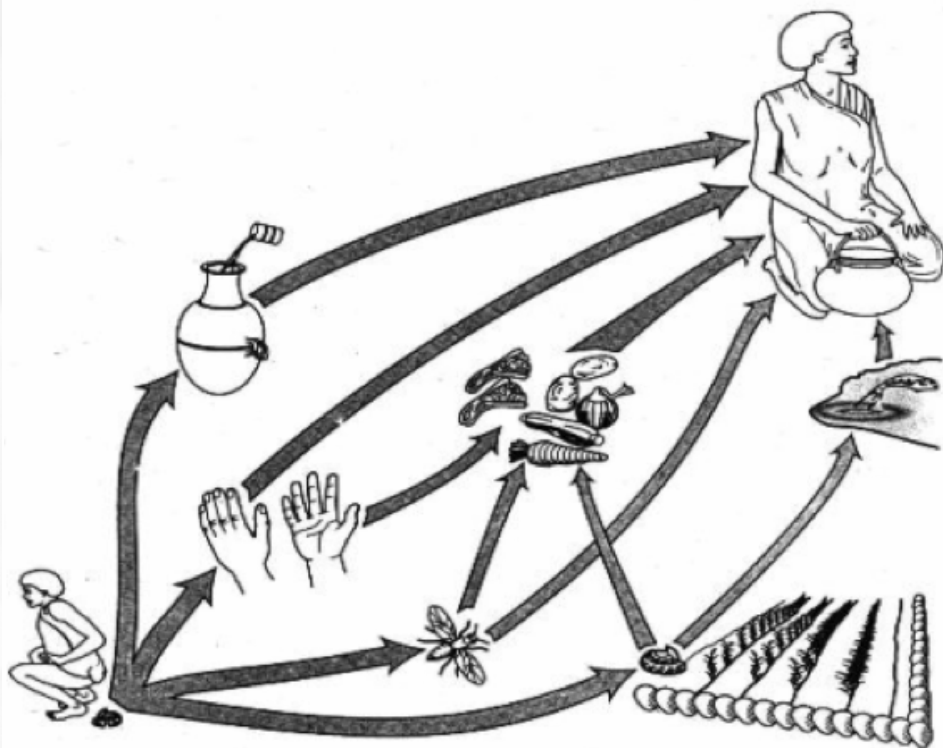
Resource 1.1 Q & A Health Promoters Briefing Guide from Sudan¹⁶:

WHAT is cholera?

- Acute watery diarrhoea, sometimes with vomiting
- If not treated early can lead to death within hours in a previously healthy persons
- Affects adults and children
- Stool of sick person can contaminate many others



¹⁶ MSF (2013). Health Promotion and Cholera Vaccination Mass Campaign in Sudan, January 2012.



HOW do you get it?

- By poor hygiene
- By not washing hands after latrine use
- By not washing hands before making or eating food
- By not cleaning/preparing food well
- By shaking hands with someone who did not wash his/her hands
- By drinking contaminated water



HOW do you prevent it?

- Drink safe water
- Cover your food after cooking
- Safe, well cooked food
- Wash hands with water and soap after latrine, after washing baby, before preparing food and before eating,
- Use latrines, no open defecation
- Vaccination with oral cholera vaccine



WHAT is the cholera vaccine?

- Called Shanchol
- The vaccine is an oral vaccine – you drink it
- Take 1.5ml per dose
- Need 2 doses 2 weeks apart
- Taking only 1 dose is not effective
- 1 vial is for 1 person
- The person needs to drink the full vial
- The vial contains a small amount of liquid



Is the vaccine safe?

- OCV is safe
- OCV Is PREVENTION, NOT treatment
- Lifesaving!
- Gives protection, but still possible to get cholera or other diarrheal diseases
- Other prevention measures are still important for cholera and other diseases!
- Minimal side effects, like some diarrhea, but you can come to the clinic for free treatment if you feel sick after vaccination



WHO can receive this vaccine?

- Everyone over 1 year of age
- Pregnant women
- The vaccine is for everybody, except for children < 1 year old
- Each person must receive two doses 2 weeks apart for full protection!
- Not for very ill persons and those already with cholera
- If anybody feels sick after taking the vaccine, address them to an Health Facility
- The vaccine tastes very bitter: it is normal, don't worry, inform the person about the bad taste

- As all other vaccines, OCV can have side effects.
- Side effects are generally mild: abdominal pain, vomit, diarrhea
- If any side effects, send the person to the Health Facility





WHERE is the vaccination going to take place?

- In Doro camp and direct surrounded host communities
- House to House (like the Polio Campaign)

WHEN?

- Camp: 17th -19th January and 31st January until 2nd of February
- House to house: 22- 23 January and 4th to 5th February

Resource 1.2 Leaflet on Oral Cholera Vaccine from Orissa, India

<p>What is Cholera? Cholera is caused by a germ ingested through Water or food.</p> <ul style="list-style-type: none"> • Is a watery diarrhea that can make some people die within a day if untreated. • Can make a large number of people sick or die during a short time period. <p>Oral cholera vaccine Yes, there is a vaccine to prevent cholera.</p> <ul style="list-style-type: none"> • This vaccine is produced by an Indian-company and approved by the government of India. • It has been proved to be SAFE and EFFECTIVE. <p>How to use oral cholera vaccine?</p> <ul style="list-style-type: none"> • It is given ORALLY. • To protect yourself fully, you need two doses at least 2 weeks apart. 	<p>Can I receive oral cholera vaccine at free? Yes, you can. There is a vaccination booth nearby your house.</p> <ul style="list-style-type: none"> • Please bring HOUSEHOLD ID CARD when you visit to vaccination booth on vaccination day! • There will be NO house-to-house visit in this campaign.  <p>Where?</p> <ul style="list-style-type: none"> • ASHA/ AWW will inform you where are vaccination booths nearby your house. <p>Who should NOT receive the vaccine?</p> <ul style="list-style-type: none"> • Young children under 12 months of age. • Pregnant women. • Too sick people. <p>Who is leading this vaccination?</p> <ul style="list-style-type: none"> • This project will be leaded by the State Government of Orissa. 	<p>Mass Vaccination Campaign Oral Cholera Vaccine</p>  <p>Protect Yourself and Your Loved Ones From Cholera With the Cholera Vaccine</p> 
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Source: OCV mass vaccination campaign in Orissa, India, 2012

Resource 1.3 Poster on OCV from mass vaccination campaign in Orissa, India

Mass Vaccination Campaign Oral Cholera Vaccine

Satyabadi Block, Puri District, Orissa

GET ORAL CHOLERA VACCINE!
Protect Yourself and Your Family From Cholera

2 doses

Target All people aged 1 year and above

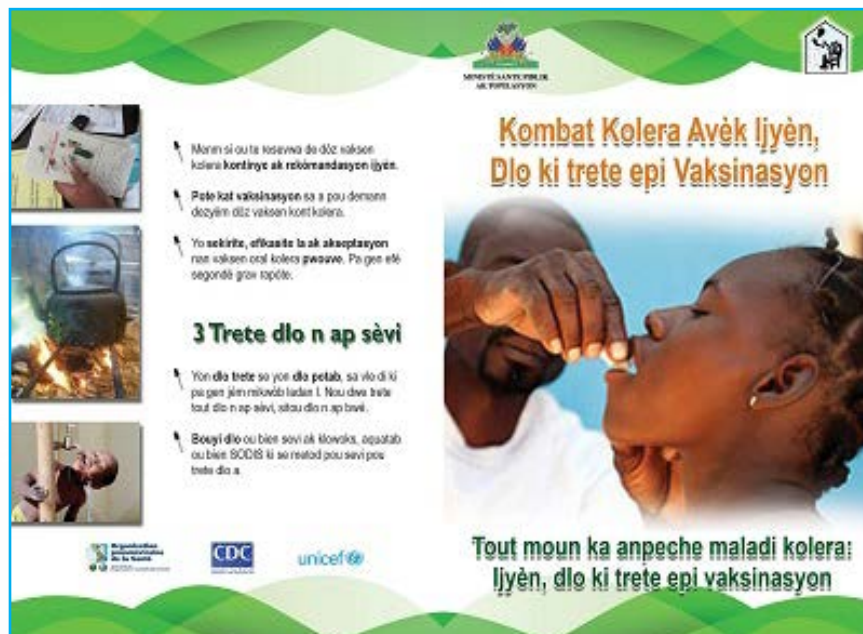
Date 1st dose on May 5th, 6th, 7th
2nd dose on May 26th, 27th, 28th

Place Go to the nearest booth



Source: OCV mass vaccination campaign in Orissa, India, 2012

RESOURCE 1.4 OCV and cholera prevention leaflet from Haiti



Source: OCV Vaccination Campaign in Haiti, 2012

Resource 1.5 Key messages on OCV and cholera prevention from Guinea

A l'attention des populations

Qu'est-ce que le choléra ?

- Le choléra est une diarrhée grave
- Il peut entraîner la mort par perte d'eau dans le corps en quelques heures s'il n'est pas soigné rapidement

Comment attrape-t-on le choléra ?

- On attrape le choléra par manque d'hygiène :
 - Si on ne se lave pas les mains après être allé aux toilettes
 - Si on serre la main de quelqu'un qui ne s'est pas lavé les mains
 - Si on ne se lave pas les mains avant de préparer la nourriture

- Si on ne nettoie pas la nourriture
- Si on boit de l'eau contaminée

Que faire si on attrape le Choléra ?

- Si vous avez de diarrhées ou des vomissements, allez directement au centre de santé
- Il faut beaucoup boire! Même en allant au centre de santé, il faut boire!

Vaccination contre le choléra

- Le vaccin est pour tout le monde dès l'âge de 1 an
- Le vaccin se prend par la bouche
- Il faut le prendre 2 fois: une fois aujourd'hui et une fois dans 2 semaines au moins pour qu'il soit efficace
- Prendre 2 fois la même journée n'est pas bon
- Nous passerons distribuer la 2ème dose dans 2 semaines
- Gardez la carte que nous vous donnons pour recevoir le 2ème vaccin
- Même les 2 prises ne protègent pas complètement. Les règles d'hygiène doivent être suivies ! Si vous avez de diarrhées ou des vomissements, allez directement au centre de santé

Hygiène : 3 messages clé

1. Utilisez **les latrines** pour faire caca
2. **Lavez-vous les mains avec du savon**
 - a. après chaque caca
 - b. avant de manipuler de la nourriture (cuisiner, manger, pour nourrir les enfants aussi)
 - c. Les mères qui allaitent doivent se laver les mains **et les seins** (verify) avec du savon et de l'eau avant de nourrir l'enfant.
3. Utilisez de **l'eau traitée avec le SUR'EAU**. Nettoyez très bien les aliments, les ustensiles avant de préparer la nourriture :
 - d. Utilisez des bidons propres pour garder l'eau de boisson traitée avec le SUR'EAU.
 - e. Lavez le récipient à boire immédiatement après usage avec du savon.

Source: MSF cholera vaccination campaign in Guinea, March 2012.

TOOL 1. Sample template for behaviour analysis of participant groups in OCV introduction and cholera prevention programme

Level in the Socio-Ecological Model (SEM)	Individual/Family Level
Communication Strategy	Behaviour Change Communication (BCC)
1. RESEARCH QUESTIONS FOR BEHAVIOUR ANALYSIS	
1.1 Who is/are the participant group(s)?	<p>Individual level: Head of household; father; mother, primary caregiver</p> <p>Family and friends: Children; mother-in-law, grandparents, other relatives, neighbours, friends, peers</p>
1.2 Current Behaviour: What is/are the current behaviour related to (OCV) immunization and cholera prevention and control?	Not aware of OCV; Not practising good hygiene; open defecation
1.3 Key Behaviour: What is/are the recommended key behaviour/s?	Bring family for OCV vaccination and complete 2 doses
1.4 Other Supporting Behaviours: What other behaviours are recommended to prevent cholera infection and spread?	Family members continue practising good hygiene and sanitation, drinking safe water, safe waste disposal. Understand that cholera causes severe diarrhoea and dehydration and that it can quickly cause death if not treated early.

Community Level	Organizational/ Provincial, District	Policy Level
BCC; Community Mobilization; Social Change	Social Mobilization; Social Change	Advocacy
Community level: Community leaders, health workers, vaccinators, community volunteers, religious leaders, village influentials, CBOs, school teachers, school children, community media	Provincial/State and District level: Governor, Mayor, Representatives of health, educational institutions, business; leaders of socio-cultural and or socio-economic organizations, CSOs, NGOs, mass media, social media	Head of State, policy makers, representatives of national institutions, Ministry of Health, other ministries, National Cholera Task Force/ Coordinating Committee, mass media organizations, telecommunications companies
Not aware of OCV; not assuming role as mobilizer for cholera prevention	No intent to integrate OCV into cholera prevention programme	No political will to include OCV in cholera programme
Motivate constituents to go for OCV and practice WASH	Motivate cholera-prone communities to adopt OCV as an added measure against cholera.	Issue policy that integrates oral cholera vaccination in the national cholera programme; allocate funds
Treat all persons coming for OCV with respect; answer their questions and address their concerns and show active interest in their opinions	Help cholera at-risk to know prevention and control; explain added value of OCV.	Understand limitations of implementing traditional interventions in some settings, and how OCV may help mitigate disease transmission

TOOL 1. Sample template for behaviour analysis of participant groups in OCV introduction and cholera prevention programme (cont'd)

Level in the Socio-Ecological Model (SEM)	Individual/Family Level
1.4 Key Behaviour Barrier: What is the key behaviour barrier to the recommended behaviour/s?	<ul style="list-style-type: none"> • Resistance to vaccination • Poor knowledge of vaccines and their benefits
1.5 Other barriers: What are the other underlying (behaviour and non-behaviour) barriers to the recommended behaviour? <i>(What perceived benefits come from NOT adopting the recommended behaviour?</i> <i>What social norms hinder the adoption of the recommended behaviour?)</i>	<ul style="list-style-type: none"> • Poor attitude toward health worker • Negative past experience with HW • Long distance to vaccination venue; costs • Competing priorities
1.6 Motivating factors: What current or traditional practices and existing social norms could support adoption of recommended behaviour/s toward OCV uptake and cholera prevention and control?	<ul style="list-style-type: none"> • Desire to maintain good health, freedom from cholera and other diseases

Community Level	Organizational/ Provincial, District	Policy Level
<ul style="list-style-type: none"> • Low capacity to facilitate community mobilization • Poor IPC skills 	<ul style="list-style-type: none"> • Lack of leadership/ initiative/commitment–Low capacity to facilitate social mobilization 	<ul style="list-style-type: none"> • Lack of leadership and political will to support OCV initiative
<ul style="list-style-type: none"> • Low self-esteem • Careless attitude towards clients • Weak supervision and monitoring structures • Lack of resources 	<ul style="list-style-type: none"> • Lack of political commitment • Not clear about the issues • Several competing programmes for limited resources; • Desire for political image building/ conflict of interest 	<ul style="list-style-type: none"> • Lack of political commitment • Not clear about the issues • Several competing programmes for limited resources; • Desire for political image building/ conflict of interest
<ul style="list-style-type: none"> • Professional / political pride, • Playing a role in saving lives 	<ul style="list-style-type: none"> • Professional / political pride, • Playing a role in saving lives 	<ul style="list-style-type: none"> • Key role in agenda-setting and resource allocation

TOOL 2. Sample template for a communication action plan for an OCV mass vaccination campaign in Country X

Audience/ Participants	Behaviour Objectives/ Desired Actions	Key Messages	Activities	Support Materials	Outcome Indicators
I. National Level Advocacy					
II. Provincial/State Level Advocacy					
III. District Level Advocacy					
IV. Media Engagement					
V. Social Mobilization of Partners and Allies					
VI. Community Mobilization for Behaviour and Social Change					

TOOL 3. Monitoring checklist for OCV communication strategy implementation¹⁷

1. Are there a communication team and a working communication coordination structure in place with competent, committed, and collaborative members with clear terms of reference?
2. Was an assessment done to identify:
 - 2.1. The KAP gaps, barriers and motivators to desired practices among your participant groups (i.e. health workers, parents, guardians, children, volunteers, at risk groups particularly the hard to reach and resistant to immunization)?
 - 2.2. The information-seeking and sharing patterns of the affected communities (communication network analysis)?
 - 2.3. The main barriers for affected families and communities to practice the intended behaviour (e.g. all family members availing of cholera vaccination services, practicing safe hygiene and sanitation)?
 - 2.4. Are the problem behaviours, as well as the desired behaviours, clearly identified? Are the communication objectives “SMART” (specific, measurable, appropriate, realistic, time-bound)?
3. Did you integrate a training module on interpersonal communication skills and social mobilization into the clinical training on OCV for health workers?
4. Did you develop an OCV communication plan that includes components of effective service delivery; key messages in IPC tools, communication materials and mass media pretested? Do these communication tools support advocacy, social mobilization and community engagement? Does national level provide encouragement, guidelines and funding to support decentralized planning and implementation of integrated communication plans? How are national and sub-national plans coordinated? Is the whole sub-national management staff involved in the design and implementation of the communication work plan? Are those plans implemented? Are district administrators, religious leaders, public officers, local opinion leaders, and chief of villages aware of on-going cholera vaccinations? Are national communication plans regularly revised and updated? Are lessons learned integrated regularly within the existing plan?

¹⁷ Adapted from UNICEF ROSA (2006). Behaviour Change Communication in Emergencies: A Toolkit, Tool 12, p. 219.

5. Does the plan clearly state the behaviour objectives you seek to influence by participant group?
6. Did you prepare an implementation plan for each communication strategy (advocacy, social mobilization, behaviour and social change)?
7. Is there a current advocacy strategy, which integrates the lessons learned from other country experiences? Are the objectives of the advocacy strategy “SMART”? Do the advocacy activities for OCV vaccination also address preventive practices against a cholera outbreak in the country? Do the advocacy activities stress the role of the political and social leadership and do they focus on the actions that can be taken by them to improve their performance?
8. Who are the partners and allies involved in social mobilization for OCV vaccination and cholera prevention? Are there mechanisms in place to track the partners and allies’ involvement in social mobilization? Which other organizations should be involved? Do the partners receive recognition and credit for their support in all the social mobilisation activities?
9. Briefly describe community mobilization activities to address barriers and to encourage families to get immunized against cholera:
 - 2.1. Parents, heads of household, caretakers: Do family heads have a positive or negative attitude in relation to immunisation? What is done to address existing barriers to immunisation among family decision-makers?
 - 2.2. Service providers: Are there mechanisms in place to track health workers’ involvement? Are they fully informed and trained in interpersonal communication in addition to clinical aspects of OCV vaccination?
 - 2.3. Resistant groups, misconceptions on vaccination, and/or hard-to-reach: How does the local communication committee use coverage data to identify low coverage areas, resistant groups, lost opportunities and zero-dose and one-dose areas? Have pockets or groups with low coverage and dropout rates at national and sub-national level been identified at all, and where are they located?

- 10.** Does it include opportunities for community ownership and participation in areas such as formative research, material preparation, message design and dissemination, monitoring and evaluation?
- 11.** Did you establish a monitoring system to keep track of your operations and to gather feedback about desired behaviour outcomes?
- 12.** Did you determine the communication budget? Were there efforts to mobilize resources to ensure funding allocation for the communication component?
- 13.** Are messages and materials gender-, age- and culture-sensitive and appropriate?
- 14.** Did you choose the most appropriate mix of the most effective communication channels – interpersonal, mid-media, mass media and social media?
- 15.** Did you invite and receive feedback from the various audience(s) of the affected community on your suggested messages and materials (pre-testing)?
- 16.** Do you know if the material and the messages in it reached the people they were meant to reach (e.g. affected population, health workers, volunteers, etc.)?
- 17.** Do you have a system to document, share and manage the information with partners, humanitarian organisations, UN sister agencies, government bodies, professional organisations and other concerned partners?

TOOL 4. Preparing for an OCV Communication Campaign

Creating on-going demand for oral cholera vaccination involves time-bound communication campaigns, which is a reality of immunization programmes. Campaigns often require national leadership support to ensure implementation at lower levels. The participation of local leaders is crucial in micro planning as well as in mobilizing their constituencies particularly the most at risk and the hard to reach members of the population.

Planning for a campaign regardless of duration, involves the same steps in planning a C4D strategy. Because it is time-bound, a campaign requires that actual implementation is coordinated and monitored at local level by local leaders with maximum participation of community stakeholders.

Elements of a Campaign The following are the necessary elements of an evidence-based campaign for OCV uptake combined with other cholera prevention approaches:

- Coordination structure and internal communication system
- Communication micro plans or weekly plans with daily activities.
- Positioning key messages for different participant groups
- Advocacy with local leaders and influentials
- Social and community mobilization using IPC tools, IPC materials, TV, radio, print media formats
- Media engagement
- IPC training of frontline workers
- Training of spokespersons
- Capacity building of implementers and stakeholders in communication for development
- Working on resistance
- Communication protocol to respond to crisis and adverse events following immunization
- Monitoring and evaluation protocol

TOOL 5. Organizing training on interpersonal communication for health workers and vaccinators

- Prepare a training needs assessment, a training plan, modules and session plans with presentation materials and group dynamic tools for groups that require strengthening skills in interpersonal communication (IPC) and social mobilization.
- These are aimed at vaccinators, community health workers, community mobilizers and youth volunteers.
- Be sure to integrate modules on IPC and social mobilization in the practical component of the training of trainers (ToT) and training rollout for vaccinators of OCV immunization.
- Select experienced training facilitators/consultants in IPC Skills and Social Mobilization.
- Conduct the training in a timely manner, at least one month prior to the start of programme activities.
- You can access some examples of training modules and session facilitator's guides on IPC and social/community mobilization. See for example see: [Training Manual on IPC¹⁸](#). These can be adapted to the training needs of your specific training participants and programme context.

¹⁸ Training Manual on Interpersonal Communication for Field Activators. Water and Sanitation Programme, Government of Tanzania, USAID/BASICS (2009).

References and Additional Resources with Links

- **AidsAlliance:** Tools together now! *100 participatory tools to mobilize communities for HIV/AIDS*. Supported by USAID and Bill and Melinda Gates Foundation, 2009. www.aidsalliance.org/includes/Publication/Tools_Together_Now_2009.Pdf
- Anh, DD, Lopez, et al. (2011) Use of oral cholera vaccine in Vietnam: a case control study ([Link](#))
- Afghanistan's successful response to cholera outbreak (2006). www.msh.org/Documents/JournalArticles/upload/Successful_Response_to_an_Outbreak_of_Cholera_in_Afghanistan.Pdf
- **Africa Health Communication:** Bryan Pearson Coping with cholera: the importance of coordinated planning. Africa Health Com, January 2011. www.africa-health.com/articles/january_2011/Cholera.Pdf
- **Bangladesh:** Knowledge of, attitudes toward, and preventive practices relating to cholera and oral cholera vaccine among urban high-risk groups: findings of a cross-sectional study in Dhaka, Bangladesh. BMC Public Health. 2013, 13:242 www.biomedcentral.com/1471-2458/13/242
- **BBC - Research Summary:** Governance in three African countries http://downloads.bbc.co.uk/mediaaction/Pdf/research_summaries/BBCMA_RS_National_Conversation_GTF_overview_August_2012.Pdf
- **CDC - US DHHS:** Community Health Worker Training Materials for Cholera Prevention and Control, Haiti, 2012. www.cdc.gov/cholera/Pdf/chw_trainingmaterialsforcholera_v2.Pdf
- CDC Inform, Inspire, Improve Health (2012) CDC National Conference on Health Communication Marketing and Media. August 7-9 , 2012. Hyatt Regency, Atlanta, Ga. USA. www.cdc.gov/nchcmm/Pdf/2012NCHCMMConferenceProgram.Pdf
- **Cameroon:** IFRC Emergency Appeal Cholera Outbreak www.ifrc.org/docs/appeals/11/MDRCM011ea.Pdf
- **Lightings:** Cameroon Strategic Health Information Bulletin, Vol. 3, No. 3, Nov – Dec 2011, p. 3: "Socio-cultural factors in the spread of cholera": www.cdbph.org/documents/Eclairages_cholera_English%20Version%2026%20March%202012.Pdf

- CDAC InterNews, October 2010.
www.internews.org/our-stories/program-news/internews-supports-vital-communications-response-cholera-outbreak-haiti
- **Case study:** CDAC Haiti and cholera research, 2010
www.cdacnetwork.org/sites/www.cdacnetwork.org/files/cdac_and_cholera_research.Pdf
- Communication Initiative, 2012. Raising Women's Voices Thru Radio Drama in South Africa www.sigauqueproject.com/Raising%20Women%27s%20Voices%20Radio%20Drama_CMFDPOWA2012.Pdf
- **"Communicate to vaccinate":** the development of taxonomy of communication interventions to improve routine childhood vaccination. *BMC International Health and Human Rights* 2013, 13:23
www.biomedcentral.com/content/Pdf/1472-698X-13-23.Pdf
- **Citizens, media & Good Governance:** a guide for journalists
www.mwananchi-africa.org/storage/Mwananchi%20Governance.Pdf
- DRC considers cholera vaccination – Jan 31, 2013
http://article.wn.com/view/2013/01/31/DRC_considers_cholera_vaccination/
- **ELD – Case Study Writing Handbook** www.eldtraining.com/docs/Case%20Study%20Writing%20Handbook%202010.Pdf
- **GAAC - 6th World Water Forum Water and Health:** An Integrated Approach For A Sustainable Fight Against Cholera, Presented By The Global Alliance Against Cholera
March 13, 2012 www.choleraalliance.org/wp-content/galleries/TheGlobalAllianceAgainstCholera-recommendations-v4.Pdf
- **Ghana – Prilutski, MA. (2009). *A Brief Look at Effective Health Communication Strategies in Ghana*.** Elon University.
www.elon.edu/docs/e-web/academics/communications/research/vol1no2/04PrilutskiEJFall10.Pdf
- **Ghana – Fast reports on cholera action, 2009**
<http://factsreports.revues.org/188>
- **MSF – Vaccinating against cholera in Guinea (June 2012)**
www.doctorswithoutborders.org/press/release_print.cfm?id=6051
- **Infoasaid – Beneficiary communications in Haiti, June 2012**
<http://infoasaid.org/news/beneficiary-communications-haiti>

- **IFCR** – Guinea cholera report – Sept 2012
<http://reliefweb.int/sites/reliefweb.int/files/resources/full%20ifrc.Pdf>
- **Haiti**: Cholera Outbreaks Coordinated Preparedness and Response – WASH Cluster Operational Plan, 2011. www.cdbph.org/documents/Eclairages_cholera_English%20Version%2026%20March%202012.Pdf
- **Haiti** – Research on KAP related to treatment and prevention of cholera, 2010 www.ncbi.nlm.nih.gov/pmc/articles/PMC3310585/
- **Haiti** – Research: Cholera vaccines effective even after outbreak. SciDev News, Jan 2011. www.scidev.net/en/news/cholera-vaccines-effective-even-after-outbreak-begins-.html
- **Haiti** –IFRC Cholera Update Info Bulletin, Oct 2010
<http://w3.ifrc.org/docs/appeals/rpts10/MIBHT22102010.Pdf>
- **Haiti** – IFRC 6 month update – cholera, June 2011
www.ifrc.org/docs/appeals/10/MDR49007eu6.Pdf
- **Haiti** – Isabel Bergeri (2011) OCG response to cholera in Haiti, October 2010 – March 2011: Evaluation report (external), MSF.
www.alnap.org/pool/files/eval-report-cholera-haiti-external-dec-2011.Pdf
- **Haiti** – Cholera Inter-Sector Response Strategy for Haiti, Nov 2010 – Dec 2011 http://reliefweb.int/sites/reliefweb.int/files/resources/8B2E07AB1A31BABEC12577D8004FE057-Full_Report.Pdf
- **Haiti** – K Sholtes, K Schilling, C Hough, et al. (2011) Cholera Prevention Training Materials for Community Health Workers, Haiti/CDC, 2010–2011. <http://wwwnc.cdc.gov/eid/article/17/11/Pdfs/11-0806.Pdf>
- **Haiti** – UN investigation report on cholera spread in Haiti, 2012.
www.un.org/News/dh/infocus/haiti/UN-cholera-report-final.Pdf
- Haiti Beneficiary Communication Practices and the Effectiveness of Cholera Communication Campaigns in Haiti, ALNAP, 2012.
www.alnap.org/event/201.aspx
- **Haiti Case study**: CDAC in Haiti and cholera research, 2010
www.cdacnetwork.org/sites/www.cdacnetwork.org/files/cdac_and_cholera_research.Pdf
- **Haiti** – Cholera Outbreaks Coordinated Preparedness and Response Operational Plan, 2011.
<http://haiti.cridlac.org/XML/eng/doc90907/doc90907-contenido.Pdf>

- **Haiti** –Cholera and the Ministry of Public Health, 2010
www.cdacnetwork.org/public/content/cholera-and-ministry-public-health
- **Haiti** – Risk Factors Early in the 2010 Cholera Epidemic, Haiti, 2011.
http://wwwnc.cdc.gov/eid/article/17/11/11-0810_article.htm
- **Haiti and Dominican Republic** - Elimination of Cholera Transmission in Haiti and the Dominican Republic, 2010.
www.cdc.gov/globalhealth/features/cholera.htm
- **Haiti** – UNICEF supports Strategic Nutrition Framework for cholera response in Haiti, Dec 2010. www.unicef.org/media/media_57145.html
- **Haiti** – UNICEF supports community mobilization to stop spread of cholera in Haiti, 2011. www.unicef.org/infobycountry/haiti_57354.html
- **Haiti** – Beneficiary Communications Evaluation, Haiti Earthquake Operation, 2011. www.ifrc.org/Global/Publications/disasters/reports/IFRC-Haiti-Beneficiary-Communications-Evaluation-EN.Pdf
- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC, 2007. www.icva.ch/doc00002621.Pdf
- **IFRC** – Advocacy Report: 100,000 cases -The spectre of cholera remains in Zimbabwe, May 2009 www.redcross.org.au/files/Zimbabwe-Report.Pdf
- **IFRC**: DREF final report: Dominican Republic: Cholera
<http://reliefweb.int/sites/reliefweb.int/files/resources/Dominican-Republic-Cholera-IFRC.Pdf>
- **IFRC**: Owner-driven housing reconstruction guidelines: *Community mobilization process and tools*, 2010, p. 79 – 82. www.ifrc.org/PageFiles/95526/publications/E.02.06.%20ODHR%20Guidelines.Pdf
- **IFRC**: Behaviour change communication (BCC) for community-based volunteers: A trainer's Manual (2009) www.ifrc.org/PageFiles/53437/119200-vol4-BCC-trainers_LR.Pdf?epslanguage=en
- **India** – Pilot introduction of OCV in Orissa, India, 2012.
<http://clinicaltrials.gov/show/NCT01365442>
- India (Delhi) Call for action to intensify RI in India, 2012
www.searo.who.int/entity/immunization/documents/hlmm_delhi_call_for_action_2011.Pdf

Indian Immunization Programme: A literature review

www.imprimispr.com/indian-immunization-programme-nov2012.Pdf

- **Journal of Health Communication** – S Waisbord, L Shimp, E Ogden & C Morry. *Communication for Polio Eradication: Improving the Quality of Communication Programming Through Real-Time Monitoring and Evaluation*. Journal of Health Communication: International Perspectives, 2010.15:S1, 9-24
<http://dx.doi.org/10.1080/10810731003695375>
- **R Obregón & S Waisbord**. *The Complexity of Social Mobilization in Health Communication: Top-Down and Bottom-Up Experiences in Polio Eradication*, Journal of Health Communication: International Perspectives, 2010. 15:S1, 25-47
<http://dx.doi.org/10.1080/10810731003695367>
- **Kenya** – E. Maitha, C Nyundob, E Bauni and D Mulewa. *Twin Innovative Strategy to Sustain Cholera Prevention: Evidence from Kilifi, Kenya HDSS*. The African Journal of Health Sciences, Jan 2013.
www.ajhsjournal.or.ke/?p=775
- **Lancet** – A case for control of cholera in Africa by vaccination, The Lancet Infectious Diseases, Volume 12, Issue 11, Pages 818 - 819, November 2012 (Published Online: 04 September 2012)
www.childsurvival.net/?content=com_articles&artid=1546
- **MSF** – JF Corty. Medical Innovations in Humanitarian Situations. Chapter 5: Cholera, 2013. www.doctorswithoutborders.org/publications/book/medicalinnovations/book.cfm?id=5241
- **MSF** – Vaccinating against cholera in Guinea, June 2012.
www.doctorswithoutborders.org/press/release_print.cfm?id=6051
- **MSF South Sudan** – Preventing Cholera in South Sudan's Remote Refugee Camps – Feb 2013
www.doctorswithoutborders.org/news/article_print.cfm?id=6655
- **Nigeria** – M A Basorun, *Designing A Communication Intervention Using Radio as an Effective Tool in Communicating Anti-Cholera Related Information to Rural Dwellers in Idi-Iya Community In Iseyin Local Government Area Of Oyo State*, 2012.
<http://odinakadotnet.wordpress.com/2012/09/22/designing-a-communication-intervention-using-radio-as-an-effective-tool-in-communicating-anti-cholera-related-information-to-rural-dwellers-in-idi-iy-a-commuinty-in-iseyin-local-government-area-of-stat/>

- Oxfam Cholera Guidelines http://policy-practice.oxfam.org.uk/blog/2012/08/cholera-guide?cid=rdt_choleraguide
- **Pakistan** – Understanding barriers to immunization in Pakistan: Volume I: Qualitative Study of Issues Related to Programme Management and Service Delivery Knowledge, Perceptions and Views of Mothers and Fathers about Service Delivery. Commissioned by UNICEF to Arjumand and Associates; Submitted to Federal EPI Cell, Islamabad, December 2009. ([Pdf](#))
- **SciDev Journal** – Countries failing to report on cholera www.scidev.net/en/health/news/countries-failing-to-report-cholera-outbreaks-says-report-1.html
- **Sierra Leone** – FRC Emergency appeal operation update - Sierra Leone: Cholera Epidemic (revised) www.ifrc.org/docs/Appeals/12/MDRSL003REA.Pdf
- CARE Sierra Leone intensifies efforts to combat cholera outbreak (2012) www.careinternational.org.uk/news-and-press/latest-news-features/2138-care-sierra-leone-intensifies-efforts-to-combat-cholera-outbreak
- **The Sphere Project:** Humanitarian Charter and Minimum Standards in Disaster Response handbook. Geneva, 2004. www.sphereproject.org
- Somalia BCC and hygiene promotion for AWD/Cholera – PPT presentation http://healthsomalia.org/documents/bcc_cholera.Pdf
- **Somalia WASH/Health/Comms Clusters** – AWD/Cholera Task Force Responsibilities www.healthsomalia.org/documents/tors_and_responsibilities_matrix_for_awd-cholera_task_force.Pdf
- Somalia AWD/Cholera Preparedness and Response Plan, Feb 2012 http://healthsomalia.org/alerts_weekly_documents/health_cluster_awdcholera_preparedness_and_response_plan_feb2012.Pdf
- **South Sudan** – Preventing Cholera in South Sudan's Remote Refugee Camps (MSF) – Feb 2013 www.doctorswithoutborders.org/news/article_print.cfm?id=6655
- **South Africa Development Cooperation** – MD Said, N Funke, I Jacobs, M Steyn and S Nienaber (Oct 2011). *The case of cholera preparedness, response and prevention in the SADC region: A need for proactive and multi-level communication and co-ordination*. Euroconsult Mott MacDonald –Technical Assistance Support Team (TAST), Ministry of Water Resources & Irrigation, PO Box 476, Juba, South Sudan and Council for Scientific and Industrial

- **UNICEF Essentials for Excellence:** Researching, Monitoring and Evaluating Strategic Communication for Behaviour and Social Change, with special reference to the prevention and control of avian influenza/pandemic influenza, prepared by W. Parks, 2008.
www.unicef.org/cbsc/files/Essentials_for_excellence.Pdf
- **UNICEF Advocacy Toolkit:** A guide to influencing decisions that improve children's lives, 2010.
www.unicef.org/evaluation/files/Advocacy_Toolkit.Pdf
- UNICEF Guidance Note on the use of Oral Cholera Vaccines, New York. July 2011. www.unicef.org/immunization/files/UNICEF_OCV_Guidance_20_July2012_final.pdf
- **UNICEF** – What is C4D? www.unicef.org/cbsc/index_42148.html
- UNICEF Cholera Toolkit. New York, May 2013.
www.unicef.org/cholera/Cholera-Toolkit-2013.pdf
- Global Communication Framework for New Vaccines and Child Survival. Commissioned by UNICEF New York as part of a collaborative effort of the global communication group for new vaccines, pneumonia and diarrhoea control, 2011.
<https://docs.google.com/>
- Socio-ecological models of health behaviour
<https://www.google.com/>
- **UNICEF Liberia** – Communication Strategy on Water, Sanitation and Hygiene for Diarrhoea and Cholera Prevention prepared by Rudrajit Das, October 2012. ([Pdf](#))
- UNICEF ROSA Behaviour Change Communication in Emergencies: A Toolkit. www.unicef.org/ceecis/BCC_full_Pdf.Pdf
- UNICEF WCARO-Dakar Workshop Fight against cholera and diarrhoeal diseases in West and Central Africa, May 2008 www.unicef.org/wcaro/04.Recommandations_Atelier_Dakar_GB_final_2009_06_19.Pdf
- West and Central Africa Region situation update on humanitarian crises, 2012 www.unicef.org/hac2012/files/WCAR_UNICEF_2012_HAC_update.Pdf

- **UNICEF Press release:** Cholera upsurge kills more children in the Sahel. DAKAR/GENEVA, 10 July 2012 - www.unicef.org/media/media_65267.html
- **UNICEF Press release:** UNICEF collaborates with partners to fight cholera outbreak in Nigeria, Sept 2010 www.unicef.org/nigeria/media_5719.html
- UNHCR Cholera Preparedness and Response in Refugee Camp Settings www.unhcr.org/4f707f509.Pdf
- **USAID** – Sarah K. Fry (April 1992). *Cholera Prevention and Control: Guidelines for Assessing the Options in Water Supply, Sanitation and Hygiene Education*. Prepared for the Bureau for Research and Development, Office of Health, U.S. Agency for International Development, under WASH Task No. 323 http://Pdf.usaid.gov/Pdf_docs/PNACA703.Pdf
- **USAID:** Haiti – Cholera Situation Update, Dec 2010 http://transition.usaid.gov/our_work/humanitarian_assistance/disaster_assistance/countries/haiti/template/fs_sr/fy2011/haiti_ch_fs08_12-10-2010.Pdf
- **USAID:** Cholera: technical description, prevention and management <http://www.icm.tn.gov.in/idsp3.html>
- **WHO** – Cholera and other epidemic diarrhoeal diseases control – Technical cards on environmental sanitation, 1997, WHO/EMC/DIS/97.6 [Pdf 2.4MB] http://whqlibdoc.who.int/hq/1997/WHO_EMC_DIS_97.6.Pdf
- **WHO** – Cholera outbreak: assessing the outbreak response and improving preparedness www.who.int/topics/cholera/publications/cholera_outbreak/en/index.html
- **WHO** – Acute diarrhoeal diseases in complex emergencies: critical steps www.who.int/topics/cholera/publications/critical_steps/en/index.html
- **WHO** – First steps for managing an outbreak of acute diarrhoea www.who.int/topics/cholera/publications/first_steps/en/index.html
- WHO Communicable diseases control in emergencies: A field manual. WHO, 2006. http://whqlibdoc.who.int/publications/2005/9241546166_eng.Pdf
- **WHO/UNICEF/USAID** – Communication for polio eradication and routine immunization: Checklists and easy reference guides. Polio Eradication Initiative, March 2002. http://whqlibdoc.who.int/hq/2002/WHO_POLIO_02.06.Pdf

- WHO integrated disease surveillance programme.
www.who.int/csr/labepidemiology/projects/surveillance/en/index.html
- **WHO** – Hyer, RN and VT Covello, Effective Media Communication during Public Health Emergencies: A WHO Field Guide. 2005.
<http://www.who.int/csr/resources/publications/WHO%20MEDIA%20HANDBOOK.Pdf>
- **WHO** – Statement –World Immunization Week, 2012 - SEARO Director www.searo.who.int/entity/immunization/topics/rd_statement_wiw_searo_2012.Pdf
- **WHO** – Periodic intensification of routine immunization (PIRI) www.immunizationbasics.jsi.com/Docs/PIRImonograph_Feb09.Pdf
- WHO OCV in mass immunization campaigns: guidance for planning and use http://whqlibdoc.who.int/publications/2010/9789241500432_eng.Pdf
- WHO Addendum to OCV in mass immunization campaigns: guidance for planning and use www.who.int/cholera/vaccines/AddendumGuideVaccinationForShanchol050913.pdf
- WHO Oral cholera vaccine stockpile http://www.who.int/cholera/vaccines/ocv_stockpile_2013/en/
- WHO Technical Working Group on creation of an oral cholera vaccine stockpile (2013). Oral Cholera Vaccine Stockpile for cholera emergency response www.who-cc.dk/cholera/vaccines/Briefing_OCV_stockpile.pdf
- WHO Outbreak Communication Planning Guide, 2008 http://new.paho.org/hq/index.php?option=com_content&view=article&id=4387&Itemid=3807&lang=en
- WHO Situation reports on cholera outbreak in Haiti, Oct 2010 - <http://new.paho.org/>
- **WHO/PAHO** – Controlling Cholera: A checklist for Planners <http://bvs.per.paho.org/texcom/colera/controlling.Pdf>
- **WHO** – Report of Risk Comm Inter-agency Working Group (2012) http://cursos.campusvirtualsp.org/pluginfile.php/20952/mod_page/content/1/documentos_modulos/Final_Report_Summary_Report_-_FINAL_-_IHR_Risk_Comms_Working_Group_-_Lyon_-_March_2011.Pdf
- WHO Fact Sheets on Water Sanitation and Health http://www.who.int/water_sanitation_health/emergencies/envsanfactsheets/en/index3.html

- **WHO policy and recommendations:** Prevention and control of cholera outbreaks www.who.int/cholera/technical/prevention/control/en/index3.html
- **WHO:** Cholera Outbreak: Assessing the Outbreak Response And Improving Preparedness www.who.int/cholera/publications/final%20outbreak%20booklet%20260105-OMS.Pdf
- **CDAC Haiti** – Beneficiary Communication Practices and the Effectiveness of Cholera Communication Campaigns in Haiti (announcement) <http://www.humanitarianfutures.org/content/beneficiary-communication-practices-and-effectiveness-cholera-communication-campaigns-haiti>
- **WHO:** Cholera in Sierra Leone - update (8 October 2012) www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/outbreak-news/3703-cholera-in-sierra-leone-update-8-october-2012.html
- WHO Outbreak Communication Guidelines 2005 www.who.int/infectious-disease-news/IDdocs/whocds200528/whocds200528en.Pdf
- WHO Outbreak Communication Guidelines summary. (2005) from Communication Initiative Network www.comminet.com/print/186954
- **WHO** – The global burden of cholera (2011) www.who.int/bulletin/volumes/90/3/11-093427/en/index.html
- **WHO** – Abraham, Thomas (2009). Risk and outbreak communication: lessons from alternative paradigms, in Bulletin of the World Health Organization 2009; 87:604-607. doi: 10.2471/BLT.08.058149. www.who.int/bulletin/volumes/87/8/08-058149/en/#
- Onlymyhealth Editorial Team (2011) Disease Outbreak Communication Guidelines www.onlymyhealth.com/disease-outbreak-communication-guidelines-1298540554
- **WHO** – J Lanard M.D. (2011) WHO Outbreak Communications Guidelines Evaluation And Coaching, Global Health Security Epidemic Alert and Response. www.psandman.com/articles/OCBD-3.Pdf
- **Zimbabwe** – Proposal for funding WHO cholera emergency operations in Zimbabwe, 2008 (with sample terms of reference for Cholera Response Team www.who.int/hac/crises/zwe/zimbabwe_proposal_5dec08.Pdf

- **Amanda Atwood (2009).** Using Communication Technology in the Fight Against Cholera in Zimbabwe
www.pbs.org/idealab/2009/02/using-technology-in-the-fight-against-cholera-in-zimbabwe052.html
- **Zimbabwe:** Cholera Information, Education and Communication Materials - This section contains some Cholera Information, Education and Communication materials that may be useful during the cholera response. <http://ochaonline.un.org/CholeraSituation/IPCMaterials/tabid/5359/language/en-US/Default.aspx>
- **100,000 cases** – The spectre of cholera remains in Zimbabwe
www.redcross.org.au/files/Zimbabwe-Report.Pdf

- 1 See: WHO (2010). OCV in mass immunization campaigns: guidance for planning and use, Annex 1.
- 2 During an outbreak, pregnant women may receive OCV according to protocol.
- 3 MSF (2013). Health Promotion and Cholera Vaccination Mass Campaign in Sudan, January 2012.
- 4 Adapted from UNICEF ROSA (2006). Behaviour Change Communication in Emergencies: A Toolkit, Tool 12, p. 219.
- 5 Training Manual on Interpersonal Communication for Field Activators. Water and Sanitation Programme, Government of Tanzania, USAID/BASICS (2009).

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