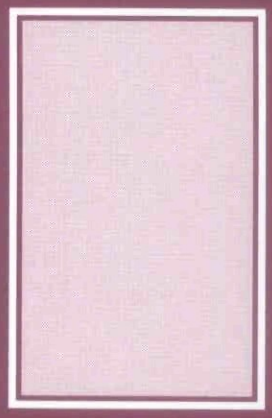
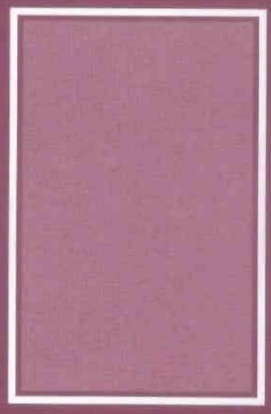
HARNESSING THE POWER OF IDEAS

Communication and social mobilization for UNICEF-assisted programmes

A case-study





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United Nations Children's Fund

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Communication and social mobilization for UNICEF-assisted programmes

A case-study by Colin Fraser

*"Social programmes, in rich countries too, can only succeed when people are motivated to do them. Motivation requires noise, and motivating a body of people takes time. You have to be **in** society, acting and interacting with its various sectors, mobilizing them, feeling like them, changing their priorities. Once social mobilization starts, it becomes contagious, creating demand. And the more forceful the demand, the more the government apparatus is compelled to listen. The quality of life can only be changed by participation, and this needs communication and messages. Social mobilization is an essential sector for social programmes in third world countries."*

Mujibul Huq
Ex-Secretary, Cabinet Division
Government of Bangladesh

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FOREWORD

Social development is linked to concerted public action. No matter how valid and worthy the cause, little progress is made in achieving it until a ground swell of public support is built up and diverse sectors of society become actively involved in the process of change.

An unprecedented gap now exists between what could be done and what is being done to overcome the worst aspects of poverty that claim the lives of 35,000 children a day and affect the health and well-being of millions more. In such circumstances, the gaps between what is and what could be, between knowledge and need, are not likely to be closed by any automatic or inevitable process of social development; they are closed most often by the commitment and action of large and growing numbers of people who begin to exert pressure for change.

It was this realization that led UNICEF in the 1980s to think increasingly in terms of mobilizing society for social action in favour of children. We felt that major achievements could be made in improving the condition of children only if these issues were elevated to a status of national awareness and promoted in such a way that all sectors of a country's society that could make a contribution were mobilized to do so.

Communication would be an essential part of this process. Serious advances could be made only when large numbers of people began to know more and care more and do more. Fortunately, we live in a communication epoch in which mass media are constantly expanding their outreach and influence. Therefore, the argument went, it should be possible to use these media to gear people towards the changes of attitudes and behaviour needed to improve the situation of children. For example, the simple actions required of parents to bring about a dramatic reduction in infant mortality and morbidity, encompassed in the child survival and development revolution (CSDR) of the 1980s, lent themselves to being promoted by communication media. Demand for health services could be created through increased awareness and dialogue.

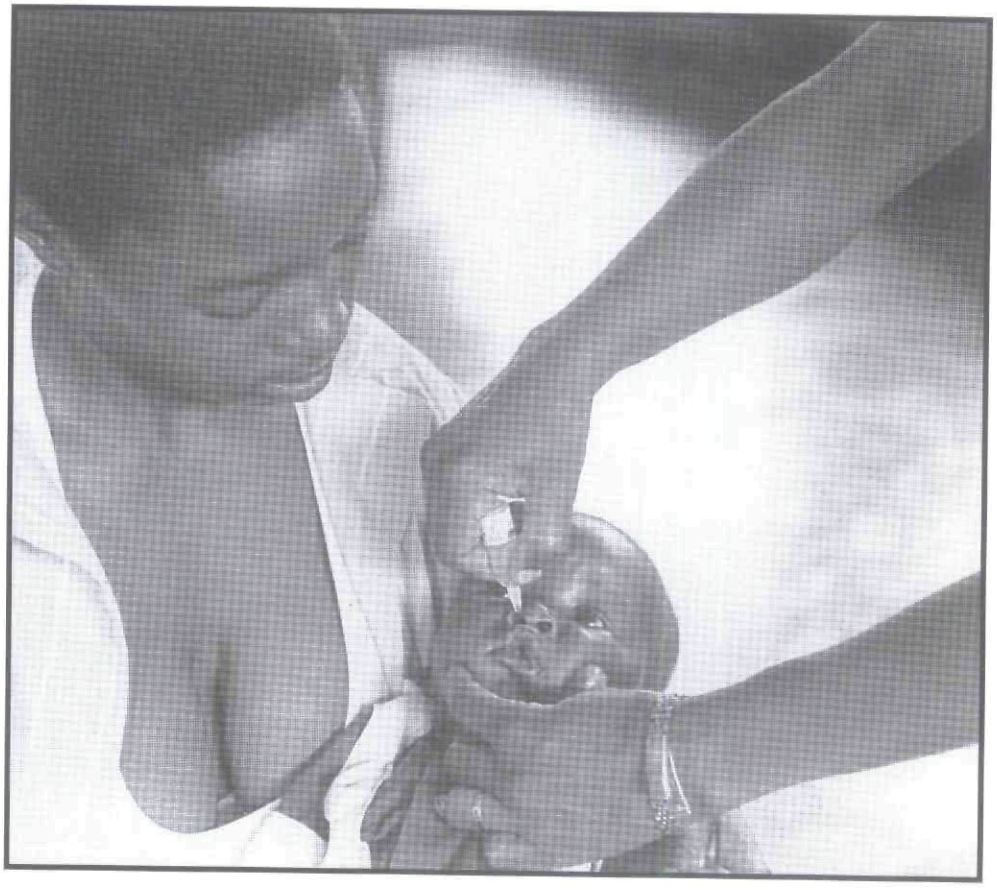
In some countries, fairly good health services were in place, but were underutilized, while in others, human and material resources would need to be mobilized to meet the demand for services as it was created. Although mass media could play a role in mobilizing these resources, other strategies for advocating the cause of children, for creating alliances in their favour and for promoting effective services would also be needed. These strategies would include lobbying and other forms of interpersonal communication, and the orientation and training of health care staff.

UNICEF collaboration with the World Health Organization (WHO) towards the goal of universal child immunization (UCI), which aimed to vaccinate 80 per cent of the world's children by 1990, provided a major opportunity, as well as a need, for demand creation and the mobilization of resources and services to respond.

That UCI goal was achieved, and widespread immunization is now saving the lives of approximately 3 million children each year and protecting the health and normal development of millions more. This achievement can be attributed largely to the social mobilization process that was created around it. This case-study describes that process, with examples from many countries, while explaining social mobilization as a strategy and operation for converging societal forces on social actions.

Its author, Colin Fraser, an independent consultant, was one of the first practitioners of communication for development in the United Nations system. He brings over 20 years of background experience to describing and assessing social mobilization for UCI.

James P. Grant
Executive Director
UNICEF



INTRODUCTION

In only six years, the immunization coverage of the world's children was raised from about 20 per cent to 80 per cent. This was largely a result of 'social mobilization', a strategy that recognizes the human nature of development, and that social progress requires behavioural change.

In history, six years is but an instant, too brief, it would seem, to bring about any fundamental improvement in the human condition. Yet the six years between 1984 and 1990 saw a process take place that was without precedent in its magnitude and global scope. Before 1984, the number of the developing world's children who were immunized against the principal childhood diseases was about 20 per cent, and not increasing much. Then, a worldwide movement was launched which, in only six years, increased coverage to 80 per cent. Much of the increase was in countries so poor, with so little infrastructure, and with such a long history of high infant mortality, that there had seemed to be no hope of bringing about radical improvements in child health. The stunning achievement of raising immunization coverage in this way was the result of what is called 'social mobilization'.

Social mobilization represents the first practical recognition and operational strategy to take into account the essentially human nature of development and, furthermore, to acknowledge that social progress can take place only as a result of attitudinal and behavioural change across broad sectors of society.

A DEFINITION OF SOCIAL MOBILIZATION

Social mobilization can be described as a planned process enlisting the support and active involvement of any and all sectors within a society that can play a role in achieving an agreed social objective, converging the interest and actions of institutions, groups and communities towards the objective, thereby mobilizing the human and material resources to reach it, and rooting it in society's, and particularly, in the community's conscience to ensure its sustainability.

Social mobilization defined.

In the UNICEF context, social mobilization is a planned process to support large-scale delivery and acceptance of services that will benefit children and families. In practice, the achievement of UNICEF programme goals often depends upon changing some aspect of human behaviour. These changes may include parents having their infants fully immunized, or boiling drinking water, or giving oral rehydration salts to children with diarrhoea, or allowing their daughters to attend school.

Reaching UNICEF programme goals depends on changing the behaviour of the various people involved, whether they be parents or policy makers, health workers, or journalists and media professionals.

The changes may also include modifying government policy, or persuading national or provincial planners to give greater priority and budget resources to child survival and development, or improving the social skills of health workers, or changing the way journalists and media professionals perceive and report on social issues, or changing a community's perception of its problems and its ability to solve them.

Communication and social mobilization are integral to the process of behavioural change, hence their crucial importance. However, they are not substitutes for programme activities in a country. Rather, they must be an integral part of programmes, and when they are, they can spread and multiply their impact enormously.

Communications and social mobilization, while crucial to changing behaviour, must be an integral part of programme activities in a country.

The purpose of this case-study is to try to bring social mobilization into clearer focus, and to dispel some of the misconceptions that have grown up around it. Social mobilization, as an operational strategy, could offer possibilities in a number of development fields, but since UNICEF has taken a lead in it, this case-study will confine itself to UNICEF-related issues.

The purpose of this case-study is to bring social mobilization into focus mainly in the context of universal child immunization (UCI), but also to assess its potential for other areas of child survival and protection.

The study begins with a brief look at the historical evolution and conceptual framework of social mobilization. Then, some of the main social mobilization experiences to date are described, especially in the context of efforts towards universal child immunization (UCI). Where appropriate, experience in social mobilization for other areas of child survival and development is drawn upon. In the final sections, an assessment is attempted, looking at the successes, problems and potential for social mobilization, bearing in mind the goals for the 1990s concerning children.[1]

[1] The goals for the 1990s emanated from the World Summit for Children held in September 1990, and in particular from its Declaration on the Survival, Protection and Development of Children and the related Plan of Action.

THE HISTORICAL AND CONCEPTUAL PERSPECTIVE[1]

Social advances in democratic societies are more often brought about through the action of pressure groups than through the wisdom and spontaneous benevolence of governments. In fact, democratic society generally functions and adapts to needs and circumstances through the influence of pressure groups.

Democratic society usually adapts to needs as a result of pressure groups, and these groups have sparked great movements of the past, such as those against slavery and colonialism and those for civil rights, women's liberation, and the current and growing one for the environment.

GREAT MOVEMENTS OF THE PAST

In the past, pressure groups have sparked the fire of great movements that have radically changed the way whole societies perceive a social issue. The new perception has also brought major changes in the way people actually behave on the issue. One early example is the movement against slavery led by William Wilberforce in the United Kingdom at the end of the 18th century and the first quarter of the 19th century. More recently, we have seen mass movements that have had a radical impact in changing attitudes and courses of action in dealing with such issues as colonialism, women's liberation, civil rights, apartheid and the green revolution, which transformed the agricultural economy of so many countries. It now seems as though a great movement is building around environmental issues.

A common factor of all great movements has been intensive communication, using a variety of media channels, but also including interpersonal communication.

In these post-World War II movements, the media have played an increasingly important role. Earlier movements, such as that launched by Wilberforce against slavery, had few communication media that could be enlisted in support, apart from the press. Although he was a member of the British Parliament, the primary power-base built by Wilberforce was the anti-slave-trading and anti-slavery leagues that he established — non-governmental organizations (NGOs) in today's terms. However, whether media have been used or not, a common factor in achieving all great movements has been intensive communication, often using a variety of channels, but always using interpersonal channels. In fact, some of the most recent initiatives in developing countries that have brought major behavioural change have been based almost exclusively on interpersonal communication channels.

THE ARRIVAL OF SOCIAL MOBILIZATION

Social mobilization grew over time and out of practical communication experiences in the field. It groups various types of communication activity into a cohesive whole.

Social mobilization for child survival and development may have its philosophical origins in the experience of great movements, but it did not suddenly appear in the UNICEF sky like a flash of lightning. On the contrary, it grew over time, building on some enlightened and yet pragmatic experiences in the field, and as various types of communication activity were dovetailed into a cohesive whole.

The strategies and activities of communication for development have changed over the years as development thinking itself changed, and as development efforts based on the supply of inputs and technology, in the style of the Marshall Plan, generally failed to achieve the hoped-for 'modernization' in developing countries.

UNICEF was one of the earliest among United Nations agencies to become involved in communication for development, beginning in 1968. However, over the intervening years, both the terminology and the strategies used for that activity have changed. These changes have come with insights derived from experience, and also from changes in development thinking itself. A major factor was the relative lack of progress in the international development efforts of the first decades after World War II. Most of these efforts were in the tradition set by the Marshall Plan of providing inputs, services and

[1] See Annex for further information on the historical and conceptual development of social mobilization in UNICEF work.

technology. It had been assumed that they would be enthusiastically absorbed in developing countries and lead to 'modernization' modelled on the industrialized countries of the North.

However, as the real difficulties of development work were learned, especially among the poorest sectors of society, a different pattern began to evolve in the 1970s and 1980s. The need for participation of the so-called beneficiaries in planning and executing development programmes, and for 'demand creation'[1] for services, began to gain ascendancy in the more progressive areas of development thinking.

In the 1970s and 1980s, it became clear that, for development programmes to succeed, people should participate actively in planning and executing them.

Demand creation for child health services was a particular concern, for there were countries with quite effective health services where people persisted in ignoring them, while at the same time infant mortality and morbidity rates remained high.

It was also recognized that there was a need to create demand for health services, which even where they existed, were often underutilized.

THE CHILD SURVIVAL AND DEVELOPMENT REVOLUTION — A NEW COMMUNICATION FRONT

In 1982, an effort to reduce the infant mortality rate through a number of of low-cost interventions brought new challenges and opportunities for communicators. The four cornerstones on which this child survival and development revolution (CSDR) was based were: Growth monitoring, Oral rehydration therapy, Breastfeeding and Immunization (known by the acronym of GOBI). These were actions that parents could easily take, and they could be promoted through communication processes and media.

The child survival and development revolution (CSDR) brought new challenges and opportunities for communicators. The behavioural changes required for CSDR were suited to mass media support and social marketing approaches and principles. Techniques of marketing were adopted in UNICEF communication work.

The behavioural change objectives of GOBI lent themselves well to social marketing, a relatively new approach at the time which UNICEF embraced for several years. Social marketing is based on the idea that if marketing can sell products, as has been proven, it should also be possible to use the same strategies and techniques to sell ideas and practices that would be socially and economically beneficial. However, instead of the profit going to the marketer, as is the case with classical marketing, the 'profit' would take the form of improvements in the lives of the poor.

It is true that 'social marketing' has been criticized as being manipulatory and top-down in nature, but although the phrase is not used widely by UNICEF today, many of the principles and techniques of marketing have been incorporated into UNICEF communication work.[2]

'Advocacy' and 'strategic alliances' were the other elements of social mobilization. Advocacy in a country context means pleading the cause of children, or of specific actions in their favour, in order to generate moral and substantive support, mainly from decision makers and the influential. Advocacy has always been inherent in the work of UNICEF.

In addition to techniques of marketing, other elements in the process that led to social mobilization were 'advocacy' and the formation of 'strategic alliances'.

The idea of forming strategic alliances began to assume identity and prominence in the early 1980s. With its limited resources, UNICEF could never be more than a catalyst within any given country. There was little, if any, chance of making a major impact without the support and preferably the active involvement of as many allies as possible.

Then, over a few years in the early 1980s, and in a few countries, the various strategies began to converge on the GOBI programme elements, and a new pattern began to emerge. Within a country with UNICEF-supported programmes, advocacy, alliance-building, mobilizing resources, and programme communication to create demand and impart information as a basis for informed decisions became part of a single continuum. Properly planned and implemented in an orchestrated way, this continuum was an essential part of improving the quantity and quality of programme delivery and acceptance.

When advocacy, alliance building, mobilization of resources, galvanizing of service delivery, and communication to create demand and provide information for informed decisions, were all brought together and conducted in a planned and orchestrated way, the whole continuum came to be known as social mobilization.

The use of advocacy to mobilize support and resources and to galvanize service delivery, linked in an integral way with programme communication to create understanding, knowledge and demand among programme beneficiaries, became known as 'social mobilization'.

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[1] The term 'demand creation' is not ideal, for it connotes some sort of manipulation to persuade people to want something they do not really need, even if this is not the case in the area of health that we are considering. To be exact, it is more a question of uncovering people's latent demands and helping them to realize that those demands *can* be satisfied, largely *by their own* actions.

[2] For further details on the debate on social marketing, see Annex.

PLANNING AND IMPLEMENTING SOCIAL MOBILIZATION

Mobilization of people towards certain goals can be achieved in a number of ways. These could include force, legislation, social sanctions, direct or indirect incentives, information, education, motivation, skills training and communication to help people see their own situation differently and consider alternatives for improving it.

However, mobilization through the use of force, legislation or sanctions has little place in social development. We should be concerned, therefore, with other means of mobilizing people.

TARGETS FOR MOBILIZATION

Sectors and people to be mobilized for promoting child survival and development usually include political leaders, policy makers, programme managers, service providers, NGOs, religious leaders, the commercial sector, the media and, of course, women, parents and child caregivers.

Whom to mobilize depends on who has the moral or political authority, or the power or influence, to tackle the specific problem, or to help achieve a particular goal. In most countries, the targets for social mobilization related to child survival and development issues begin with political leaders, decision makers and opinion leaders. Programme managers and providers of services, such as health workers, teachers, extension and cooperative agents comprise another target group. In many countries, government partners, at both central and community levels, can be successfully mobilized. These may include ministries and institutions dealing with education, information, social affairs, defence, planning and finance, and their decentralized offices may also be involved.

In the non-governmental sector, targets for mobilization are usually voluntary organizations, private sector media producers and advertisers, and local, traditional and religious leaders. The industrial and commercial sector may also be mobilized.

Finally, and in every case, of course, the users of services must be mobilized. These include women, parents and child caregivers.

ANALYSIS AND PLANNING

A good situation analysis is needed for planning social mobilization.

The planning for social mobilization begins with a situation analysis. This examines potential allies and points of resistance, effective media channels (mass and traditional), the characteristics of major target audiences (including their media habits), study of societal information flow, ways to improve provision of services and the knowledge and motivation of beneficiaries, constraints to attitudinal and behavioural change and how to overcome them, and the potential for community participation.

The analysis calls for quantitative and qualitative information and behavioural science research.

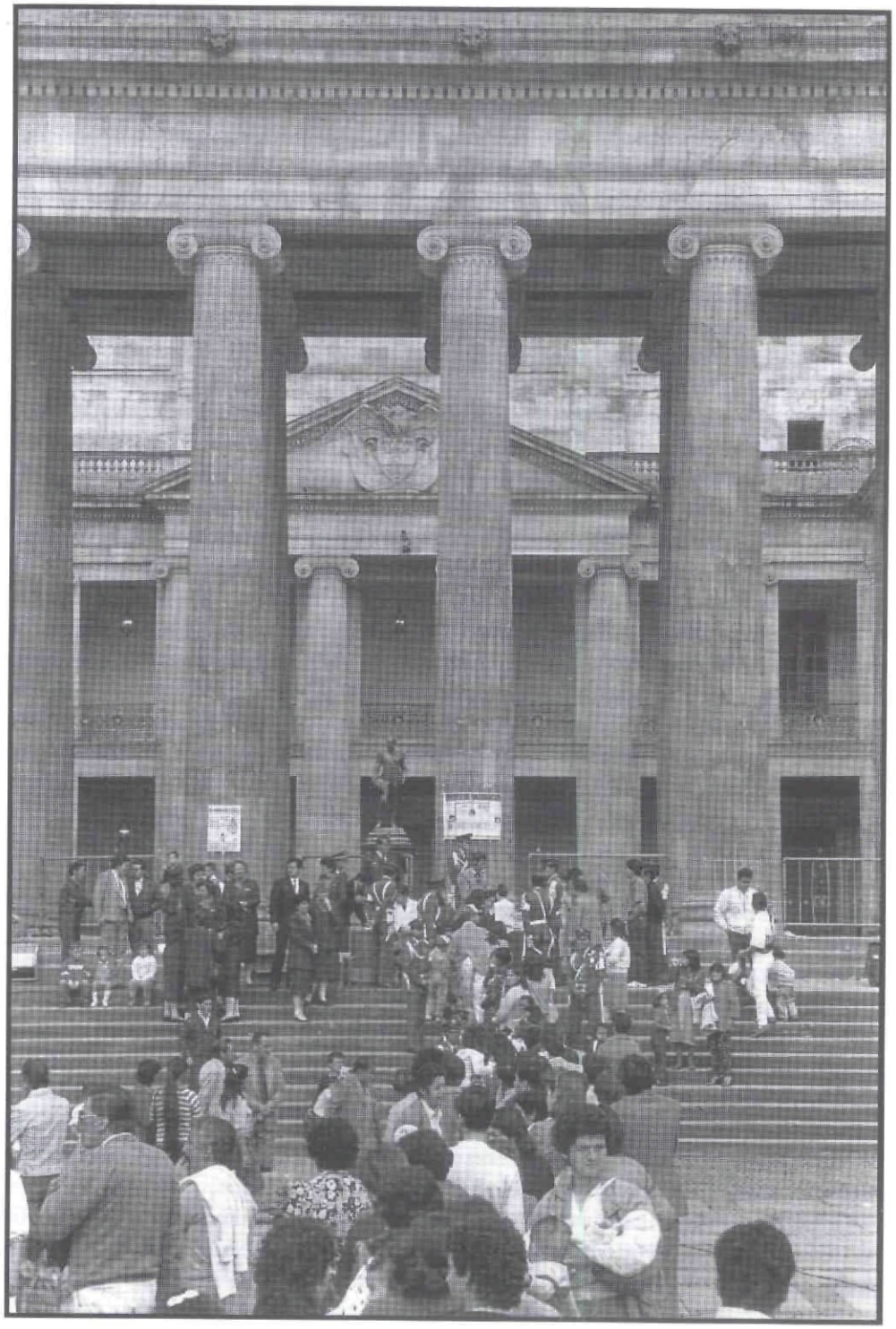
Clearly, research will be needed to obtain quantitative and qualitative information for the analysis. This research uses techniques, including some current in marketing, such as focus-group discussions. The importance of behavioural science research is primordial; it is no accident that commercial marketing invests so much in it, for it is a prerequisite for communication aimed at behavioural change, a field in which commercial marketing is conspicuously successful.

A communication plan is required to reach and influence specific audiences. Various communication channels may be used, ranging from mass media

An examination of the social mobilization analysis in conjunction with the national objectives helps to identify what kind of action or behavioural change is required of each of the audiences in order to enhance service delivery and use. A communication strategy and plan is drawn up to reach and influence each of the audiences. The plan may include lobbying and individual contacts, orientation and training workshops, mass media

campaigns, etc., according to the specific audience. The overall social mobilization plan is made up of a series of dovetailed and complementary communication and other programme activities. The planning and conducting of social mobilization calls for skill and experience.

to individual contacts and lobbying. An overall social mobilization plan consists of a range of dovetailed and complementary activities.



SOCIAL MOBILIZATION FOR IMMUNIZATION

Social mobilization as such first came into prominence in connection with the expanded programme on immunization (EPI) and efforts to achieve universal child immunization (UCI). It is therefore appropriate to describe and examine some of the social mobilization activities used to reach the UCI goal.

A few words of background are necessary for those unfamiliar with the two programmes. EPI was an initiative of the World Health Organization (WHO), and it was formally launched in 1974. In 1977, in relation to EPI, WHO declared its aim of immunizing all children by 1990 against the six principal and preventable childhood diseases — tuberculosis, polio, diphtheria, pertussis, tetanus and measles. This was to be achieved through a steady build-up of health services. However, by 1982 it became clear that the target of immunization for all children by 1990 could not be met at the existing rate of progress, and this was communicated to the World Health Assembly session that year.

Social mobilization first came into prominence for child immunization. The expanded programme on immunization (EPI), launched by WHO in 1974 with the aim, declared in 1977, of vaccinating all children by 1990 was still well behind schedule in 1982. UNICEF proposed a massive drive to immunize 80 per cent of children — enough to block disease transmission. The proposal met with misgivings among some health professionals.

UNICEF, in launching CSDR in 1982, gave initial emphasis to oral rehydration therapy (ORT) in many of its country programmes, but very soon turned also to immunization and the possibility of launching a massive drive to immunize at least 80 per cent of the world's children by 1990. Eighty per cent coverage was agreed as a compromise figure in that it would be enough in the first instance to make a major impact on the prevalence of the main childhood diseases, by blocking their transmission. It was also realistic, given the extremely low coverage in many countries.

The UNICEF idea initially met with some misgivings in WHO, which not so long before had seen the collapse of its campaign to eliminate malaria from the world. That set-back caused many in WHO to doubt the wisdom of such single-strategy, vertical campaigns. They still felt that it was more important to build up primary health care (PHC) services, and through them gradually achieve immunization of all children, accompanied by other health inputs. The critics also maintained that to achieve UCI would require extraordinary efforts that might work against routine activities and prove unsustainable in the long run.

The same misgivings were also present in the health services of some countries. However, there were also many health officials, including a key one in Colombia, who summed up the opinion in favour of UCI/1990 by saying: "There were millions of children who needed to be immunized *then and there*. We could not wait for the health services to build their capacity to reach all children on a regular basis. We had to begin a national drive to try to reach every unprotected child."

After much discussion, involving many international development agencies, a joint UNICEF/WHO programme entitled universal child immunization by 1990, or UCI/1990, was launched in 1984 to immunize 80 per cent of the world's children by that year.

This opinion was similar to the thinking that inspired UNICEF. If one waited for the services to be in place, UCI would simply take too long to achieve. Urgent action, based on provisional structures and temporary measures if necessary, should begin. UCI would be the catalyst accelerating the reaction that would, in a very few years, bring about regular and expanded health services.

A number of international development agencies became involved in the discussions on UCI, including the World Bank, the United Nations Development Programme and the Rockefeller Foundation. Finally in 1984, the objective of fully immunizing 80 per cent of the world's children by 1990 was agreed upon as a joint UNICEF and WHO programme.

This was ratified by the United Nations General Assembly at its 1985 session. The title given to the programme was UCI/1990.

THE CHALLENGE OF UCI

To achieve UCI would mean overcoming some formidable problems. Some of these were logistical. For example, vaccines need to be kept cool if they are to retain their potency. Cold-chain facilities would have to be created to keep them cool, from the moment they were unloaded from the aircraft, during transit to a refrigerated store, from there to outlying health centres, and up to the completion of their journey on foot or bicycle for use in some remote community without electricity. Everyone handling the vaccines, from the aircraft unloaders to the vaccinators, would need orientation and training, and so would technicians to maintain and repair the cold-chain equipment. Transport would be needed. Health service staff would have to be motivated to accept the goal of UCI/1990 and be trained for their part in achieving it. Information and monitoring systems would have to be set up to keep track of progress. Individual countries would have to work out the best strategy and plan to reach UCI in their particular circumstances.

Last but by no means least, parents would have to be convinced to bring their children for vaccination, and to return as many times as necessary to provide their children with full immunity. And this would have to be done despite the difficulty of explaining a concept such as immunization to illiterate parents, and despite the mother's concern when her child reacted to a vaccination by running a slight fever and being generally miserable for a short time.

Formidable problems faced the achievement of UCI. Cold-chain services and transport, even into the remotest areas, would be required. So would massive orientation, training and motivation of health staff and of those handling vaccines or servicing equipment. Information systems to monitor progress would be needed, and parents, who would often be illiterate and conservative, would have to be convinced to bring their children for the cycle of vaccinations needed for full immunity.

The challenges of UCI/1990 were considerable, but it was achieved nonetheless. In 1981, the average immunization coverage in all developing countries for children under one year of age was about 20 per cent. There were some countries where it was much lower. For example, Bangladesh had only 2 per cent coverage, even though immunization services were readily available to about 20 per cent of the population. Yet, by 1990, coverage in Bangladesh was 62 per cent. Worldwide coverage had multiplied fourfold to about 80 per cent and, taking into account population increase in the intervening years, this actually represented a fivefold increase in the numbers of children immunized.

The main acceleration really began only after 1985. For example, the weighted average for all Asian countries showed that for some of the antigens there was a tenfold increase in coverage between 1985 and 1990.

Despite the problems, UCI/1990 was achieved. In 1981, average immunization coverage in developing countries was about 20 per cent, although it was much lower in some countries such as Bangladesh, which had 2 per cent coverage, despite health services that could reach 20 per cent of children. Taking into account population increase, the number of children vaccinated was multiplied fivefold between 1985 and 1990. The acceleration in coverage began with the launching of social mobilization, which, in effect was instrumental in reaching UCI/1990.

The acceleration in coverage began with the launching of social mobilization efforts. A review of most developing countries showed that very few were able to reach and maintain 80 per cent coverage without major promotional activities. The few exceptions that were able to advance without mobilization support were countries with such excellent health systems that they were able to reach into the communities and follow up directly with defaulters. Some countries, such as Malawi, the United Republic of Tanzania and Zambia relied primarily on their routine health services and supported them with only moderate levels of social mobilization.

Overall, however, social mobilization was so instrumental in reaching UCI/1990 that it is appropriate to examine it in that context.

In the following pages, social mobilization is described by the sectors that were mobilized, since this is the most practical way to present the information. However, it should be remembered that where social mobilization was successfully carried out in a country, all or almost all of the sectors described separately here were mobilized in an interlocking and mutually reinforcing way, thus converging them on the social action to be carried out.

This case-study describes social mobilization by the separate sectors that were mobilized for UCI, but it should be remembered that all the sectors were mobilized in an interlocking way, so that they converged on the intended target.

The reader should also realize that the information presented is by no means exhaustive; the material included has been chosen either because it is typical of what was done in many more countries than are mentioned by name here, or because what was done seems to be particularly interesting and imaginative.

CREATING THE POLITICAL WILL AND THE LEGISLATIVE CONDITIONS

More than 30 Heads of State lent their personal prestige and political support to UCI/1990. Their roles varied from publicly launching the campaign and appearing on television or posters to personally organizing and overseeing intersectoral implementation and monitoring of the programme.

More than 30 Heads of State personally supported UCI/1990. Such high-level political support was essential for the success of the action.

This was rarely a spontaneous commitment by Heads of State, and UNICEF played a key role in obtaining it. By examining the experience of the green revolution, the UNICEF Executive Director, James P. Grant, had learned that political will in favour of a social development action was instrumental in conducting it to a successful conclusion. For the green revolution in India, Pakistan, the Philippines and Turkey — all countries that pulled off the revolution rapidly — Heads of State or senior ministers personally took charge of the task, mobilizing all the ministries and departments whose involvement was needed to make it happen.

Therefore, bearing in mind that the highest level of political will would be crucial to the immunization programme, Mr. Grant took an active role in obtaining it. His interventions were primarily of three types: direct meetings with Heads of State; opening doors at a very high level for UNICEF Representatives who could subsequently, with access assured, sustain the advocacy effort; and finally, encouraging UNICEF Representatives to push for a higher level of political commitment than they might have otherwise attempted.

The Executive Director of UNICEF, James P. Grant, played a major role in obtaining high-level political support, either through his direct intervention or through helping UNICEF staff to obtain it.

Spouses of Heads of State also played an important role. In Egypt, Suzanne Mubarak, the First Lady, had a long-standing involvement with an NGO concerned with children, in particular with children's libraries. Her interests were such that when CSDR got under way in the mid-1980s, she was a natural and committed ally. She later won the UNICEF Maurice Pate Award for her work.

First Ladies played an important role: Suzanne Mubarak of Egypt was a prime example. After Egypt's pioneering efforts in ORT and immunization, President Hosni Mubarak declared a Decade forthe Protection and Development of the Egyptian Child. This has provided the framework and legitimacy for the necessary promotion and action.

Egypt was one of the first countries to launch a major ORT programme, followed by an equally forceful child immunization programme. In fact, Egypt was the first country in the world to reach full coverage for ORT *and* immunization. Immunization coverage of more than 80 per cent was achieved as early as 1987, but, striving to continue improvements in the condition of children, President Hosni Mubarak declared a Decade for the Protection and Development of the Egyptian Child (1989-1999). That pithy declaration, which includes precise, demanding and measurable objectives, such as the eradication of new outbreaks of polio by 1994 and reducing infant mortality to less than 50 per 1,000 live births, is providing the framework and legitimacy for those promoting and organizing the necessary actions. It is constantly used for advocacy and media work.

In India, Mr. Grant had met with the then Prime Minister Indira Gandhi in 1984 and gained her commitment to UCI/1990. However, it was her son Rajiv who launched the universal immunization programme — UIP, as it was known in India — in 1985. He chose his late mother's birth date, 19 November, to launch UIP as a living memorial to her. Later, in 1987, he created a Technology Mission on Immunization attached directly to his Office. Clearly, in a country as large as India, the Prime Minister's commitment and involvement were crucial in giving UIP the prestige and momentum it needed to succeed as well as it did.

Former Prime Minister Rajiv Gandhi launched India's immunization drive in memory of his mother, Indira Gandhi.

In numerous countries, the Head of State opened immunization campaigns by

personally immunizing a child. In the case of Colombia, the first country to carry out integrated social mobilization for UCI beginning in 1984, President Belisario Betancur administered a dose of oral polio vaccine to an infant in front of television cameras.

Heads of State embraced the cause of UCI for several reasons. They wanted to be associated with a highly visible and humane initiative that would reflect well on them personally, as well as on their government. Some of the Heads of State were also strongly humanitarian, and that alone would have been sufficient reason for them to support UCI. A less obvious reason cited was that certain countries were undergoing severe structural readjustment programmes, inevitably resulting in cuts in health budgets. With this background, some Heads of State saw child immunization as a way, through preventing illness, of reducing the demands and costs of curative health services.

In some countries, Heads of State launched UCI/1990 by immunizing the first child of the campaign in front of television cameras. They saw that their personal involvement would reflect well on them and, through prevention of disease, cut down health costs.

Once the highest levels in the State had committed themselves to UCI, government structures, particularly those of the health services, were usually motivated too and began to look for ways of improving their delivery of services. However, in some countries, such as Senegal, the political will at the top was inconstant. Immunization campaigns were launched in a rather spasmodic fashion, with the result that the constant and widespread commitment necessary from those responsible for service delivery was never created. Immunization therefore tended to occur in fits and starts, and much of what was achieved was the result of the personal commitment of a relatively small number of health sector staff, often working in isolation rather than as part of a motivated and enthusiastic team.

With continuous high-level political support assured, the health sector looked for ways to improve its delivery of services.

It could be thought that it was Mr. Grant's interventions, and his alone, that led to so much high-level political commitment for UCI. A logical conclusion could be that mobilization of top-level political will can only be achieved by such a persuasive leader. However, without diminishing the importance of his initiatives, it should also be made clear that much advocacy was going on, and pressure being created by UNICEF staff in general, in a more routine fashion. UNICEF Representatives, their staff and visiting officials from headquarters all played their part. In one country, the UNICEF Representative was advocating for UCI and for a strategy and plan for achieving it with such intensity that the Ministry of Health actually asked her to desist. They would commit themselves to UCI, but they would do it in their own way, and they succeeded.

Nor should UNICEF Goodwill Ambassadors be forgotten. The visits of international celebrities such as Audrey Hepburn and Liv Ullman, and Special Representative for sports Imran Khan, their contacts in the country and the publicity that surrounded their visits were also very important in generating high-level political will.

Supporting the persuasive interventions of the UNICEF Executive Director were UNICEF staff and UNICEF Goodwill Ambassadors, who also played a large part in securing high-level political support.

Local elections as a springboard

Generating political will at the local level was not left out. In Colombia, a law had been passed in 1986 decentralizing the nation's administration, politics and finance. As part of this process, the first popular elections of mayors for the 1,009 municipalities was planned for 1988.

Staff of the local UNICEF office took the intellectual lead in mounting a remarkable and imaginative campaign in favour of children's issues around the election of the mayors. UNICEF formed a partnership with the National Federation of Coffee Growers and with a newly created organization known as the Promotional Corporation for Municipal Communities of Colombia, or Procomun, as it was called. This was an association to promote good local government following the introduction of the decentralized administration system.

The mayoral campaign consisted of a series of interlocking communication activities and materials. Television in Colombia, as in most of Latin America, is powerful and pervasive, and a prime element in the campaign was a television spot. This showed an eight-year-old girl, Juanita, coming out of school and talking to her companions about the mayoral elections, with Juanita saying that when she grew up, she wanted to be mayor so that she could improve the situation for children. Then, turning to the camera, looking straight into the lens, and raising her index finger in a gesture of discovery, she exclaimed, "I have an idea!"

As part of a decentralization process in Colombia, and during the run-up to the first popular elections of mayors in 1988, a campaign was mounted to persuade the candidates to include children's issues in their platforms and programmes. The campaign consisted of interlocking communication activities centred on an eight-year-old girl, Juanita. Juanita was introduced to the public through a television spot in which she decided to write a letter to her mayor.

Juanita's letter appeals to the mayor to improve conditions for children and asks for his support even if she cannot yet give him hers.

Juanita's idea was to write a letter to mayoral candidates. The resulting text was written on a page torn from a school notebook, in Juanita's clear but still unformed hand, with the punctuation errors and faulty syntax of an eight-year-old left uncorrected:

Mayor,

I am Juanita, you do not know me, but I know you. I know you are a very important person. Who is going to be in charge here. Who is liked and respected. My mother says that you are going to do a lot for us, because now there is money to do things in this community, and that you will do them. For this, I must think about myself and the other children like me. I would like you to know that we are lacking schools, clean water, food, health.... Our problems are many but there are easy solutions, that don't need much money, only that you want to do them. I cannot vote because I am a child. I cannot give you my support yet, but you, yes, you can give me yours.
Excuse me and thank you!!!

Juanita

The Juanita television spot was aired several times daily, her voice reading her letter was repeatedly broadcast on the radio and her face on large posters appeared all over the country with the punch-line from her letter — "I cannot give you my support yet, but you, yes, you can give me yours." All 3,500 mayoral candidates received a leaflet with Juanita's photograph, her letter as written on a page torn from her school notebook and a wealth of information about the condition of children in Colombia, with suggestions as to how they might improve things if elected.

A recording of the text of this letter read by Juanita was broadcast repeatedly over the radio, and posters appeared all over the country showing Juanita's face. And to make the link in people's minds when they saw the poster, the punch-line of her letter — "I cannot give you my support yet, but you, yes, you can give me yours" — was reproduced at the top of the poster in her handwriting. At the same time, a pamphlet, again with Juanita's photograph and her punch-line, was sent to each of the 3,500 mayoral candidates. Inside was reproduced the full text of Juanita's letter, shown on the page torn from her school notebook, and a charming child's drawing of a model community with a school, community hall, clinic, children's playground and sweetshop. On the other side of the pamphlet, information about the state of children in Colombia was presented. In simple language, it provided data on child mortality, malnutrition, lack of access to primary education, school drop-out rates, street children, uncared-for and abandoned children and so on. To stimulate the candidates to reflection, the text asked them whether they knew what the situation was concerning these issues in their own communities.

Under the heading, 'As mayor, what could you do?', it suggested actions they might take at the municipal level to improve the situation and described the positive results that could be obtained.

Hundreds of mayoral candidates wrote to pledge their support for the betterment of the condition of children, and to ask for more details and advice. In fact, so many wrote in that the ministries concerned and UNICEF could not really cope adequately. It is also worth noting that Juanita became morally committed to what she was doing and took the matter very seriously.

MAYORS UNDER PRESSURE . . .

The person elected mayor of Bogota was the only city candidate to address children's issues in an informal and positive way during the campaign. Once elected, he initiated a social service project for the poor, with UNICEF support.

The election of the mayor of Bogota was given extra and special attention because that office carries great prestige and importance in the country. After the candidates had received their packet of information materials about children's issues in Colombia, Caracol, the main radio network in the country (about which more will be written in this case-study), invited all of them to a round-table discussion, at which children's issues were raised.

Only one of the candidates had read the material about children's issues that had been sent to them all.

The candidate who was able to address the subject in a knowledgeable and positive way was later elected mayor. It is not being claimed here that his electoral success was merely the result of his ability to talk meaningfully on children's issues, but it is an agreeable speculation that it may have helped. One thing is certain. Once elected, he began a basic social service project in the poor quarters of Bogota, with UNICEF support.

Those who had conceived the campaign linked to the election of mayors realized that many of the mayors did not have a high level of education. For this reason, generalized

information about the children of Colombia might not be easy for them to assimilate and relate to the particular circumstances of the children in their municipalities. Therefore, after the mayoral elections, and when the national vaccination days of 1989 were in the offing, a campaign targeted at mayors was carried out on the theme of immunization. Partners in this, and identified in the material, were the Ministry of Health, UNICEF, WHO/Pan American Health Organization, Rotary International and Procomun.

Posters customized for every single one of the 1,009 communities in the country were printed. At the top was Juanita's punch-line to make the thematic link, then the name of the community, followed by the number of children in the community under one year of age who had not been immunized fully against the six child-killer diseases.

The communication specialists realized that numbers alone might mean little to the mayors, so they included in the poster a rating of the immunization coverage as 'good', 'average' or 'poor'.

Finally, there was an exhortation on the poster. 'Mayor, let no child remain without immunization at the end of your term of office.'

It was necessary to have these posters prominently displayed in each municipality. For obvious reasons, this might not happen if they were sent only to the mayor. So they were also sent to the telecommunications office, schoolteachers, priests, agricultural credit banks, and so on. A covering letter from the management of the different entities asked them for support for children's concerns and, in particular, to display the posters.There were seven separate dispatches of the material for each municipality, some 70,000 dispatches in all. Negotiations with the postal services resulted in totally free distribution in return for the post office logo on the packaging of the material.

This pressure produced varied responses. The mayors with good coverage were, of course, delighted that their entire community could see and appreciate the results of their work. For those with poor coverage, a first reaction was quite frequently to complain to the Ministry of Health that the figures were wrong, but they soon accepted the challenge and got to work.

As a follow-up to the Juanita campaign, customized posters were produced for each of the 1,009 communities in the country. The posters provided precise information on the numbers of children in the commmunity still not immunized, rated the community's coverage as good, average or poor, and exhorted the mayor to leave no child unvaccinated at the end of his term of office. The posters were sent to a variety of institutions in each community to ensure that they were prominently displayed.

. . . AND PRESIDENTIAL CANDIDATES

Building on the success of the advocacy work with mayors, the Colombian presidential elections in 1990 were similarly exploited in the interests of children. UNICEF again played a catalytic role, supported this time by the Presidential Council for Human Rights. A folder was sent to each of the main presidential candidates with party representation in Congress. Identical folders were distributed to the press and electronic media.

The folder contained a short paper emphasizing the rights of children and describing their general situation in Colombia. There were even shorter papers on specific issues such as child health, education, street children, child abuse and so on. Each of these issue-specific papers ended with a series of questions to the presidential candidate, asking what and how he would tackle the issues, if elected, and giving him a deadline by which to reply.

Each candidate was obliged to put his party machinery to work formulating a political platform concerning children's issues. Once all of the replies had been received, the media were called in. The main newspaper, *El Tiempo*, carried a full-page spread describing each of the presidential candidates' political platform for children.

For the 1990 presidential elections in Colombia, all of the candidates were presented with a folder on the conditions of Colombian children and asked a series of questions about what they would do if elected, with a deadline by which to answer. The replies, which in effect were each party's political platform for children, were given wide media coverage.

INFLUENCING LEGISLATION AND DEVELOPMENT PLANS

So far we have dealt only with political opinion in favour of children's issues, but linked to this is the creation of a legislative or constitutional framework that will legitimize action in favour of children and mothers. Of course, at the global level, the Convention on the Rights of the Child was aimed at this objective. At the country level, in 1987 and even before the Convention was formally signed, Brazil was writing a new Constitution. Intensive advocacy and mobilization had ensured that a section would be devoted to child rights. However, the first draft was not very satisfactory and, with UNICEF support, a working group drafted an alternative. Under Brazilian law, if 50,000 signatures can be obtained on a petition or proposal, the Government is obliged to receive and consider it.

For the new draft on child rights, 1.3 million signatures were easily obtained, and the result was that the Brazilian Constitution, ratified in 1989, contained all the provisions of the Convention. This was useful for the drive towards UCI, for it allowed the irrefutable argument that 'if a child has a right to life, the child also has a right to immunization'.

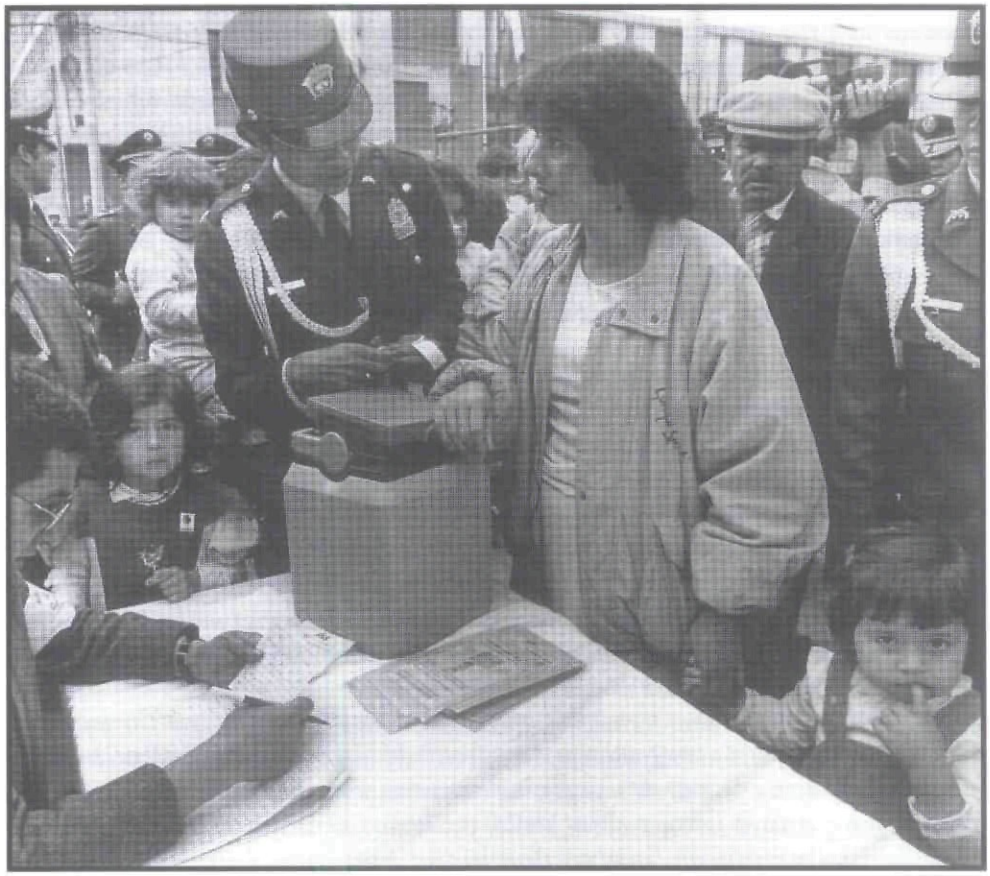
A similar process took place in Colombia, where much patient groundwork by UNICEF and its allies in the country ensured that the Constitution was rewritten to fully reflect the Convention on the Rights of the Child.

To legitimize action for children and mothers, pressure groups that had UNICEF support and backing managed to influence the final versions of new national constitutions and five-year development plans in several countries, including Bangladesh, Brazil and Colombia.

Yet another example of intervention to influence national policy took place in Bangladesh, where the importance of women in development had been successfully advocated. Nevertheless, the first draft of the fourth five-year plan (1990-1994) was a trite affair that would have been unlikely to bring about any real changes. Its tone was thoroughly complacent. It stated that action had already been taken in many areas and that, for example, under Muslim law, men and women had equal rights in marriage and in inheritance, and that education was obligatory for both male and female children. Furthermore, the reserved quota for women in government service had been increased.

Ignoring the fact that, whatever Muslim law said about women's rights or whatever legislation dictated that girls go to school, women continued to suffer grave discrimination and few girls were educated, the draft expressed the hope that matters would improve. Special attention would be paid to integrating women in income-generating activities. However, in the light of experience, they would need help from their male counterparts at the initial stages in organizing themselves, the draft concluded.

A pressure group of about 100 women, with UNICEF help, went to the Government and engaged in a lively and loud public debate with the planners. The result was a final version of the fourth five-year plan that threw out all the platitudes and pious hopes of the draft and identified precise objectives, strategies and activities that would integrate women into the mainstream of economic life and reduce gender inequities.



GALVANIZING DELIVERERS OF SERVICES

In the 1980s, almost all developing countries were struggling to deal with their overwhelming debt problems and being forced into structural adjustment programmes that cut back on government spending. Health services were therefore working on increasingly tight budgets and, as in all other government services, salaries were low. With few prospects for improvement, and with scarce resources, staff could hardly be expected to be enthusiastic and motivated. Furthermore, the policies and resource allocations in a number of countries militated strongly against PHC services. Unless these factors could be changed, UCI/1990 would never be achieved.

PERSUASIVE ARGUMENTS

Nigeria provides an interesting example of how things stood in the early 1980s. At that time, only 2 per cent of the national budget was devoted to health, and 80 per cent of this was allocated to 12 teaching hospitals that catered to only 6 per cent of the population of about 96 million. PHC delivery hardly existed, and it is not surprising that four children out of ten were dying before reaching five years of age. This represented 2,000 child deaths *per day*.

Cuts in health spending, low morale of health staff, and policies that militated against PHC were obstacles to UCI. In Nigeria, UNICEF staff developed a strategy to galvanize the health sector into action in favour of child health based on 12 angles for appealing to those responsible for health service delivery.

The premise that inspired UNICEF staff in the country was that governments, if approached correctly, can be made to change their policies and galvanized into activity. To do this, UNICEF staff had to come up with solutions as opposed to problems — solutions that could be a monument to the national regime. Another tenet was that governments have an insatiable need to be loved, and this should be played upon.

In analysing the different approaches that could be used to change policies and galvanize deliverers of services, UNICEF staff in Nigeria identified the following 12 angles for appealing to their audience:

1. **Alarm and shame** — with 2,000 children a day dying in Nigeria, it should not be difficult to create a sense of alarm and shame among officials.

2. **Facts and information** — providing insights into the real situation, for example by taking people to the field to see for themselves and telling them what could be done.

3. **Giving credit** — making people feel good, feel warm inside, about something they have done, or ostensibly done, or something worthwhile they are going to do. This makes them into allies.

4. **Endorsement from the eminent** — bringing in people eminent in the sphere of child health and development and having them comment favourably on what they see being done.

5. **Local and national pride** — praising the success of a local or national endeavour outside its immediate environment.

6. **Intermediate achievement** — calling attention to the fact that a programme is well on the way to success and that its objectives can certainly be achieved if the effort is made.

7. **Praise** — praising directly, or better still, indirectly, the efforts of national individuals concerned with a programme.

8. **Fear of not performing** — pointing out that the highest authorities in the land are supporting the programme and expect results.

9. **The bandwagon effect** — exploiting the competitive spirit in a society to persuade all departments of an administration to work together, with each eager to have a share in the action.

10. **Legitimacy and authority** — exploiting policy commitments or legislative provisions to make providers of services pay attention.

11. **Ownership** — telling people that the programme belongs to them, and that what is being accomplished is due to them.

12. **Hijack** — taking advantage of contacts with eminent persons to associate them with what needs to be done, and in such a way that they cannot evade responsibility.

In the early 1980s, there were 480 Nigerian children dying each day of measles alone, and of these, 50 a day were dying in the main children's hospital. It was clear that the immunization programme itself needed a shot in the arm. The first step was to convince the health authorities that the existing immunization services were not functioning. A short video that showed 80,000 doses of vaccine languishing against the outside wall of a cold store was a good beginning. Fact-finding trips to the field were not common for Ministry of Health officials; the institutional culture did not perceive them as essential. So UNICEF arranged and paid for a series of field visits for national staff because this was the only way for them to see the realities of their health service.

Tapping unusual resources

Typically, in most countries, once the top management of the delivery services was committed, the mobilizing of staff began with a series of meetings or workshops. The purpose of these workshops was to reach consensus on what had to be done and the problems that would have to be resolved, and to start formulating a strategy.

In Colombia, the health directors from the provinces were called together for a preliminary discussion about an intensified immunization drive. The director from the Atlantic Department had, of his own initiative, been carrying out some mobilization in his area, and he therefore had some practical experience.

Mobilization of health staff began with a series of workshops. Lateral thinking was promoted to bring in unconventional resources including the army, police and religious authorities, to help the health services towards UCI.

A first question raised by a health director, and a perfectly normal one before social mobilization came on the scene was, "Who's going to give us the vehicles to transport our vaccination teams?" "We don't need vehicles," replied the director from the Atlantic Department. Amid the general scepticism of his colleagues, he went on, "The army and the police have plenty of vehicles. If we go about it right, we can get them to provide the transport."

Such lateral thinking, and the suggestion of calling on allies to help, was a revolutionary step for staff of the Ministry of Health. Yet it became commonplace as the immunization drive went on and as problems were resolved by staff who came up with imaginative solutions.

In this connection, in Colombia, there is the anecdote of the light aircraft that was to deliver vaccine to a remote area. It was delayed by bad weather, and when it was finally able to take off, it was scheduled to arrive after nightfall at the airstrip, which had neither lights nor navigational aids. After some frantic telephone consultations, the local health staff mobilized as many of the local population with vehicles as they could. They all drove out to the airstrip, where they parked strategically and turned on their headlights so that the pilot could locate the field and make his landing safely.

The importance of management

Management is the key to energizing service delivery, once the commitment has been created among the managers themselves. Traditionally, health services had never, or almost never, been managed by objectives. Programmes launched under CSDR, such as promotion of ORT to reduce child mortality caused by dehydration during acute diarrhoea, or accelerated programmes of immunization, set precise national and local objectives for the first time in many countries. This provided the framework and the motivation for improving the management of the health delivery system.

A first step for creating the preconditions for good management proved to be the setting up of an appropriate management structure. In most countries, this took the form of a special body called a steering committee, task force, executive board or coordination committee. The titles varied from country to country, but scope and function were similar. Although they were located in some part of the Ministry of Health, they were separate in the sense that their only function was that of conducting the programme for which they had been created.

The management groups were almost invariably interdisciplinary, bringing people from other ministries, such as education, information, social affairs and defence, as well as representatives from NGOs. Thus, they were the focal point from which coordination and teamwork among various partners could be promoted and managed.

The best of these special groups set up to plan and run a specific programme were led by remarkable people. They had to combine good technical knowledge with excellent management capabilities, and also with the social skills that would make it possible for them to promote cooperation and teamwork among the diverse partners. The author was privileged to meet some of these people; they were outstandingly impressive in their breadth of view, the sense of technical competence and commitment they conveyed, and their human qualities of modesty and humour.

The work schedules these special management groups set themselves were often gruelling. For example, the National Coordinating Committee set up initially in 1984 in Colombia for the immunization crusade would meet every day for most of the morning, beginning at 7.30 a.m. This went on for several months each year as preparations were being made for the annual vaccination days.

However, they were not meetings in the normal sense of the word. They were more akin to the proceedings in an operations room. There were continual incoming and outgoing telephone calls to the 33 Sectional Health Services in the country. Each of these had to prepare a monthly work plan and timetable, and this was monitored every other day by the Coordinating Committee. Incipient problems were identified, and immediate actions taken to resolve them before they could snowball out of control.

In addition, in the early years of the UCI drive, the Coordinating Committee had to draw up norms and instructions to ensure uniformity in the 33 Sectional Health Services and more than 10,000 immunization posts. These norms had to cover a multitude of technical criteria for such things as cold-chain management, vaccine handling, indications and contraindications for immunization, age ranges and techniques applying to each vaccine, organization of vaccination posts, and the functions of each person involved in the operation. Staff training had also to be planned and put into operation. It was a mammoth task, and most members of the Coordinating Committee carried it out in addition to much of their routine work.

The setting of precise targets for such actions as ORT or immunization offered a framework for improving health service management. Multidisciplinary steering committees were set up in most countries, with remarkable and dedicated people who worked extra hours on the technical, organizational and logistical aspects of achieving UCI/1990.

Orientation and training

Orientation and training of health staff have been central to galvanizing them into action in every country where social mobilization has taken place. In the case of ORT, in many countries there was resistance from health professionals, who did not agree easily that it could replace intravenous rehydration.

This was certainly the case in Egypt, which was among the first countries to put its weight firmly behind ORT on a national scale and to achieve dramatic results in reducing child mortality caused by dehydration. However, before any of this could be done, the health professionals in the universities had to be enlisted and then used to convince their

A key element in galvanizing service delivery was training and orientation for health staff. In some countries, such as Egypt during its ORT drive, mass media had aroused awareness and demand among the population before all the health professionals were convinced and mobilized.

professional colleagues of the value of ORT. The history of ORT in Egypt went back to 1966, when a WHO consultant to the Ministry of Health recommended its use in cases of acute diarrhoea. In 1977, the Ministry of Health adopted the WHO-recommended formula for oral rehydration salts (ORS) and began to distribute ORS to health centres. In 1978, local production of ORS was begun, and yet in 1982, when the major ORT project began operations with the support of the United States Agency for International Development (USAID), there was still widespread scepticism among health professionals, some of whom even rejected ORT.

In fact, as the project got under way and television spots promoting ORT began to make an impact on public opinion, there was a period in which mothers knew more about, and were more in favour of, ORT than many health professionals. There is an anecdote about a Cairo physician who, incensed by the prominent profile of ORT in the media, went onto the balcony outside his office with a loud hailer and harangued people in the street below about the dubious benefits of ORT over intravenous rehydration.

Reverting to the question of orientation and training of staff, the range and scope of the training activities that were carried out as part of the ORT programme in Egypt were remarkable. Training of trainers was a first priority, but after that, training was provided for a wide spectrum of people that ranged from pre-service and in-service physicians to nurses, schoolteachers, pharmacists, social workers, laboratory specialists, keepers of ORS depots and statistics specialists. In just under 10 years, up to July 1991, more than 70,000 people were trained.

The training was carried out on a massive scale. For example, India's immunization drive involved training 150,000 health and NGO staff, and Egypt's more than 70,000.

India provides another illustration of the vast training and orientation programmes undertaken to galvanize service providers. This successful programme, known in India as UIP, required the retraining of the entire personnel of the national health system, or about 150,000 medical and paramedical staff. In addition, the training was extended to NGOs and private practitioners.

Training for EPI in India had begun in 1979, but it was the mobilization linked to the aim of universal immunization declared in 1985 that sparked an intensive three-tier orientation and training programme. State and district health officers were trained in five-day courses using WHO training modules; these officers in turn trained the medical officers of the PHC system at district level in four-day courses; and finally, these last trained their field staff in two-day task-oriented courses. Simultaneously, training for cold-chain mechanics was being conducted. Manuals were produced in local languages.

The training programme in India was evaluated and modified as necessary. For example, it was found that the training of trainers, while satisfactory in terms of technical content, also needed to provide insights into training methods. It was also found that communication skills had to be incorporated, especially in the training of staff in direct contact with the community.

Improving social skills

In many countries, problems were identified that related to social skills, or more precisely the lack of them, among field-level health workers.

In many countries, the social skills and attitudes of health workers towards clients needed to be improved to reduce dropping out before a child's immunization cycle was complete. Training workshops in interpersonal communication were organized to overcome the problem.

In Algeria, research into the reasons for dropping out before the immunization cycle was complete revealed that mothers were deeply resentful of the authoritarian and superior behaviour of the paramedical staff towards them.

By the late 1980s in Bangladesh, where BCG vaccine against tuberculosis is given in the first days of a baby's life, over 90 per cent of parents in most of the country were bringing in their children for this first shot spontaneously, only to drop out later in the immunization cycle. As we shall see later, mass media were hardly used in Bangladesh in mobilizing for immunization, and research showed that the reason for dropping out was that health workers were not taking the trouble to talk to parents about the immunization cycle and the need to return for further vaccinations on certain dates.

An in-depth analysis of the training needs of field-level health workers in Bangladesh led to a programme of interpersonal training workshops for which the curriculum was being developed with health workers, during the preparation of this case-study.

Also in Bangladesh, beginning with senior staff, attempts are being made to break

down hierarchical attitudes in government services, inspire an openness towards participatory planning and encourage more democratic attitudes among field workers. UNICEF has been promoting and supporting workshops on various aspects of its country programme. These workshops bring people together from the various ministries involved, and from other interested institutions, to discuss a problem and plan a strategy for tackling it. The use of such participatory meetings rather than seminars, where the audience listens to an address, is a relatively new approach.

A technical input from the Programme Communication and Information section of the UNICEF Office in Bangladesh has been Visualization in Participatory Planning (VIPP). Based originally on a German system for planning in groups, this uses coloured cards on which people can write objectives, strategies, actions, and so on. The cards are then stuck to a large board or on the wall for the whole group to see. As the plan is developed during discussions, the cards can be moved around, changed, deleted and new ones added, providing a visual reference of the group's progress towards an agreed definition of the problems and a plan for resolving them.

Apart from assisting logical thought processes by providing a visual reference to the state of play, VIPP invariably improves participation in the group. It is very rare for someone not to become involved in the discussion and in writing up and moving the cards around. This participation leads to a sense of 'ownership' and improved commitment to the plan worked out by the group. At the same time, through a practical experience, it shows that problems can be defined and solutions sought in a democratic and participatory way. It is hoped that this will have some effect on the way the managers subsequently deal with their staff, and also on the way in which they in turn deal with the community. Certainly, the subjective impression is that Bangladeshi officials exposed to the participatory workshop style were surprised by what could be achieved and endorsed it with enthusiasm.

In some countries, such as Bangladesh, UNICEF helped to inspire more democratic attitudes among health service staff, beginning with top management who were exposed to participatory problem analysis and programme planning sessions as a means of helping them to break out of the traditional culture in which only the eminent speak and few others ever ask for the floor.

ENLISTING THE MEDIA

Communication — through mass media, group media, traditional and folk media, and interpersonal channels — is the tool of social mobilization. It is generally held that the most effective approach for creating awareness, the first step along the path towards attitudinal and behavioural change, is to apply an integrated communication approach. This will use all possible communication channels to reach people with messages in a different form, but on the same subject, so that the messages are mutually reinforcing.

Social mobilization is achieved through communication, using as many channels as possible. Some countries organized integrated communication activities, while others relied mainly on a single medium, usually television, but strongly backed by interpersonal channels, or used interpersonal channels only. The choice of strategy depended on the media infrastructure and how it was organized.

A VARIETY OF APPROACHES

Some countries were very successful in developing integrated communication activities. Others used a single mass media channel almost exclusively, usually television, but also backed it with interpersonal channels. Others used interpersonal channels intensively,and hardly any mass media at all.

Of all these strategies, the integrated communication approach is the most successful, and it is cheaper to reach large numbers of people through mass media and interpersonal channels than it is to reach them through interpersonal channels only.

However, there were specific factors that favoured one approach or another in a given country. One of these was the way the mass media were organized. This varies in different parts of the world. For example, in Latin America, the United States model of commercial media has been generally followed, with thousands of radio and television stations scattered all over the continent.

In other parts of the world, notably in Africa, the Middle East and Asia, where there was a European colonial influence, the usual pattern is one of state-owned radio and television. State-owned systems invariably have central production and broadcasting of programmes and, unless the country is very small and flat, they have relay stations that boost the signal into the remoter areas not reached from the centre. In some countries, the state-owned systems also have regional stations, which may produce and broadcast their own programmes locally, as well as relaying central programmes for part of the day.

Bangladesh used primarily interpersonal channels. Egypt relied heavily on television, while countries such as Colombia, the Congo, Syria and Turkey mounted integrated actions.

There were implications for UCI in these distinct media arrangements; in countries where the strategy for UCI was to accelerate on a region-by-region basis, increasing the number of regions each year, and where the media were state owned and broadcast to the whole nation, it was not possible to use radio and television in support until the acceleration process had covered the country. This was the case in Bangladesh, which started its accelerated EPI by concentrating on eight *upazilas* (subdistricts) in the first year, multiplied to 64 the next, and so on until the whole country was covered in four years. In fact, a survey in Bangladesh showed that 78 per cent of mothers who took their children for immunization had first heard information on the subject through interpersonal channels, in most cases from a health worker.

India also accelerated on a phased basis, but since the mass media in India, although state-owned, are decentralized to a certain extent, it was possible to use regional broadcasting services in support.

Among countries that were able to develop a truly integrated communication strategy that used all the mass media and numerous interpersonal channels were Colombia, the Congo, Syria and Turkey.

An integrated approach

Colombia, as the forerunner among countries that developed an integrated use of communication, warrants special attention. Its mass media infrastructure is excellent. Its 520 radio stations reach everywhere. In 1987, television was reaching about 70 per cent of the population, and the written press about 20 per cent.

The largest radio network is Caracol, which owns 123 stations. Its director at the time was concerned with social issues. Earlier, he had seen children in Barranquilla with bellies swollen from the effects of water-borne parasites, and he had launched a radio campaign about the need to boil drinking water. Given this social awareness, it was not difficult to persuade Caracol to put its resources into promoting immunization.

In any event, Caracol became totally committed to promoting immunization during Colombia's drive towards UCI. Initially, it worked alone, but then in the final years leading up to 1990, Caracol itself took the initiative of approaching other radio networks in the country and inviting them to participate in an endeavour it called 'United Radio for Colombia's Children'.

With regard to television, apart from the 'Juanita' television spot mentioned earlier, there were a number of other television spots that were creatively produced by some of the best commercial talent in the country.

The main involvement of the written press in Colombia was through *El Tiempo*, one of the most important and prestigious newspapers, and one which threw its weight behind the immunization drive. Given the relatively small distribution of newspapers in Colombia, its audience was primarily the urban élite. However, as part of social mobilization, it is very important to reach this small sector too, for its interest and moral support are very influential in creating a favourable climate of public opinion. Of course, the written press also reaches the medical profession. In addition to helping unify opinion in favour of UCI among the medical profession, it was also motivating for them to see their efforts being given prominence.

A pertinent point about the communication work done in Colombia for UCI is that, according to several interviewees, the perception among the general population was that the campaigns belonged to *El Tiempo* and Caracol rather than to the Ministry of Health. Given the rather poor image that most state institutions have in developing countries, this was almost certainly an advantage. It also speaks well for the Colombian Ministry of Health that it was willing to keep a low profile and let the media run with the ball.

Colombia provides a prime example of an integrated and well-orchestrated approach. The media became so committed that the general population saw the campaigns as belonging to them, rather than to the Ministry of Health.

Using a single media channel

Egypt provides an example of a country that relied primarily on a single mass media channel, television, backed by interpersonal communication. It achieved remarkable results in ORT and EPI through this strategy. Radio was used to a certain extent, but it was peripheral compared to television. There was also support from the press in Egypt, but with the 60 per cent illiteracy in the country, the main role of the written word could only be to provide information to the intelligentsia, including, of course, the medical profession.

Egypt's achievements through almost exclusive use of television may be surprising to communication professionals. That can perhaps be explained by the fact that prior research had shown that television was by far the most influential and preferred medium among 70 per cent of the population. Furthermore, Egypt's numerous health workers were available to follow up, through personal contacts, on the awareness created by television spots. Even today, however, there are serious pockets of low immunization coverage in satellite communities of Upper Egypt that have no electricity and few, if any, battery-powered television receivers. Radio might reach such groups better.

Although communication professionals often express doubts about the impact of a single media channel, Egypt obtained remarkable results by concentrating on television, with some marginal use of radio and intensive interpersonal follow-up.

Printed materials and logos

Printed materials such as leaflets, stickers, posters, banners, and so on played an enormous role almost everywhere. Some of them tried to motivate parents to bring their children for vaccination during specific vaccination days; others were of a more general information nature, explaining, for example, the various doses and their timing to

achieve full coverage; still others were in the nature of a reminder about immunization. In the last category, an innovative step taken in India was to produce millions of 'posters' on tin to give them a longer life and provide a semi-permanent reminder about immunization.

The need to provide an identity for EPI/UCI was met in many countries through the creation of a logo that appeared on all the materials produced and was also displayed on hoardings, banners, etc. Perhaps the most famous was the *moni* logo in Bangladesh. *Moni* is a term of endearment used for children, and the logo is a drawing of a child crawling towards the viewer, with six arrows pointing in towards the child to symbolize the six main diseases. But separating the arrows from the child there is a bright red ring to portray the protective effect of immunization.

Printed materials, logos, stickers and banners were used extensively in most countries. They were widely displayed and became very well known and familiar to thepopulation. The logo for UCI developed in Bangladesh appeared on the 20 million matchboxes produced and sold locally each month, and on the masthead of most of the 130 national and local newspapers for a year.

The *moni* logo for EPI, and subsequent logos for other UNICEF-assisted programmes such as sanitation, had all been carefully pre-tested before being finalized.

Evaluations show that the *moni* logo is recognized correctly by 100 per cent of the population in Bangladesh. It has appeared on matchboxes produced in the country, where 20 million matchboxes are sold a month. A shoe company put it on its boxes, and it is also displayed by several commercial companies which, when putting up a large hoarding to promote their own wares, also include the *moni* logo prominently on it. Most of the 130 or so national and local newspapers in Bangladesh printed the *moni* logo on their masthead for a year or more. Banners and flags with the logo are used to identify vaccination sites.

The remarkable thing about the *moni* logo was not the logo itself but the way it was so widely displayed. This was surely the result of some intensive advocacy, even if commercial companies realized that associating themselves with EPI would be good for their image, and thus the relationship would be symbiotic.

In Colombia, a comic-strip child was developed and tested for the UCI effort and became very popular, particularly among children.

In Colombia, Pitin, a comic-strip child, was developed and tested for the UCI effort beginning in 1984. Pitin, portrayed as a three- to four-year-old, figured in many of the television spots and as a logo on the other material. The name 'Pitin' was tested, with the objective of appealing to children. Thus, the communication strategy was child-to-child: Children, attracted by Pitin, would talk to their parents about having themselves and their siblings immunized. Pitin costumes that an adult could wear were made, like the Father Christmas garb seen in stores in Western countries in December. During the run-up to vaccination days, Pitins on fire trucks went around with the reminder that infants must be immunized. Later, Pitin was regionalized and given an ethnic identity and clothing that corresponded to the different situations in the country.

Local press was intensively used in some countries. In Bangladesh, a recently created development features syndicate, Devfeatures, run by the Centre for Sustainable Development, worked with about 120 local and regional newspapers. The circulation of these newspapers rose quickly after 1987-1988, following serious floods that disrupted the distribution of the major Dhaka newspapers elsewhere in the country. People began to read the local press, liked it and continued to do so.

Poetry and theatre

An interesting channel of communication in Bangladesh is proving to be poetry. The country has a heritage of poetry, and today there is a handful of popular poets who write epic works that are produced as very cheap booklets in print runs of 50,000 copies at a time. Over 8 million copies, with information from *Facts for Life* and about sanitation, were printed and sold in 1991 alone. The hawkers of these booklets read the poems aloud in public places, including the river launch harbour in Dhaka through which 400,000 people pass daily. Those who buy the booklets take them home as treasured possessions to be read aloud by a literate member of the family.

Popular poetry and theatre were used in some countries such as Bangladesh.

The use of local theatre groups and other traditional art forms has also been important in many countries. The Bangladesh Gram Theatre was founded in 1981 with the social aim of starting village fairs and forming theatre groups at village level all over the country. It has played, and is still playing, an important role in social action. It has 167 theatre groups, with some 7,000 amateur actors and theatre workers. With UNICEF support

since 1989, the Gram Theatre has staged hundreds of performances on immunization and other social themes.

Creativity and communication for health

In considering the intensive use of communication media for EPI/UCI, of which some examples have just been provided, we should remember how matters stood earlier. Most countries had for decades used their mass media to some extent to promote social and economic development. There were regular broadcasts on health, agriculture and the like in almost all countries. For the most part, these programmes were produced by the technical Ministry concerned and handed to the Ministry of Information for broadcasting.

It is axiomatic that creativity does not flourish in a bureaucracy. Creativity is costly, and even where a ministry is able to attract it in the first place, it can seldom retain it; the appeal of higher salaries, and more freedom to express their creativity, constantly lures talented ministry staff to greener pastures. Thus, almost without exception, the programmes broadcast for decades were unimaginative and boring. Ministry programme producers, with scarce resources and with no chance of doing the audience research or pre-testing that would allow them to improve their work, even if they wanted to, often rebroadcast the same programmes year after year to fill their allocated time slot for the health programme.

CSDR brought real creativity to health communication for the first time because it succeeded in enlisting the services of truly professional communicators. They knew that health messages had to be as attractive as those for commercial products if they were to have an impact.

Then, with CSDR, the scene changed dramatically. It will never be the same again. CSDR communication brought an emphasis on marketing approaches and intensive use of mass media, and true communication professionals became seriously and routinely involved in health issues for the first time. And for the first time, too, it became evident to all that quality in media planning and production was as important for social issues as it was for commercial promotion. Television spots for health cannot be any less attractive than a spot for a soft drink if they are going to hold people's attention and make an impact.

Drawing on advertising and marketing skills

Indonesia was a forerunner in using professionally made media spots to promote breastfeeding in the late 1970s, but following the launch of CSDR in 1982, many countries decided to adopt that strategy. Another early experience was the Brazilian breastfeeding campaign in the early and mid-1980s. This used media spots intensively, and an evaluation carried out in 1990 showed that in Greater São Paulo, the median duration of breastfeeding had increased from 84 to 146 days.

Brazil's breastfeeding campaign was followed by a series of other mobilization actions in favour of children in the following years, including EPI/UCI, child rights and street children. El Globo, the mighty media empire, committed itself to the crusade for children. It provided air time free. Equally important, however, was that talent from the advertising and promotion industry to carry out behavioural science research and to plan, design and produce materials was also enrolled.

The technical capacity and creativity, and the behavioural science research skills of marketing and promotion specialists were called upon in many countries, often at the instigation of UNICEF.

The results of the involvement of marketing professionals were television spots and other materials which, because they incorporated all the scientific methods, and the skills and the art of the marketing and advertising industry, made an impact that no materials from any Health Ministry's information unit had ever made before.

In many countries, UNICEF was instrumental in promoting the use of local advertising and marketing agencies to work on child survival and development programmes. For a United Nations agency, this was breaking totally new ground, although USAID had done the same for the ORT project it financed in Egypt.

The use of advertising and marketing agencies hardly met with instant approval in development circles, or for that matter within all of UNICEF itself. In the eyes of many, advertising suffers from an image of commercialism. This image obscures the fact that the industry also has highly developed skills in behavioural science research and in motivation towards attitudinal and behavioural change which can be applied to social themes.

In India, for example, it was the 1984 knowledge, attitudes and practices (KAP) study

on immunization, sponsored by UNICEF and carried out by an Indian market research organization, that laid the groundwork for the communication strategy used. A later series of KAP studies provided the information needed to fine-tune the communication work in order to influence left-outs, drop-outs and the hard-to-reach.

Getting a lot for little

For the most part, the mass media, whether commercial or state-owned, were ready and willing to participate in social mobilization for UCI and other CSDR actions. USAID support for ORT in Egypt included payment for air time to Egyptian television, but UNICEF has always preferred to work on the assumption that support from the media can be mobilized quite easily and without payment for social programmes concerning children.

This hypothesis has proven correct, even where the media are private. Commercial media owners are usually interested beyond making quick and easy profits; showing public concern and providing a social service is important for their image and operations in the long term. The Brazilian experience shows the extent to which the private communication sector is prepared to become involved. In addition to the air time given free by El Globo, the talents of the advertising and marketing industry were usually made available free, with only the costs of materials being paid for by UNICEF or other outside resources. It has been estimated that in the five years from 1985 to 1990, the Brazilian media and advertising industry made available US$30 million worth of services and resources for mobilization in favour of children's issues.

In many countries, broadcasting time was given free. The services of the marketing and advertising industry were usually provided free of charge or at specially discounted rates.

A final point about media is that in many countries where the Ministry of Health has its own information or communication unit, the quality of its output has made a quantum leap in recent years, mainly because the Ministry now knows it has to compete for attention with the commercial sector. It has therefore learned to do so, and if it has not, it has become disposed to contract out work, or key parts of it, to the private sector, where most of the creative talent is to be found.

ENROLLING THE ALLIES

Before the advent of social mobilization as a strategy, health issues were the domain only of a country's Ministry of Health, with perhaps some involvement of the Ministry of Social Welfare, where one existed. Social mobilization started from the principle that health issues should involve all possible allies, whether as moral supporters, as mobilizers of others, or as providers of services to supplement the efforts of the Ministry of Health. In some cases, the allies might perform more than one, or even all, of these functions.

With this general principle in mind, EPI/UCI was the focus for some remarkable experiences in the involvement of a wide variety of allies, the first time in history that the health sector had been able to enlist such broad-based support for its work. In countries all over the world, ministries and services which normally had few, if any, contacts with the Ministry of Health, and certainly no regular operational contacts, became involved in EPI/UCI. Ministries of information, education, defence, religious affairs, and post and telegraph were some examples, as were departments of statistics, police and other security forces.

In the non-governmental sector, a wide range of allies were enlisted: religious leaders, thousands of NGOs working in development, trade unions, university staff, Scout movements, theatre and other entertainment and cultural groups, volunteers of all types, as well as industrial and commercial firms, were among those that became involved in EPI/UCI.

Social mobilization started from the principle that health and other social issues could not be left as the sole responsibility of the relevant technical ministry. Allies who could provide support in one way or another were needed. Hence, in many countries, social mobilization for UCI brought in partners such as the military, education and religious authorities, many NGOs in the social and cultural area, etc.

GOVERNMENTAL VERSUS NON-GOVERNMENTAL

Without the dedicated participation of NGOs in many countries, UCI would not have been achieved. However, there were many difficulties at the beginning, for EPI/UCI entailed close cooperation between the non-governmental and governmental sectors, whereas traditionally, NGOs bypass government services. As one NGO spokesman said: "Governments usually thought that NGOs were insignificant and lightweight meddlers, while NGOs thought that government services were useless. Both sides were wrong! The government is good at supplying resources, but it is lousy at mobilizing people, which is what the NGOs are very good at."

At the community level, much of the mobilization work, and in many cases support to service delivery, too, was carried out by NGOs. It is well known that Rotary International raised US$226 million for their PolioPlus programme through which they provided polio vaccines. What is perhaps less well known is that local Rotary Clubs were also involved, taking on a variety of tasks from providing sandwich lunches for vaccination staff during campaigns in Turkey to working with local authorities and helping in mobilization efforts in Bangladeshi communities. The mobilization activities for EPI in Bangladesh consisted mainly of providing information on the 'when, where and how' of immunization. Also involved at the community level were Rotary's junior groups, Rotoractors between the ages of 18 and 30, and Rotary Village Corps members, aged 14 to 18.

However, in Bangladesh most of the mobilization work was carried out by three other NGOs — Bangladesh Rural Advancement Committee (BRAC), Cooperative for American Relief Everywhere (CARE), and Rangpur Dinajpur Rural Services (RDRS). Of these, BRAC,

Initial mistrust and lack of understanding between government and NGOs in many countries gave way to the realization that each had a distinct and crucial role to play — the NGOs in mobilizing people the government in providing resources. International NGOs such as Rotary International and CARE, national NGOs such as BRAC in Bangladesh, and local unions, made an enormous contribution to UCI.

with its field staff of 5,000 people, did the major part of the mobilization, with CARE not far behind. The importance of the mobilization work by NGOs in Bangladesh was crucial because, as will be remembered, the centralized mass media could hardly be used until the accelerated immunization services were available nationally.

During acceleration towards UCI in India, all manner of NGOs became involved, including a coal miners' union in the state of Madhya Pradesh, which assumed the responsibility for immunization of entire communities.

SCHOOLTEACHERS AND RELIGIOUS LEADERS

Schoolteachers and religious leaders were mobilized for UCI in most countries.

At the community level in many countries, the village leader, the schoolteacher and the religious leader formed the trio of influential people who, once convinced, were the most effective promoters of EPI/UCI, and for that matter of any other social action related to child survival and development. In Turkey, the 220,000 primary school teachers were asked to return to duty early after the summer break to help prepare the immunization campaign.

The religious authorities and leaders proved a major resource everywhere. In most countries, whatever the dominant religion, it was possible to reach the religious leaders in the communities through their central organization. In Turkey, in addition to asking for general support for immunization from the local imams, a sermon was prepared that was preached simultaneously from each of the country's 54,000 mosques on the Friday evening before the campaign was launched. Mosques also served as vaccination points in Turkey, as they did in Jordan and Iran. In addition, staff of the mosques often helped to identify areas of low vaccination coverage in low-income urban areas.

The active involvement of Islamic religious leaders was made easier through a UNICEF-supported publication, written by religious scholars, which linked child care to Islamic teaching and values.

Throughout the Middle East, obtaining the active involvement of the Islamic religious leaders was made easier by a publication called *Child Care in Islam*. UNICEF supported the publication of this booklet by the Al Azhar University and Mosque in Egypt, the leading centre of Islamic thought. The publication put child care in the context of Islamic teaching and gave the arguments that would convince the religious leaders to support child survival measures. For example, immunization was promoted within the context of the Islamic duty to preserve life.

In Bangladesh, it is not possible to reach local religious leaders (imams) through a central organization. Mobilizing them for EPI had therefore to be done on an individual basis. More recently, however, UNICEF has become involved in an interesting approach through the *pirs*, or holy men, whose numerous followers form an order or brotherhood. *Pirs* are the accepted inheritors of the spiritual power of the founding *pirs* of each order or brotherhood, which often believes it possesses the ultimate in spiritual wisdom. The *pir* is the repository of that ultimate and secret wisdom which spreads out in circles to his immediate disciples, and from them in attenuated form to the rest of the brotherhood. Thus, the *pirs* are immensely influential in their brotherhoods.

During the dry season these brotherhoods hold religious meetings lasting several days, at which as many as 2 million people may be present. UNICEF is holding workshops with *pirs* to sensitize them to child survival, protection and development issues. By early 1992, three of the six or seven largest brotherhoods in the country had committed themselves to promoting children's interests, and half a million leaflets had been distributed to them.

For Roman Catholic countries, the Vatican exerted pressure for CSDR, while local initiatives helped mobilize the Church in country after country.

For Roman Catholic countries, the Vatican itself became involved in CSDR issues following a meeting between the Pope and Mr. Grant in 1983. In the discussions at the Vatican, an interesting question came up: How long did it take for an order or a policy issued by the centre to become operational everywhere, even in the far-flung areas of influence? In the opinion of the Vatican spokesman, it was a process that would take 8 to 10 years, at least. In the event, however, the Catholic Church was mobilized for UCI in a much shorter time than this. The Vatican exerted pressure from above and provided legitimacy, while at the same time the Church was mobilized through local interventions in country after country.

RESPONSIBLE TEENAGERS TODAY, HEALTHIER FAMILIES TOMORROW

Many countries involved schoolchildren in the task of promoting EPI/UCI, but Colombia pulled off the biggest and most sustainable coup. Through the Ministry of Education,

extracurricular — but nevertheless obligatory — material on health has been introduced into the schools for 16- and 17-year-olds. These young people then become *vigias* (monitors) and carry out practical health work in their communities, such as tracking down left-outs and drop-outs from the immunization programme, or providing information about clean water and sanitation. As a result, in any single year, Colombia now has more than 330,000 young students active in health issues in their communities and, in addition, future generations of better informed and more health-conscious citizens.

Schoolchildren were also mobilized in many countries. One lasting result is that in Colombia there are now 330,000 secondary school children trained each year as health monitors to carry out practical health work in their communities.

Commerce and industry

Commerce and industry were important partners. They have already been mentioned in the context of the *moni* logo in Bangladesh, but they also provided logistical and practical help as, for example, when the Fish and Meat Corporation in Turkey provided refrigerated space for the 41 million doses of vaccine required for the first campaign.

However, we should not forget that individuals, as opposed to groups, were also of great importance — in particular, actors, entertainers and the famous played a central role when they made their time available at no cost, or at a small percentage of their normal rates, to appear in television spots or short skits. In almost every country, some of them offered their services with a minimum of inducement. Many were well-known soap opera stars. In the Brazilian breastfeeding campaign, the world-famous soccer player, Socrates, and his wife, who is a physician, appeared together in a television spot. Later, many other famous personalities were involved in promoting other aspects of child survival and development in Brazil.

Commerce and industry were important partners in many countries, but so were well-known actors and personalities who often gave their time to promote UCI.

In summary, mobilization of so many allies of such a wide diversity for EPI/UCI in country after country was the first time in human history that such a concerted global action had been achieved. It is a remarkable thought that in a country such as Colombia, on a vaccination day, there were close to 4 million children being immunized, at least the same number of parents bringing their children, 60,000 or so people manning the vaccination posts, countless others involved in transportation, record-keeping, data analysis and distribution, journalistic coverage and the like. About a third of the population of the country thus took part in concerted action on each of those days, without taking into account those who were following the day's progress through media reports, which often assumed the excitement of election results and used the same computerized technology. Indeed, in some countries it was calculated that more people were mobilized to action on a vaccination day than were normally mobilized for national elections.

Creating new values and motivating new actions among parents

It will be self-evident that the final link in the process of reaching UCI was the parents of the children who needed immunization. They had to be convinced of the need and motivated to actually bring their children along, and at the same time begin to internalize the value of immunizing children so that, ultimately, immunization would become part of the popular culture. If this did not happen, everything else that was being done to mobilize support and resources, and to galvanize the service deliverers, would be wasted. And it would be difficult to sustain coverage in the future unless vaccination became a felt need for people.

Parents were obviously the final link in the process of attaining UCI, and until immunization became absorbed into popular culture it would be difficult to sustain coverage.

Any form of communications for behavioural change will only succeed if it is planned with the knowledge of how the audience perceives the issue and feels about it, what actions, if any, it is taking at present, what information channels it uses and finds credible, and so on. Hence the importance of the KAP surveys carried out in most countries that mounted successful communication activities.

Different strategies for different circumstances

Mobilization to create new values and actions among parents varied according to the EPI/UCI strategy adopted by the country. Most countries, aiming for national coverage from the start, placed great emphasis on vaccination days, with campaigns leading up to them. On these days, the health services took vaccination to the people in a massive nationwide

The strategy for creating new values and actions among parents varied from country to country, but initially there were usually intensive campaigns leading up to vaccination days. These later gave way to moreroutine vaccination promotion and services as the health sector improved its capacity to deliver.

operation. This was usually the case in countries in which the medical services were initially unable to provide regular immunization services for the whole of the population. Later, as the regular medical services started to expand their coverage, they had to promote the idea that people should use those services in a routine way, rather than wait for vaccination days. They also had to develop strategies for reaching the left-outs and drop-outs, and this almost always involved physically seeking out these families, using health staff, health monitors, volunteers, NGOs and the like.

In countries where EPI was carried out by geographical phases over several years, vaccination days or weeks were still organized, but their purpose was to remind people about vaccination in general, rather than persuade them to take specific action on a certain day.

The nexus between media and interpersonal communication

In most countries, the media offered the quickest and easiest way to reach people with information that could create awareness on a massive scale. However, actual behavioural change almost always requires personal contact — from a development worker, an influential member of the community or someone who has experience of the proposed new behaviour. The media will still play a supporting and reinforcing role, however, facilitating the interpersonal communication work and giving it legitimacy and credibility. For example, there is a widespread belief in many societies with a low level of education that "if the TV (or radio) said it, it must be true." When a health worker says much the same thing a few days later during a personal contact, his or her credibility is immediate.

Mass media proved the easiest way to reach large numbers of people, but behavioural change normally calls for personal contacts too. The need for media and interpersonal channels to complement and reinforce each other emerged clearly.

An example of how media could and should provide this supporting role, but for various reasons could not at the time, comes from a BRAC experience. BRAC has a history of community-level mobilization for health that goes back to 1980 when it began working on ORT. Its field workers managed to talk about ORT and demonstrate how to mix the solution to at least one woman in every single household in the whole of Bangladesh, a mammoth operation.

Unfortunately, a later study showed that although over 95 per cent of women knew about ORT, only 25 per cent could remember, from the single demonstration they had received, how to mix the solution. This problem of reinforcing the memory of how to mix the solution might have been overcome by use of mass media, but in those days their spread was rather limited. Today, however, their spread is wider, and probably about a third of the population has access to television. For this reason, recent years have seen an increased use of television for social messages.

Message content

The majority of the messages used in most countries for EPI/UCI were based on a positive approach. The notion of protecting children, of giving parents peace of mind concerning their children's health, was a commonly used theme. The logic behind this is the same as that which determines the UNICEF policy of showing happy and appealing children in publicity photographs. It was thought to be generally more effective to take a positive approach that appealed to parents' sense of responsibility, rather than to create fear in parents' minds about what might happen if their children were not immunized.

Most of the messages promoting immunization took a positive approach, apart from some heart-wrenching television spots on polio, which seem to have had a dramatic impact.

Polio, however, was often treated differently. Compared to the other immunizable diseases, the effects of polio are more visible, as well as being horribly permanent. Television spots in many countries played on this. One example was a series made in Egypt. Among them was one showing a small crippled girl watching while her friends ran and played together in a garden. The expression of sorrow on her face, and the tears running down her cheeks as the spot closes, are heart-wrenching. Equally moving were other spots showing children with wasted and distorted legs struggling to drag themselves by their arms along a rail fixed to a wall. Although no precise quantitative data is available, many people in the Egyptian Ministry of Health state that the day after these spots appear on television, parents flock to the health centres to have their children immunized against polio.

In Algeria, on the other hand, the polio spots were positive, except for the opening logo

which showed the silhouette of a person crippled by the disease. After the logo, one spot cuts to a pair of feet in football boots manoeuvring a ball with great agility. The camera then moves up the legs and body until the face of a national football star comes into view. He says on camera, "If you want your children to have legs like mine, vaccinate them against polio!" This Algerian spot was also highly effective, and it is difficult to reach a conclusion regarding the positive versus the negative approach.

Appealing through stars

The use of well-known and popular actors in soap operas and spots was a very successful strategy almost everywhere it was used. Occasionally, there would be a negative research finding to the effect that a certain comedian should not be involved in promoting health issues because he would not be taken seriously, but this was very rare.

The use of famous actors in health promotion was a successful strategy.

Social constraints and imaginative solutions

In the area of interpersonal communication, as was highlighted in the section on galvanizing service deliverers, the training of field staff was of extreme importance, and still is in many countries. It was quite common for management in health ministries to react negatively when behavioural research findings showed that a main reason for vaccination drop-out was that paramedical staff treated clients in an arrogant and impatient fashion, not taking the time to exchange a few words and provide some explanations. Sometimes health managers did not believe this was true until there was massive evidence that the problem was widespread, and only then would they agree to training in social skills for their field workers.

Social constraints were serious obstacles. It was not always easy to persuade health managers that their staff needed training to improve their social skills.

The BRAC experience with mobilization for ORT in Bangladesh, and other mobilization work involving women, provided a lesson that was fundamental for EPI. In a society such as that of Bangladesh, it is a mistake to try to convince women to take a decision without first convincing the influential males, who include the religious leaders, the local village leader and, through them, the husbands, too.

When working for ORT, BRAC had run into resistance among the more conservative religious leaders, many of whom were spreading the rumour that ORT was a hidden form of birth control. So BRAC field staff had to go to the mosques and convince the religious leaders otherwise.

When it came to EPI, the issue of how far women could move alone to take their children for immunization was critical. In Bangladeshi society, the general rule is that a woman is confined to an area rather close to her home in which the other members of her family's social group live. The vaccination point was often outside that area. Since the male opinion leaders are the guardians of such traditions, it was first necessary to convince them that immunization was important and that it was morally correct that mothers be allowed to take their children to the vaccination point, even if it was outside their normal area of movement. It is interesting that in Bangladesh today it is stated that this extra freedom for women to move, brought about by EPI, has become a feature of society.

In many Muslim countries, such as Bangladesh, women cannot be persuaded to take a decision without first convincing the influential males in the community. In addition, women's traditional lack of freedom to move away from their home compound, even to take children to a vaccination post, was an impediment that had to be overcome, first by convincing the men. Mothers of fully immunized children are a channel now being used to reach hard-core left-outs and drop-outs.

Although Bangladesh has achieved high immunization coverage nationally, there are still pockets where coverage is relatively low. To reach the hard-core left-outs and drop-outs, an innovative tactic is now being tried. Mothers of Fully Immunized Children, known as MOFICS, are being enlisted to mobilize women in their communities whose children remain unprotected. Quantitative results of this initiative are not yet available, but as an approach, it seems to hold much promise, for who better than the women in the community to reach and convince their peers?

Success and sustainability

Worldwide experience in creating new values and action among parents shows that there is no one model of communication strategy that can be applied. Every country needs to examine its own situation and come up with its own strategy and plans.

Although there is no single communication strategy that can be generally applied to creating new values and actions among parents, common factors of successful experiences have emerged.

However, there are certain common factors of successful experience that do emerge. These include good KAP research among intended audiences; truly creative use of media, integrated with and in support of interpersonal communication; training in social skills

for field workers; and the identification of intermediate audiences that can influence parents.

The issue of the sustainability of immunization coverage is linked to two basic considerations. The first is whether it has been possible to decentralize responsibility for health services to the point at which the community begins to assume the major role in identifying its own needs and in planning and contributing to appropriate actions. This is happening in Colombia where 4,000 Committees for Community Participation in Health have been set up as a result of the mobilization and interest created by the drive towards UCI. These are presided over by the mayor and include members of the municipal council, community organizations, the Church, parent associations, producers' associations, and so on. It is also significant that under the decentralized management system in the country, the local medical services are responsible to the mayor. Such a system allows the community to set its own collective health objectives, rather than having them passed down from the capital, and empowers local authorities to look for locally appropriate and innovative solutions for mobilizing community resources to meet their needs.

Immunization sustainability depends, first, on community participation and action and second, on immunization becoming a felt need in society. It is evident that social mobilization for UCI has moved many countries well along the path towards meeting those two conditions.

The second main factor determining sustainability is whether immunization has become a felt need in society, at which point little further promotion or reminder will be required. In many of the countries that achieved UCI/1990, immunization is now taking root in the conscience of society, so much so that in several countries there exists an 'immunization culture'.

SOCIAL MOBILIZATION UNDER THE SPOTLIGHT

All that has been said so far in this case-study shows social mobilization in a favourable light, but it would not be correct to conclude the study without taking into account what some critics still say about social mobilization and seeing whether, under the spotlight, their criticisms hold up. The main contributions of social mobilization to EPI/UCI, and to health services in general, will be identified.

TRUE OR FALSE?

Much of the criticism of social mobilization results from improper understanding. Some people associate social mobilization only with campaigns and follow up by saying that campaigns lead to unsustainable actions.

It is true that, in some countries, excellent campaigns were carried out for EPI/UCI and that coverage proved difficult to sustain afterwards. Turkey is one example. Its campaign in 1985 was a model of organization and effectiveness, mobilizing every conceivable sector of the population that could play any useful role. However, coverage dropped in later years and is only now climbing back to the levels reached in 1985. Some of the decline in coverage after 1985 can be attributed to difficult access to many areas of the country in winter, but it is also true that there was a certain one-big-effort-for-all-time feeling about Turkey's 1985 campaign.

Burkina Faso suffered a similar experience after its very successful 'Operation Commando' in 1984, the first such operation in Africa. Over 1 million children were immunized in a single three-week period, but thereafter the impetus was not maintained. However, political changes also played a role in this.

Other countries that used social mobilization during campaign periods did not fall into this trap and were able to piggyback on the campaigns and gradually build their regular health services to the point where routine immunization could be promoted. In Colombia, this situation has now been reached, and vaccination days are carried out only as a reminder to people and to get immunization services to the remotest areas that are still not served regularly.

A number of African countries, in striving to meet the target of 75 per cent coverage set by African ministers of health, decided in favour of simultaneous development of other PHC infrastructures and services, with excellent results. Among these countries were Benin, Sierra Leone and Togo, with especially intense mobilization activities in Togo.

The lesson learned from social mobilization for EPI/UCI is that social mobilization should be a process planned and implemented over time, and not thought of as a one-shot effort. It should also be remembered that officials in many governments are rotated at quite short intervals of time. They are therefore a fleeting target, and mobilizing one 'generation' of officials in a short, sharp effort may not lead to sustained interest as their successors take over.

It should be clear from the above that social mobilization is not a campaign in itself, although a campaign may form part of the strategy.

One concern of health professionals is that social mobilization may create so much demand on unprepared health services that they will become uncooperative, both in the short and long term. And the users of the services will be frustrated.

There are criticisms of social mobilization, but they often originate from misunderstanding. Many people think of social mobilization as being only a campaign, and it is true that some highly successful campaigns such as those in Burkina Faso and Turkey have not proven sustainable initially.

In other countries, social mobilization and its related campaigns were part of a broader picture of long-term development of the health services and of demand creation, and social mobilization was highly effective in that context. Thus, social mobilization is not a campaign in itself, but it may use them.

Fears that social mobilization would create demand that the health services could not meet have been unfounded.

However, experience shows that demand creation should be kept roughly apace with delivery capacity, or perhaps slightly ahead of it to put the service deliverers under some pressure.

There seems to be no record of this happening, but it does raise the issue of matching the mobilization of demand to the ability of the services to respond. At one extreme in that discussion are the cautious who say that all the health services must be in place before any mobilization can occur, while at the other extreme are those who would like to mobilize demand to the point where the pressure forces health services to respond. The latter may be valid in countries where the health infrastructures are in place but where the staff are not enterprising enough. However, in most countries, the correct strategy lies somewhere between the two extremes: Keep mobilization and delivery capacity more or less in balance, but if anything, keep mobilization slightly ahead to put the services on their mettle.

Social mobilization is criticized for being top-down in nature. In fact it is top-down and bottom-up at the same time. Although people say it is top-down because it promotes actions, such as immunization, without prior consultation with the community, it is true too that in many countries UCI resulted in building community organizations that now decide their own agendas.

Social mobilization is considered by some people to be top-down in nature, and, for these, the word mobilization has military connotations that help them to believe this. In fact, good social mobilization is top-down and bottom-up at the same time, since it works at all levels of society. It may be true that it is top-down if one wants to take the extreme view that the action for the mobilization (e.g. immunization) was decided without consulting the community. On the other hand, the active involvement and participation at community level in EPI/UCI, for example, has led in many countries to the creation of groups and structures that will be able to set their own agendas in future.

Social mobilization's contribution

EPI was making slow progress until social mobilization came on the scene as part of UCI/1990.

Little delving is required to come up with evidence that EPI had made very slow progress in the years after its launch in 1974. Then in 1984 social mobilization began as part of UCI/1990, and immunization coverage accelerated rapidly thereafter. So in general terms, despite hiccups here and there, and despite the different approaches used in different countries, social mobilization was fundamental to the achievement of UCI/1990.

UCI saved 12 million lives and continues to save 3 million a year. There are now some 500 million contacts between children and organized delivery systems each year.

In concrete terms, UCI/1990 means that the lives of more than 12 million children were saved after mobilization towards UCI began, and on an annual basis, more than 3 million lives continue to be saved. It also means that over 100 million infants during the first year of their life are being reached four to five times with vaccines each year, which adds up to some 500 million contacts between children and organized delivery systems, sometimes in areas so remote that not even the postal services reach them. More children are fully immunized in El Salvador, India, Nepal and Nigeria at age one than are the children of London, New York and Washington, D.C. at age two.

At the country level in Bangladesh, for example, social mobilization for EPI led to the creation of 108,000 outreach posts for immunization, most of them in private houses lent regularly for the purpose. These outreach posts are being used for family planning services, too, and are a resource onto which other PHC inputs are now being grafted. Other examples of permanent strengthening of health services were mentioned earlier in the text, such as the 330,000 secondary school children who become health monitors each year in Colombia, and the creation of community-level health committees in that country.

Social mobilization for UCI has led to the creation of better health infrastructures and services in many countries (e.g. 108,000 health outreach posts in Bangladesh), to new patterns for future social actions based on interministerial cooperation and good teamwork among various partners, to greater media interest in, and coverage of, social and health issues, to much improved management of health services, and to health becoming the concern and property of large sectors of the population, with increased community-level interest and action.

Almost everywhere, the mobilization of allies and the creation of interministerial cooperation on EPI have set new patterns for future social action. Good teamwork among many and varied partners set the foundation for reaching UCI in most countries. The shared satisfaction in the achievement is evident when talking to the partners in the effort, and the recollection remains a stimulus for further joint activities in the future.

The attitudes of the media have changed. They are more interested in social and health issues than they were before their involvement in supporting EPI/UCI, and they are giving those issues much more coverage. In turn, this has led to a push-pull effect, with the public taking a greater interest in health coverage in the media. One recent readership survey in Colombia showed that, after national news, the next most appreciated subject was health.

Management of health services has improved immeasurably. Naturally, during EPI/UCI itself, good planning, management, and monitoring through improved information systems were of the essence, and these have generally remained in place. Furthermore, as mentioned by WHO, good management for EPI/UCI has pointed the way to the use of

some of the same management approaches and criteria in other health sectors. Today, when WHO staff tell health ministry officials that their management of EPI/UCI was outstanding and suggest that they try to apply the same techniques and criteria to other health services, the response is usually excellent. Before the success of EPI/UCI in the developing countries, there had been few health management precedents by which to set new standards.

Perhaps the most important consequence of social mobilization for EPI/UCI was that for the first time in history and on a massive scale, action for health became the concern and the property of large sectors of the population, and not the sole responsibility of the Ministry of Health. Just as important has been the increased community-level interest and involvement in, and assumed responsibility for, practical health actions. This results from the realization among even the poorest, the illiterate and the most marginalized, that better health for their children — even survival — lies to a large extent in their hands.

This realization manifests itself in such things as the numerous outreach posts for vaccination in Bangladesh and similar ORT centres in private houses in Colombia. These are known as *Unidades de Rehidratación Oral Comunitarias* (UROCS). Such initiatives are the building blocks of sustainable, community-run PHC services.

Finally, social mobilization for EPI/UCI focused attention on children, bringing them into the political arena in country after country. It helped create the conditions of attention and concern that led to the Convention on the Rights of the Child, adopted by the United Nations General Assembly in November 1989, and which came into force in record time for any agreement on human rights. As of 9 March 1993, the Convention had been ratified by 131 countries, with another 25 that have signed it but are still going through the ratification process.

Finally, it has brought children into the political arena in country after country. It helped lay the foundation for the Convention on the Rights of the Child and for the World Summit for Children.

The World Summit for Children was prepared and borne along by the same attention and concern. It was held in New York in September 1990 and attended by 71 Heads of State and Government and by 88 other senior officials. Never before had so many Heads of State gathered in one place. It adopted a Declaration on the Survival, Protection, and Development of Children and a Plan of Action to implement it in the 1990s. For the first time, with children firmly on the political agenda, countries are planning programmes for them and making available the necessary resources.

THE ROLE OF UNICEF

As described in this case-study, UNICEF has played a catalytic role in social mobilization. It has set new patterns in development thinking. However, UNICEF should always recognize the moment when it should step back and hand over the social mobilization process to the nationals for it to become sustainable.

The catalytic role of UNICEF in what has been described here has been significant. Within a country context, UNICEF has a unique position as an outsider, but one with international prestige, a United Nations umbrella and a mandate for children that no one with a heart can deny. Therefore, it is ideally placed as a broker to bring together distant or even dissident parts of government and society for concerted actions.

UNICEF has also been catalytic in the way it has made available financial resources for key activities that have opened the door to major actions. It has also provided intellectual contributions and coordination functions in many countries.

UNICEF has set new patterns in development thinking. However, there comes a time in a social mobilization process when the ownership of the process needs to be passed to the nationals if it is to become sustainable. Thus, UNICEF staff within a country should be constantly assessing to what extent the UNICEF identity still serves a purpose in bringing together societal forces and providing legitimacy, or when its presence might begin to seem an interference in matters that the nation is quite well able to handle. It was interesting to see that in Colombia, where UNICEF had maintained a high profile in social mobilization for years, much of the latest material for child rights does not display the UNICEF name although the organization has supported its production. This mobilization for child rights is supported by more than 40 local institutions and groups, and clearly the decision by UNICEF to remove its identity from many of the materials was wise.

WHERE NEXT?

Following EPI/UCI, many countries are now embarking on social mobilization around other programme activities. A view often expressed is that mobilization for immunization was relatively easy: All that was being done was to motivate parents to take their infants for vaccinations while stirring up the service providers and reinforcing them so that they could be ready with syringes and cold vaccines at the right place and at the right time.

Social mobilization for immunization may have been relatively easy compared to some other UNICEF programme areas that require more effort and resources from the community.

Anyone reading this case-study will realize that this is a gross oversimplification, but it is true that it was probably relatively easy to persuade people to avail themselves of a service. Other programme areas are going to call for more investment of time, effort and resources at the community level for benefits that may be less obvious.

Sanitation in Bangladesh is a case in point. With only 6-7 per cent of the rural population of about 100 million people using sanitary latrines, in the most densely populated country in the world, with rivers and water everywhere, with a tropical climate and some 30,000 metric tons a day of human excrement, sanitation has become a national priority. Mobilization for it is proceeding apace. The mobilization for EPI provided some key pointers and, in addition, a new and important ally has been brought on board. This is Ansar-Village Defence Party (VDP). Ansar is a traditional religious volunteer organization, and VDP is a paramilitary civil defence group originally set up to act in time of natural calamities. They merged recently, and VDP was to change its name to Village Development Party.

Ansar-VDP has 32 men and 32 women forming a group in each of Bangladesh's 68,000 villages, over 4 million people in all. In 1991, Ansar-VDP made sanitation a priority for the period 1992-1995. They are training people, providing the concrete to build latrines, and urging people to dig them and buy the concrete materials, or, if they cannot afford that, to use a home-made sanitary latrine design.

Sanitation in Bangladesh is an example. The need is enormous, and social mobilization efforts are now in progress. However, it requires effort and some material resources to build sanitary latrines, and these may not be forthcoming voluntarily until people understand the connection between faecal contamination of food and disease.

Progress in the first intervention areas of Ansar-VDP and the many other institutions and NGOs involved is good, but latrine construction does require the effort of considerable digging and resources for the materials required. Some maintenance will be needed, also. As long as people do not understand the link between faecal contamination of food — often by flies — and diseases such as diarrhoea, it will require the forceful presence of groups like Ansar-VDP to get things done. Whether this constitutes social mobilization and participation in the sense of empowering people to make decisions and take actions that affect their lives is open to some debate.

Other issues such as the position of the girl child in society, basic education for all — and particularly for girls in Islamic countries — child rights, street children and so on are all now being tackled using social mobilization.

The indications are that much can be achieved even in areas such as nutrition. Nutrition is particularly complex because it involves education on what a mother and child should eat for a good diet, linked to people's access to the necessary foods and/or their ability to produce them. Also important are child-care habits, in terms, for example, of the number of meals a day a child is given. Yet, despite this complexity, the United Republic of Tanzania is succeeding very well in applying social mobilization to nutrition. Its nutrition programme in the region of Iringa, covering 1.2 million people, reduced the

Social mobilization is being applied successfully to promote nutrition in Tanzania...

number of underweight children from 50 per cent to 35 per cent between 1984 and 1990, and the cases of severe malnutrition dropped from 6 per cent to 1.4 per cent.

This was achieved by involving people from the national to the village level in assessment, analysis and action. Analysing the various causes of malnutrition and poor child health in a participatory way with the population was a first step towards creating awareness and changing behaviour — for example, identifying the role of fresh vegetables and actually growing them. The use of mass and group media, training, and the involvement of cultural and youth groups also helped. The programme expanded to other districts covering three times the area of the original one, and severe cases of malnutrition again dropped dramatically, indicating that replication of the model is possible. These achievements are essentially due to the efforts of the communities themselves.

to changing attitudes and promoting action concerning street children in Brazil and the Philippines...

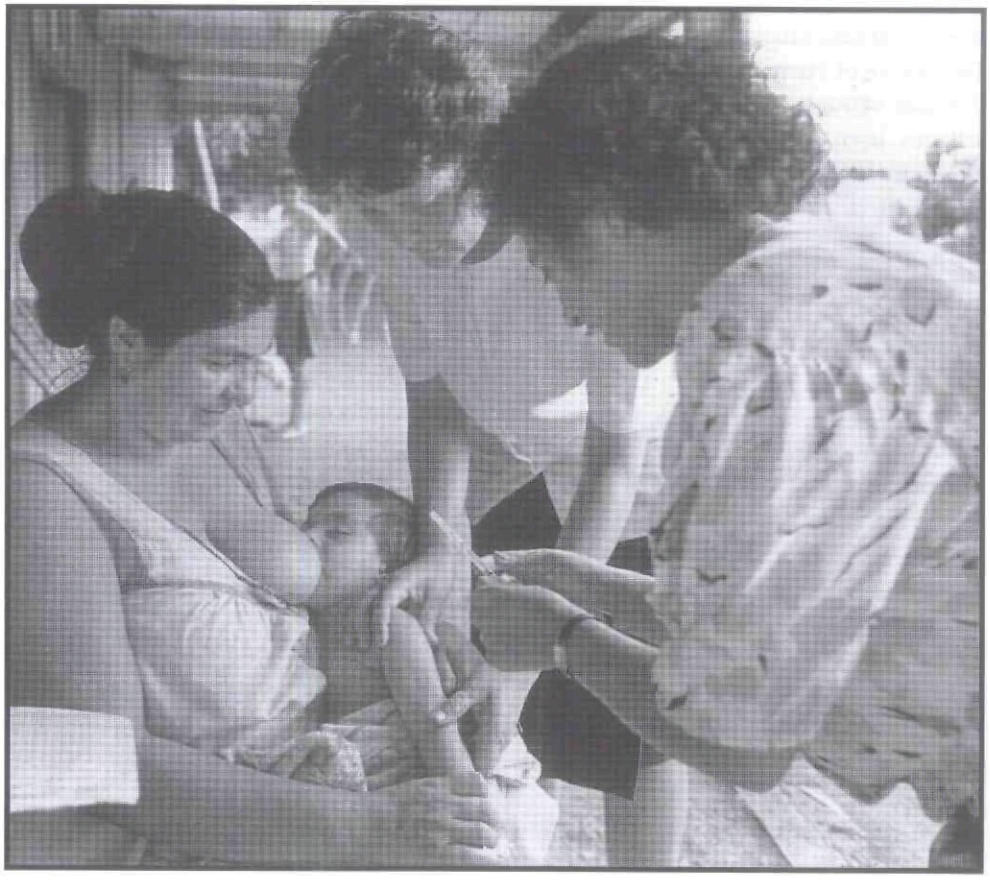
Another example of non-EPI/UCI mobilization comes from Brazil, which has one of the longest traditions of social mobilization on children's issues. Remarkable progress has been made in resolving the horrific problems of the 800,000 children who work, and often live, in its cities' streets. Similar progress for street children has been made in the Philippines, where, as a first and vital step, the general attitude towards street children has changed. They are now seen for what they really are — victims of society rather than vagrants and criminal offenders.

and to trying to improve the situation of the girl child in some Asian countries.

A beautiful animated film and supporting materials are being produced about Meena, a girl child in an unspecified South Asian country, and this will begin the work of trying to change attitudes towards the girl child in several countries of that region.

Social mobilization for EPI/UCI has proven the effect of converging attention and action of various sectors of society on a social issue. The challenge now is to make similar efforts to achieve the objectives set by national programmes of action for the 1990s.

Social mobilization for EPI/UCI has shown conclusively what can be done when attention and action are converged on a social issue, and when that attention and action involve multiple allies and partners from various sectors of society. The challenge now is to exploit and expand the example for other objectives, some of which may be even more difficult to achieve. National programmes of action for children, drawn up by governments in response to the Declaration on the Survival, Protection and Development of Children adopted at the World Summit for Children, will not succeed without major efforts in social mobilization.



ANNEX

A further note on the historical and conceptual development of social mobilization

UNICEF has been concerned since 1968 with communication for development. In that year, jointly with the United Nations Development Programme, UNICEF established what was known as the Development Support Communication Service in Bangkok. This was the first initiative in the United Nations system to apply communication to development programmes, and thus UNICEF was a pioneer in the field.

Communication for development was later adopted as an activity by many other development agencies and is now widely known under the generic title of development communication.

However, over the intervening years since 1968, the titles of the activity, the strategies and activities it employs and indeed the philosophy underlying it have changed. These changes have come with insights derived from experience in navigating what were uncharted waters when development communication was first launched. For example, the early faith placed in the power of electronic media alone to bring about mass education had to be modified: Experience showed that mass media only have real impact in changing attitudes and behaviour when their use is based on good research among intended audiences and on carefully targeted and creatively prepared messages. In addition, the importance of integrating interpersonal communication with media was affirmed, especially when promoting change in areas in which there are traditional and widely accepted beliefs.

Over the years, the titles that UNICEF has used to cover its work in the general field of development communication have changed, and taken on new meanings. In the 1970s, it was simply known as Project Support Communication (PSC) and as its name implies, it consisted of communication, mainly of an educational type, to improve the acceptance and impact of programmes in the field. It focused almost entirely on programme beneficiaries. However, PSC was often an add-on to programmes and projects that were running into problems; communication procedures were not an integral part of programme planning and implementation. Communication support as an afterthought, or when called in as a crutch to support an already limping programme, seldom had any impact in winning the acceptance and participation of people.

In 1985, in order to have communication better integrated into field programmes, the name Project Support Communication was changed to Programme Communication. Shortly after that, and for the same reason, the Programme Communication Section at UNICEF headquarters was moved from the then Division of Information and Communication to the Programme Division.

In most cases, Programme Communication in the field continued to consist of the production of information and educational materials that were not part of an overall, carefully planned strategy to promote the changes in attitude and behaviour necessary for sustainable improvements in living standards. In only a few field offices were the communication staff brought fully into programme planning so that the attitudinal and behavioural factors were taken properly into account at an early enough stage and appropriate communication activities put into effect.

The launching of CSDR in 1982 was instrumental in influencing communication policies and strategies. For CSDR was based on the hypothesis of inducing attitudinal and

behavioural change among parents about the GOBI elements, achieving this through communication, and especially through the growing reach of mass media. GOBI provided, for the first time, clearly stated and well-circumscribed objectives for behavioural change to which communicators could apply their skills.

It was in the interest of GOBI that UNICEF first adopted social marketing, and even if social marketing as a phrase is not used widely by UNICEF today, many of the principles and techniques have been incorporated into UNICEF work. For example, one of the fundamental strategies of marketing is **audience segmentation**. This is practical recognition of the fact that people's attitudes, beliefs, aspirations and behaviour are conditioned by their circumstances, including education, gender, social status and income. Thus, there can be no such thing, for example, as an 'audience of rural women'. On the contrary, there will invariably be several audience segments that can be identified under that generic title.

In order to communicate effectively with various audience segments, **research** is needed with each segment to determine its knowledge, attitudes and practices concerning the issue in question. The research also looks into what channels of information are used by the audience segment and hold credibility for it. These 'channels' may also be other people, such as religious leaders, schoolteachers or even truck drivers, who pick up information in one community and pass it on when they stop in another.

Taking the audience research findings into account allows messages to be designed that will appeal to the self-interest and aspirations of specific audience segments, as well as choosing the most appropriate channels for delivering them.

Another feature of social marketing is that it incorporates **pre-testing** of messages before they are generally disseminated, continual **monitoring** of the effect they are having and, on the basis of this **feedback**, making any necessary corrections to their design, to their form, or to the channel used to deliver them. Thus, there is an initial and an ongoing learning process from the audience.

The nature of social marketing is that it aims at the individual, who is free to decide whether or not to 'buy' what is being marketed.

The term 'marketing', however, whether preceded by 'social' or not, has negative connotations in the minds of many; it is seen by some as top-down and manipulatory, and because marketing had its origins in industrialized countries, some people consider social marketing in developing countries to be a 'cultural invasion'.

On the other hand, there are many who defend social marketing, pointing out that few development interventions, even those with community participation, do not involve manipulation of some groups by others within the community, or even of manipulation inside peer groups. Furthermore, even in societies regarded as very advanced in terms of provision of social services, such as those of Scandinavia, manipulatory exhortations to buckle up car seat belts or eat more bread are routine.

Those in favour of social marketing for health argue that what is being marketed is of certain health or social benefit by any standards. Therefore, when promoting the use of oral rehydration salts, immunization or modified sexual habits to prevent AIDS, there is every moral justification for 'manipulating' people towards behavioural change. In addition, legitimacy for using persuasion in such cases is provided by the umbrella of consensus and endorsement that exists for the specific objectives that are enshrined in the Plan of Action approved at the World Summit for Children.

It is also argued that marketing tactics used initially in a persuasive way to create demand will lead, over time, to people recognizing the advantages of what they have been 'sold', and the demand then becomes internalized as a felt need. The case-study of which this Annex is part shows that this does indeed happen — for example, in the way a 'vaccination culture' has developed in some countries.

The proponents of social marketing also point out that marketing is a process of uncovering unfulfilled demand, not creating demand. For example, in family planning it is common to find 10-20 per cent of couples of reproductive age who do not want more children but who are not using any form of contraception. Social marketing tries to determine the reasons for this and then gives people the information they need to make an informed decision.

The merits or otherwise of social marketing do not need further space here, but what should be realized is that development communication has, in the last decade, drawn heavily on marketing techniques, especially with regard to formulating careful communication strategies and plans that are based on audience segmentation and research, and on continuing to learn from audiences through a process of ongoing monitoring and feedback.

GLOSSARY

BCG	antituberculosis vaccine
BRAC	Bangladesh Rural Advancement Committee
CSDR	child survival and development revolution
EPI	expanded programme on immunization
GOBI	Growth monitoring, Oral rehydration therapy, Breastfeeding and Immunization
KAP	knowledge, attitudes and practices
NGO	non-governmental organization
PHC	primary health care
UCI	universal child immunization
UIP	Universal Immunization Programme (in India)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIPP	Visualization in Participatory Planning
WHO	World Health Organization

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