

Maximum Time: 2 Hours 30 minutes

Roll Number: _____

Maximum Marks: 50

Instructions:

1. Students are required to write Roll No on every page of the question paper, writing anything except the Roll No will be treated as **Unfair Means**.
2. All other instructions on the reverse of Admit Card should be followed meticulously.
3. This is a close book examination. All questions are compulsory.
4. Figure in parenthesis represents maximum marks for that particular question.
5. There are two sections namely A & B.
6. There will be internal options in section A only.
7. There will be case study in Section B.
8. Draw figures, charts, and tables wherever necessary.

SECTION A

Each question carries 6 marks.

Q. 1. What is Social Marketing? How Social Marketing is different from Cause related marketing, Societal Marketing and Social Marketing. (CILO 1)

Or

Q. 1. Can a Corporate Social Responsibility projects be considered as Social Marketing Programme? Give justification supporting your stand on this question. (CILO 2)

Q. 2. Describe briefly, steps in the "16 tips" for the Success of Social Marketing Plan. (CILO1)

Or

Q. 2. There are nine steps involved in developing a research plan for Social Marketing. Describe these steps briefly. (CILO1).

Q. 3. Explain the following terms (CILO1)

Segmentation, Positioning, Demographic segmentation, Psychographic segmentation, and behaviour change.

Or

Diffusion of Innovation, Exchange Theory, Benefits, Opinion leaders and Promotion.

Turn Over

Q. 4. What is positioning? Why positioning is important in Social Marketing? How positioning related to branding? (CILO2)

Or

Q. 4. Develop the Social Marketing Product platform. (CILO 1).

Q. 5. There are 10 steps involved in developing place platform for the Social Marketing Plan. List them out and explain each step very briefly. (CILO1).

Or

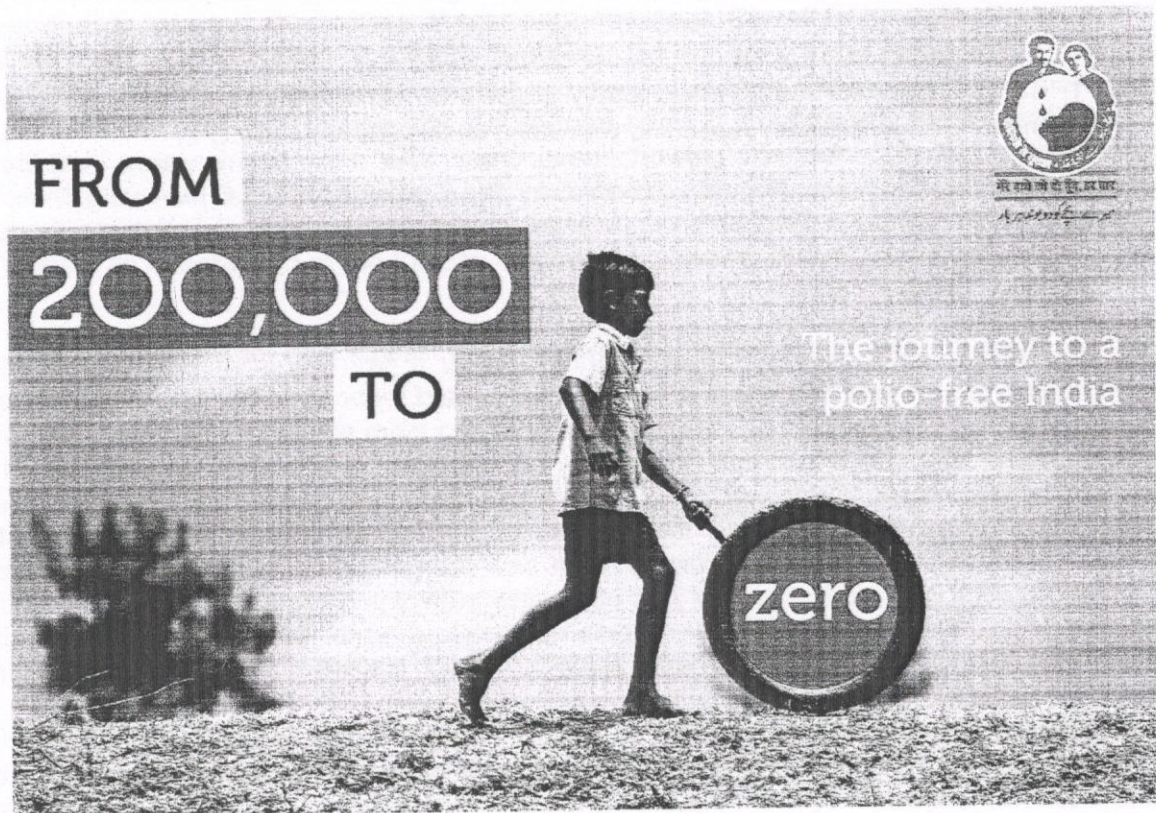
Q. 5. There are four major decisions to be kept in mind while deciding for the promotional strategy for Social Marketing Plan. What are these major decisions? Describe each of them briefly. (CILO1).

SECTION B

"Don't judge the book from its cover". Similarly, don't panic at the length of the case. Read the case carefully and answer the following questions (CILO 1, 2 & 3).

1. Why this case study is a Case of Social Marketing?
2. Discuss Marketing mix strategies used in this case.

(Max Marks=20).



Turn Over

History of polio in India

2001



UNICEF establishes the Social Mobilization Network (SMNet) in Uttar Pradesh to mobilize community for polio immunization.

Amitabh Bachchan becomes UNICEF Brand Ambassador for Polio.

2002



Taking over from private donors, the Government of India takes the lead role in financing polio eradication activities in the country using its own resources.

WHO-NPSP expands network. The over 200 surveillance medical officers now support planning and monitoring of polio campaigns in addition to surveillance.

Rotary International hosts first Polio Summit in India.

2003



The under-served strategy is introduced as part of communication efforts in Uttar Pradesh to reach out to and get support of marginalized sections of the society for polio eradication.

UNICEF expands the Social Mobilization Network to Bihar.

2004

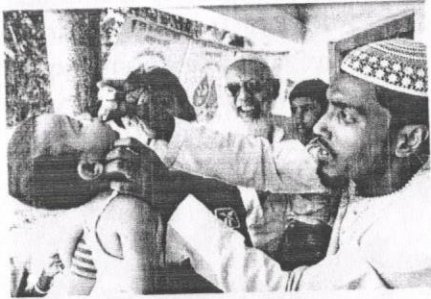


Poliovirus surveillance increases in sensitivity. The programme is now able to rapidly detect poliovirus transmission anywhere in the country.

Transit vaccination strategy launched, with teams stationed at bus stands, railway stations, highways, markets and at congregation sites.

Rotary International hosts second Polio Summit in India to accelerate Polio eradication.

2005



More effective monovalent oral polio vaccines (mOPV), tackling either type 1 or type 3 wild poliovirus, introduced.

Social mobilization intensifies, with enhanced involvement of religious leaders, Muslim institutions, mosques and madrasas.

Influencers from within the community are identified and assigned to vaccination teams to enhance acceptance of polio vaccine.

2006



Enumeration, vaccination and tracking of newborns begins in UP and Bihar. The vaccinators are given a special booklet to register all newborns and immunize them for at least eight polio rounds.

Operational strengthening takes place to improve microplanning for revisits to households with unvaccinated children following the first contact with vaccinators.

2007



Rotary International forms Ulemas' Committee in UP to enhance Muslim community support.

Accelerated immunization rounds take place almost monthly in polio-endemic states of UP and Bihar, using efficacious mOPVs.

Migrant strategy introduced. People moving out of the endemic states with families are identified and immunized in Punjab, Gujarat, West Bengal, Maharashtra, Delhi.

2008



Kosi River Plan drawn up to intensify and focus efforts in Bihar. High-risk blocks are mapped, and additional stay points built for enhanced supervision and efforts in the hardest-to-reach areas where children are being missed.

WHO-NPSP further expands – 333 surveillance medical officers on the ground cover all parts of India.

2009



107 Block Plan is introduced in UP and Bihar. Underlying factors for polio are targeted: routine immunization, sanitation, diarrhea management and exclusive breastfeeding.

Focus on migrant populations in brick kilns, construction sites, slums and nomadic settlements.

Rotary pledges US\$200 million against Bill & Melinda Gates Foundation's pledge of US\$355 million.

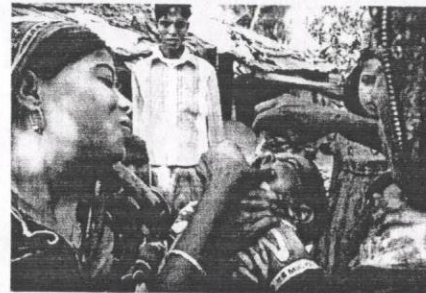
2010



Bivalent oral polio vaccine (bOPV), which tackles both type 1 and 3 wild poliovirus serotypes concurrently, introduced in India.

The Government of India, through the India Expert Advisory Group on polio eradication, recommends responding to each case of polio as a public health emergency.

2011



Aggressive response to the lone case of polio in Howrah, West Bengal. A large-scale mop-up immunization activity is launched within seven days of notification of the case, with three additional mop-up rounds conducted in seven weeks from confirmation of the case.

All States and Union Territories prepare Emergency Preparedness and Response Plans (EPRPs) to respond to any case of wild poliovirus as a public health emergency.

2012



India removed from the list of polio endemic countries after completing a year without reporting any case of polio in January, a major milestone in the history of polio eradication.



बिना
ए = गिरा
नोसे = अल
ए = अल
RR

Innovations

394 million people live in Uttar Pradesh, Bihar and West Bengal

500,000 children are born every month in Uttar Pradesh and Bihar

2.3 million health workers vaccinate **175 million children**

in one National Immunization Campaign more than 500,000 vaccinators

cover about 45 million children

in each Sub-National Immunization Campaign

9,125 community mobilizers

visit more than 3 million families each month

900 million doses of OPV were used in 2011

956,000 posters, 840 TV PSAs and 2,030 radio spots

announce campaigns in West Bengal, Bihar and Uttar Pradesh

In 2011, SMNet tracked 30,000 migrant families and helped vaccinate more than 1,814,266 children on the move in transit and border areas

India's contribution to the world's polio cases:

2007: 66%

2009: 46% 2010: 3%
2011: <1%

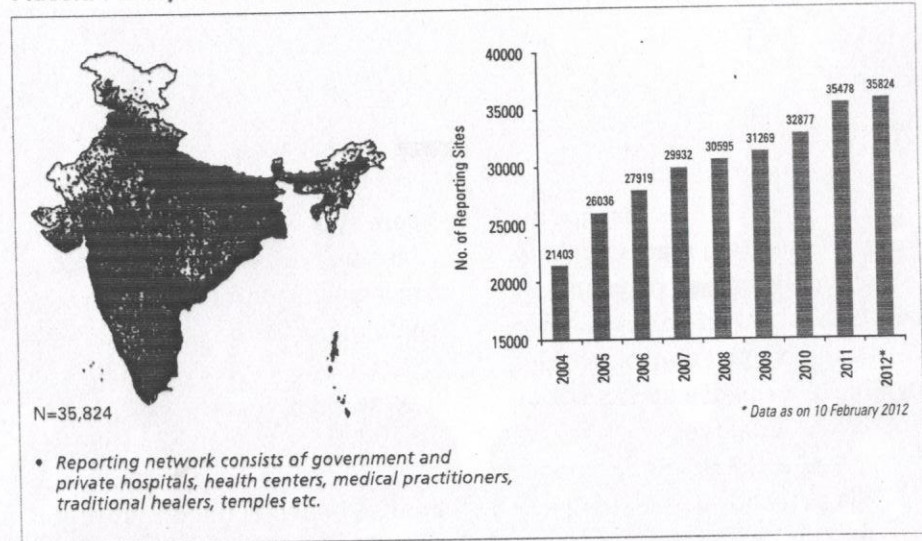
A number of major interventions and innovations have been made over the years to strengthen the polio eradication initiative in India and overcome the challenges and barriers that the programme faced. These interventions and innovations were reviewed, assessed and improvised to match the intensive efforts which became increasingly focused to address issues in the key vulnerable areas

and among the most susceptible populations.

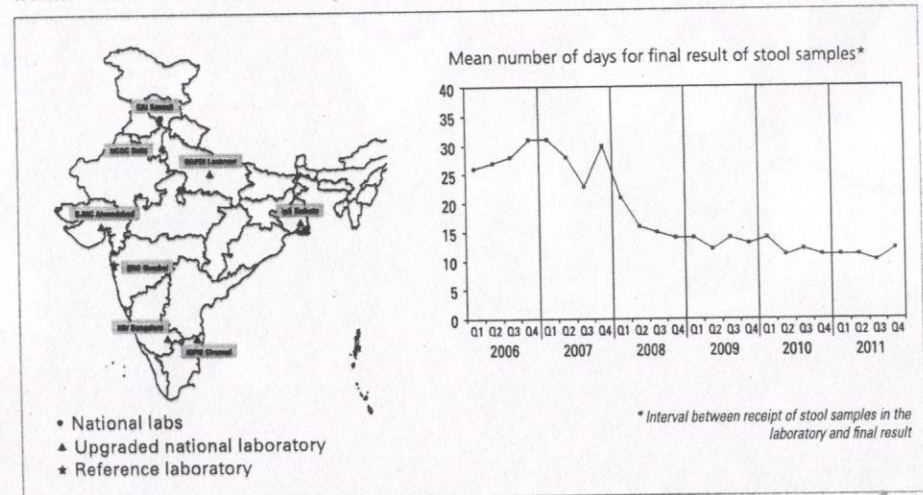
The interventions covered all aspects of the programme – surveillance, supplementary immunization activities, vaccines, communication and research – and were strongly evidence-based, with detailed data to support why and where they were being introduced.



Flaccid Paralysis Surveillance Reporting Network



India Poliovirus Laboratory Network



Innovations: Surveillance

Polio case identification – Initially, polio cases were classified based on the clinical features of polio or on a laboratory confirmation. In 2001, the case classification scheme was changed to a virological scheme where cases were classified as polio based only on a laboratory confirmation. This is a more accurate and reliable system of case identification.

Reporting network expansion – A large network of health facilities – over 33,700 sites, including public and private health facilities (ISM practitioners and quacks and faith healers included) have been enrolled as reporting sites for acute flaccid paralysis (AFP – suspected

polio) cases in India. This has resulted in an increase in the number of AFP cases detected for investigation across the country, thereby increasing sensitivity of the system including amongst migrant populations.

Increase in sensitivity of AFP surveillance – In 2004, the case definition of AFP was broadened to make the surveillance more sensitive for AFP case detection. There has been a dramatic increase in the number of AFP cases reported and investigated since.

Change in laboratory testing methodology – A new

methodology for testing stool specimens was introduced in the laboratories in 2007, reducing the laboratory testing time by half. The new system takes about two weeks, thus ensuring a more speedy action after detection of wild poliovirus. The earlier laboratory methodology for testing stool sample for detection of wild poliovirus cases took up to five weeks for confirmation of a case.

Supplementary surveillance for polio – Wild poliovirus transmits through the faecal-oral route. Therefore, environmental sewage specimen testing was started in Mumbai in 2001 to detect wild poliovirus to supplement the

AFP surveillance. This has been subsequently expanded to Delhi in 2010 and to Patna in Bihar and Kolkata in West Bengal in 2011.

Genetic sequencing of wild poliovirus – Genetic mapping and matching of every wild poliovirus is conducted to determine the origin of the virus, track the spread of transmission, and also to determine the number and spread of genetic clusters of the virus. This helped the programme carry out immunisation and follow-up action effectively, not just in the area the wild poliovirus was detected, but also the origin of the virus/area of importation and areas at highest risk of further spread.

Innovations: Polio Immunization

House-to-house vaccination – When the programme started, the Pulse Polio was a booth-only activity where children were given oral polio drops on the supplementary immunization activity days. To improve immunization coverage, the booth activity was extended to house-to-house immunization to actively search for and vaccinate missed children.

Identification of missed children – To facilitate identification of missed children, finger marking of every vaccinated child was launched in 1999. The little finger on the left hand of the child was marked with indelible ink. In order to ensure completeness of coverage, the vaccinators marked houses as P (all children in the house immunized)

or X (children missed) based on whether all eligible children in the household had been vaccinated or not by the polio vaccination team.

Categorization of X houses visited – Categorization of X houses into sub-categories such as locked houses, houses with a sick child, houses that resist vaccination etc was introduced to facilitate appropriate follow-up for vaccination. Using this categorization, houses with sick children can then be visited by doctors, refusal families can be visited by influencers, and so on.

Back-up 'B' team – The back-up team concept was introduced to ensure immunization of children who had missed being vaccinated

despite revisits of the vaccinators to the household during the days of the campaign. These missed children are usually those who are at school, sleeping in the morning, with their parents at their places of work, or those whose parents have refused vaccination. After the vaccination team 'A' has completed the morning visit to each and every household as per the micro-plan, a 'B' team visit was started to vaccinate the children missed by team 'A'.

Integration with NRHM – The polio programme has been integrated with the National Rural Health Mission (NRHM). The NRHM is aimed at ensuring effective healthcare through a range of interventions at individual,



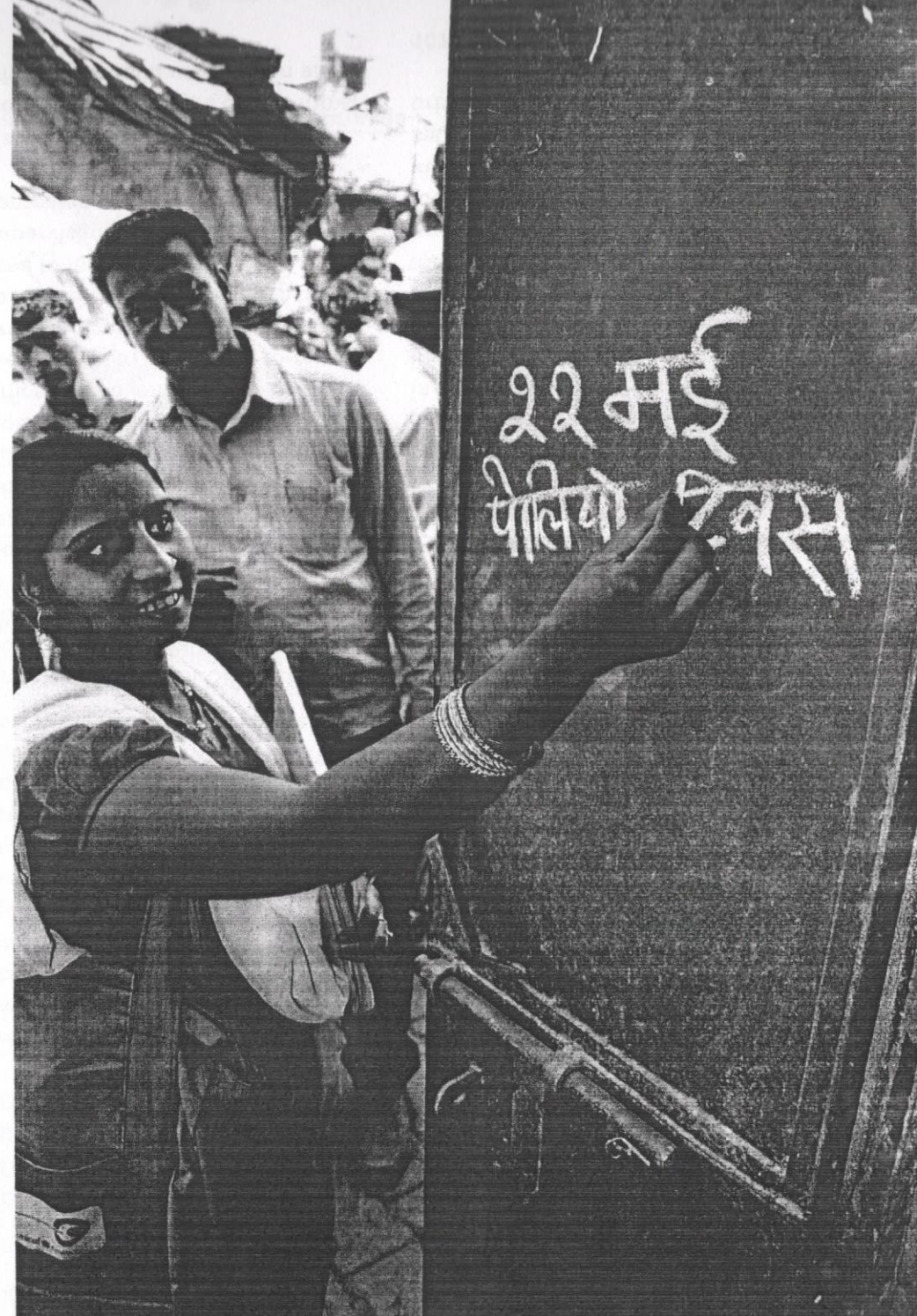
household, community, and most critically at the health system levels. The community worker ASHA – a trusted member of the community – is involved in mobilization and vaccination for polio.

Transit sites vaccination strategy – Children on the move often miss polio immunization. In order to vaccinate them, transit vaccination teams are deployed at train stations, on running trains, bus stands, highways, markets, prominent road crossings to give polio vaccine to children in transit.

Congregation site vaccination – Large gatherings at fairs and festivals provide regular opportunities for the poliovirus to spread and also for the

programme to vaccinate the vulnerable population. Polio immunization is carried out at all fairs and festivals in and around polio-endemic states – both at the venue of these gatherings, and also all along the routes which people take to reach these venues.

Newborn tracking – With data showing that most polio cases occur in children less than two years of age, a system was introduced in 2006 to identify, track and immunize every newborn child in the highest-risk areas of Uttar Pradesh and Bihar. By ensuring newborns are quickly added to microplans and introduced into the routine immunization system, each child in these vulnerable areas receives





up to eight doses of OPV through polio rounds as well as the routine doses before the age of one year.

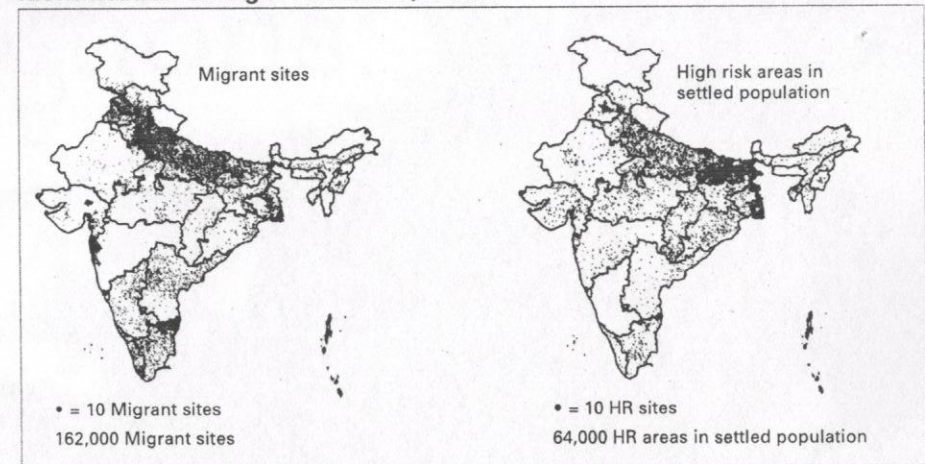
Kosi River area intensification – An intensified plan was drawn up and implemented in 2008 to reach the difficult-to-access areas along the Kosi River basin in Bihar. Satellite offices and overnight stay points were set up in these hard-to-reach areas to enable human resources to be scaled up and based in the area to facilitate better planning, supervision and monitoring of the campaigns.

Vaccination of migratory populations – People on the move often miss polio vaccination and

remain vulnerable to sustaining and spreading the virus. In 2007, identification and vaccination of migratory populations from endemic states began in Punjab, Gujarat, West Bengal, Maharashtra and Delhi. All Sub-National Immunisation Days cover the migrant populations in these states. In 2009, this initiative was intensified. Migrant and mobile population sites, both within and outside the endemic states became a programme priority. A special focus is on covering all children in construction sites, nomadic settlements, peri-urban areas and urban slums.

107 High-Risk Block Plan – As

Identification of High Risk Areas, India



the programme zeroed in on the poliovirus, 107 high-risk blocks that were responsible for the persistence and recurrence of polio transmission in UP and Bihar were identified in 2009. A multi-pronged strategy was rolled out in these blocks to address polio-associated risk factors with rapid improvement in sanitation, availability of clean water, hygiene practices, exclusive breastfeeding, and the prevention and control of diarrhea.

Special vaccination drive during festivals – To protect migrants returning home to endemic states, special vaccination drives are held

at major transit sites – railway stations and bus stands – in Uttar Pradesh, Bihar and West Bengal during popular festivals like Holi and Chhat.

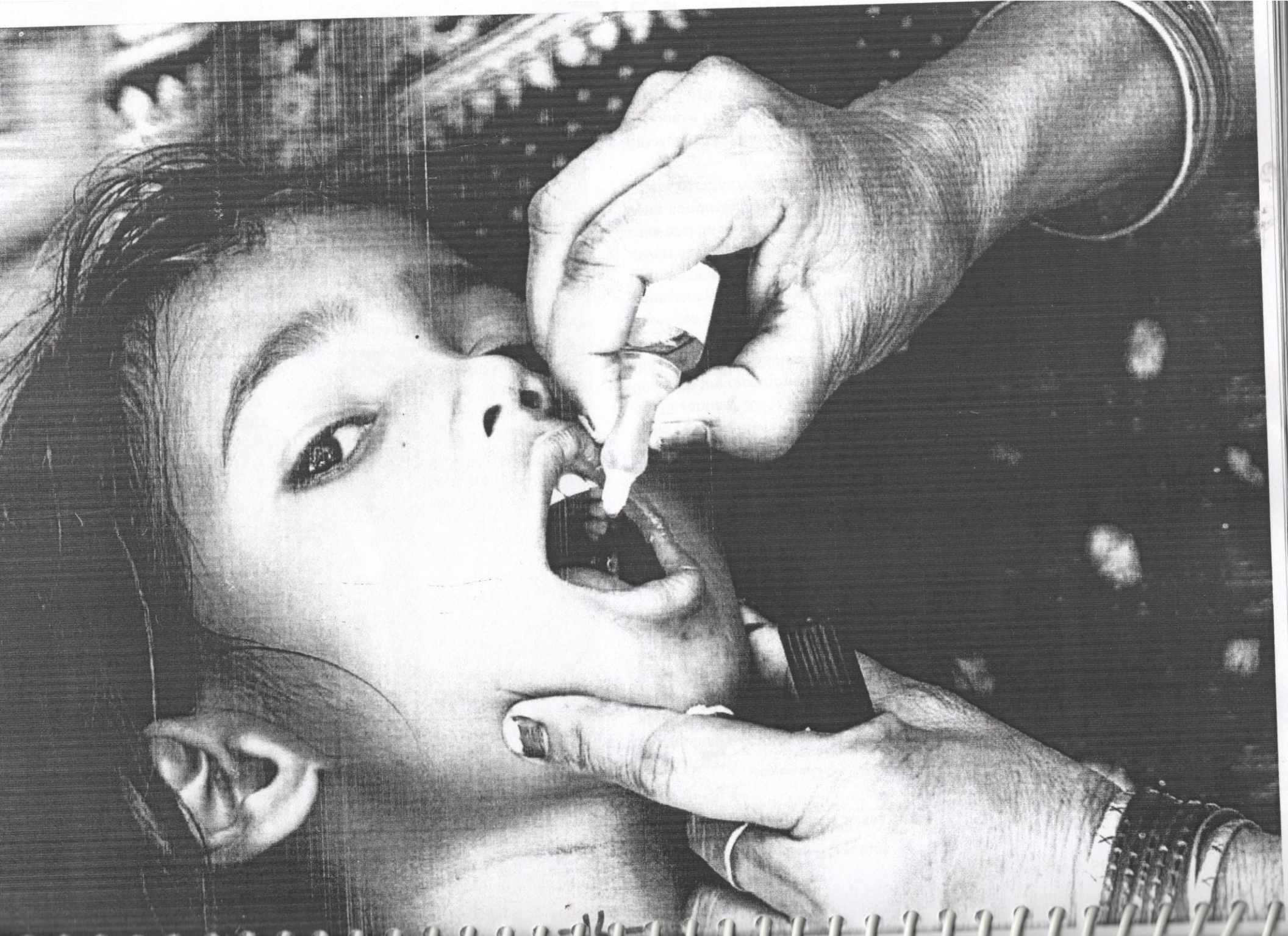
Immunization along the international borders – To mitigate the risk of importation from across the border, polio immunization has been carried out at five sites along the India-Pakistan border in the states of Punjab, Jammu and Kashmir and Rajasthan since September 2011. Polio immunization is also being carried out at 81 border posts along the Indo-Nepal border in Uttar Pradesh and Bihar.

Responding to polio as a public

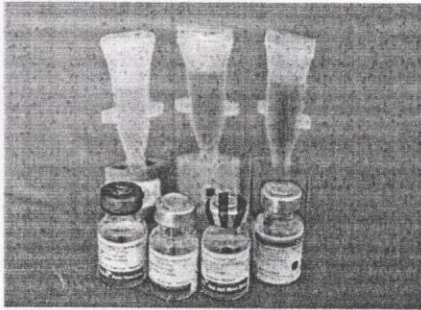
health emergency – An aggressive and rapid immunization response was launched following the lone polio case in Howrah, West Bengal, on 13 January 2011. This was in line with the recommendation of the India Expert Advisory Group in November 2010 to respond to each new case of polio as a public health emergency. A large-scale mop-up immunization was launched within seven days of notification of the case and three vaccination rounds were conducted within seven weeks of confirmation of the case.

Emergency Preparedness and Response Plan – All States and Union Territories have prepared Emergency Preparedness and

Response Plans (EPRP) to respond to any case of poliovirus as a public health emergency. The high-risk districts and blocks have been mapped and migrant sites identified. Efforts are being made to maintain high childhood immunity against polio, with a continued focus on rolling out high-quality polio immunization campaigns and boosting routine immunization coverage. The EPRP ensures that systems are in place to rapidly and effectively respond to any case of polio anywhere in the country.



Innovations: Vaccines



Introduction of monovalent vaccines in 2005 – Monovalent oral polio vaccine type 1 (mOPV1) was introduced in India in April 2005. Monovalent oral polio vaccine type 3 (mOPV3) followed in December the same year. The monovalent polio vaccines target only one strain of the virus but are almost three times more efficacious than the traditionally used trivalent oral polio vaccines (tOPV).

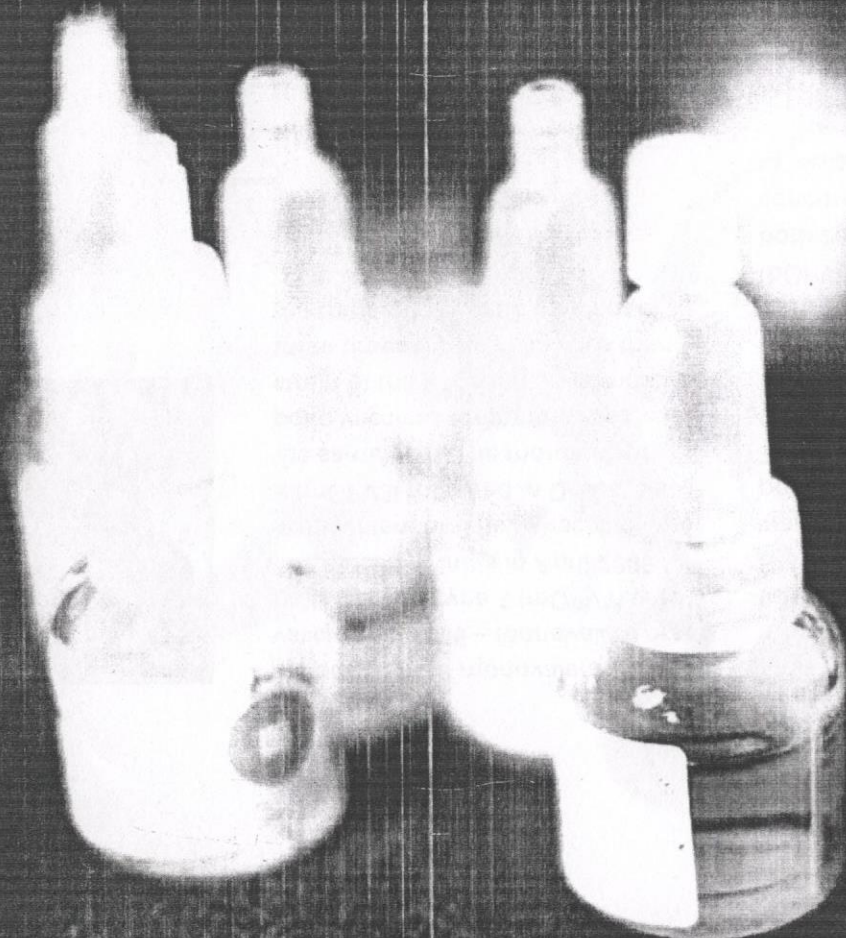
The use of mOPV1 in intense immunization rounds helped

India reduce transmission of the most dangerous type 1 poliovirus to record low levels by 2007. Stopping type 1 transmission was a programme priority as wild poliovirus type 1 accounted for 95% of polio cases in the country till 2006.

Introduction of bivalent OPV in 2010 – Bivalent oral polio vaccine (bOPV), which protects against both type 1 and 3 serotypes concurrently, was introduced in India in January, 2010. While

the use of mOPV1 in most polio rounds had helped reduce type 1 poliovirus transmission to record low levels, India experienced an outbreak of type 3 poliovirus in 2009, especially in areas with low routine immunization coverage in Uttar Pradesh and Bihar.

The introduction of bOPV simultaneously and effectively curtailed both type 1 and type 3 polio viruses.



Innovations: Research

Vaccine immunogenicity study was conducted in 2007–2008 to assess the efficacy of the monovalent oral polio vaccine (mOPV1) in hospitals of Indore and Hyderabad. The study showed that the protection provided by mOPV1 against type 1 poliovirus was superior compared to the protection provided by the traditionally used trivalent OPV (tOPV).

Seroprevalence study in district Moradabad (Uttar Pradesh) in 2007 demonstrated high level of immunity against type 1 and 3 polioviruses in children in the age group of three to five years.

Vaccine trials conducted in 2008-2009 to assess efficacy of oral polio vaccines at hospitals in Indore, Pune and Chennai showed that the protection provided by bivalent OPV (bOPV) was not inferior to the protection provided by mOPV1 and mOPV3 against type 1 and type

3 polioviruses and was superior to the protection provided by the traditional tOPV.

Seroprevalence study among AFP cases in 25 districts of western Uttar Pradesh in 2008 – 2009 found high protection levels against type 1 poliovirus and low protection levels against type 3 poliovirus.

Study to compare protection provided by mOPV1 and Inactivated Polio Vaccine (IPV) in Moradabad in 2009 demonstrated that multiple doses of mOPV1 given to the youngest children provided very high protection levels against type 1 polio. It showed that one dose of IPV can close the immunity gap to polioviruses in these children.

Seroprevalence study in 10 high-risk blocks in both UP and Bihar in 2010-2011 showed very high protection levels against

type 1 polio and an increase in protection against type 3 polio, as compared to the findings of the earlier seroprevalence studies. The results showed that bOPV was helping to quickly and significantly close the immunity gap against type 3 poliovirus while maintaining very high immunity against type 1 poliovirus.

Mucosal Immunity study conducted in October 2011 in Moradabad intends to assess the impact of bOPV and IPV on mucosal immunity in children. The results of the study are awaited.

Knowledge, Attitudes and Practices (KAP) studies are conducted annually in the highest-risk areas and among the highest-risk groups to evaluate community acceptance and understanding of the polio programme. Conducted by an established independent research agency, the studies track

a number of indicators linked to conceptual theory that provide insights into underlying public perceptions of the polio campaign, illuminate areas of risk (such as the strength of prevailing myths over vaccine safety), and identify gaps in presently available data.

The research evaluates understanding of polio in a general health context, identification of polio symptoms, threat perception, vaccine knowledge, vaccine and healthcare-related attitudes and practices, individual, group and structural barriers to addressing polio, current information channels/sources of information, information acceptability, and comprehension/memorability. The indicators from these studies help sharpen the strategic focus and responsiveness of the communication campaign.

पोलियो का आत्मा पक्का, अगर पिये हर बार हर बच्चा।
पोलियो کا خاتمہ پکا، اگر پیئے ہر بار ہر بچہ۔



UNICEF
CDC UNICEF



Innovations: Social Mobilization

Social Mobilization Network (SMNet) – The Social Mobilization Network (SMNet) was launched in Uttar Pradesh in 2001 to generate community support for polio immunization activities. Today, the SMNet of UNICEF and CORE has grown into an army of more than 7,000 mobilizers – mostly women – from the same community and area, who speak the local language. The SMNet covers all polio high-risk areas of Uttar Pradesh and Bihar. The community mobilizers go house-to-house counselling parents on the importance of polio immunization, and keep a record of all children in their area for vaccination. The main

challenges that mobilizers face arise from misconceptions about OPV and resistance from the community. They are trained to provide accurate information about polio, including how it spreads and how it can be prevented. In addition, their inter-personal communication training helps them build relationships and establish trust, so the community feels more confident in the quality of the vaccine they are receiving, and in the benefit it provides to their children. In addition to building individual relationships with families, the mobilizers develop social networks and partnerships with communities which are crucial to their success.

Community mobilizers work with local medical practitioners, religious and community leaders, school teachers and other community members who can influence local opinions, norms and practices in support of vaccination. It was not always an easy road to build these partnerships; 10 years ago in northern India, many Muslim women could not work outside their homes. Today, the women of SMNet proudly contribute to their community, and a truly global effort.

Migrant strategy – Responding to the evolving programme needs and priorities, the SMNet tracks and reaches out to the most

vulnerable migrant populations in brick kilns, construction sites, and nomadic sites, etc. They revisit families, counseling parents and caregivers and ensuring vaccination of migrants when they return home during popular festivals such as Holi and Diwali.

Convergence – In addition to providing information about polio immunization, the SMNet shares information about routine immunization, exclusive breastfeeding, the use of ORS and zinc to tackle diarrhea, personal hygiene and addresses sanitation issues, including dry toilet conversion and safe water supply.

पोलियो
मसत
मस्त



वैश्विक
परिक्षा
को
बर्खास्त
कर

Under-Served Strategy – A special strategy to reach the under-served Muslim communities was initiated in Uttar Pradesh in 2003 and later expanded to other areas. The strategy aimed to tackle the disproportionately high percentage of polio cases among the Muslim community – in 2003, despite only accounting for 17% of the State's population, the community constituted nearly 59% of polio cases. The crux of the strategy was to ensure acceptance of OPV by the communities despite their underserved conditions, through sustained confidence-building measures. Key partnerships were established with important institutions such as the Aligarh Muslim University, Jamia Millia

Islamia University and Jamia Hamdard, as well as with key Muslim institutions such as the All India Milli Council, All India Muslim Personal Law Board, Islamic Fiqh Academy, Darul Uloom Deoband, Jamait Ulama-i-Hind, All India Hajj Committee and key shrines. The focus of the strategy is advocacy, immunization and prayers for polio eradication at festivals and religious congregations; religious influencer support, mosque announcements, appeals and fatwas in support of the programme, and special Information, Education and Communication materials, including greeting cards and religious calendars for the community.

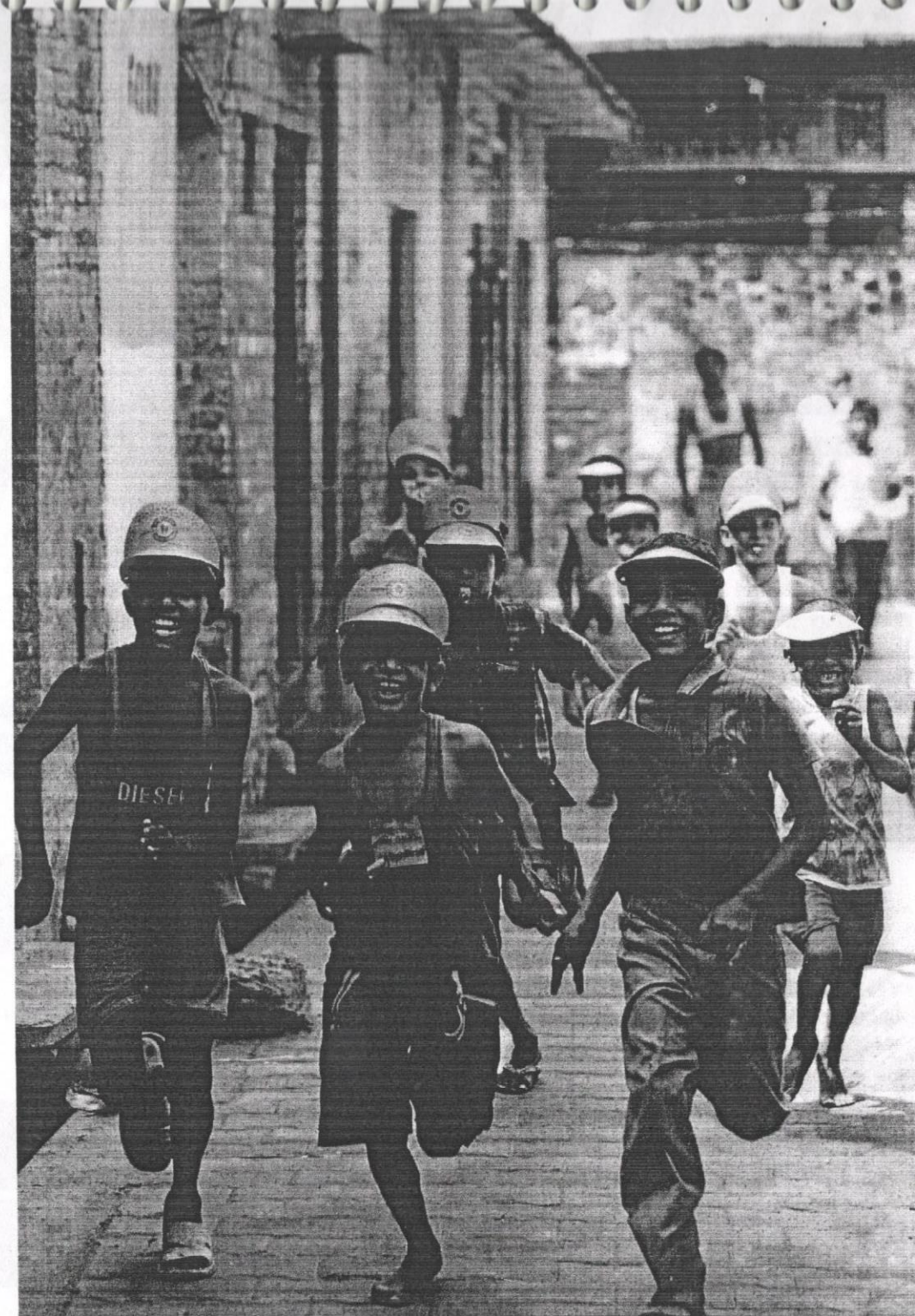
Melas and congregations

– Special communication interventions such as focused IEC, mike announcements, street theatres, puppet shows, film shows, etc, are organized during large events such as Shravani Mela, Ardh Kumbh and Urs all along the route of the population movement, creating awareness on the need for polio immunization.

Building threat perception – An emergency communication kit has been prepared with posters, Frequently Asked Questions and Answers, religious appeals, radio and TV spots, and mike announcements. The Emergency IEC kit aims at quickly tackling

the low threat perception among the community, explaining that there is risk of polio in their area, the virus is incurable and causes life-long paralysis and can only be prevented by taking the polio vaccines offered in multiple rounds. An image of a child on crutches appears on the posters to build threat perception.

Review of communication strategy – The communication programme is reviewed annually by international and national experts. These annual reviews appraise specific areas of the overall communication strategy and provide theme-specific recommendations.



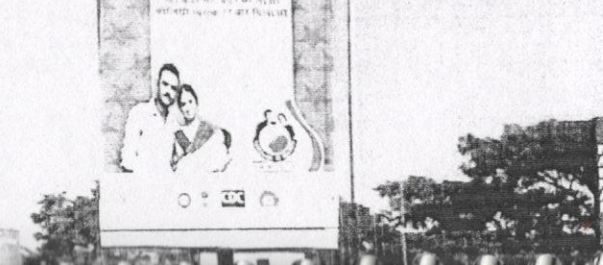


पोलियो रविवार
پوليو اتوار
5 अप्रैल

मेरे बच्चे को दो बूंद, हर बार
میرے بچے کو دو بوند ہر بار

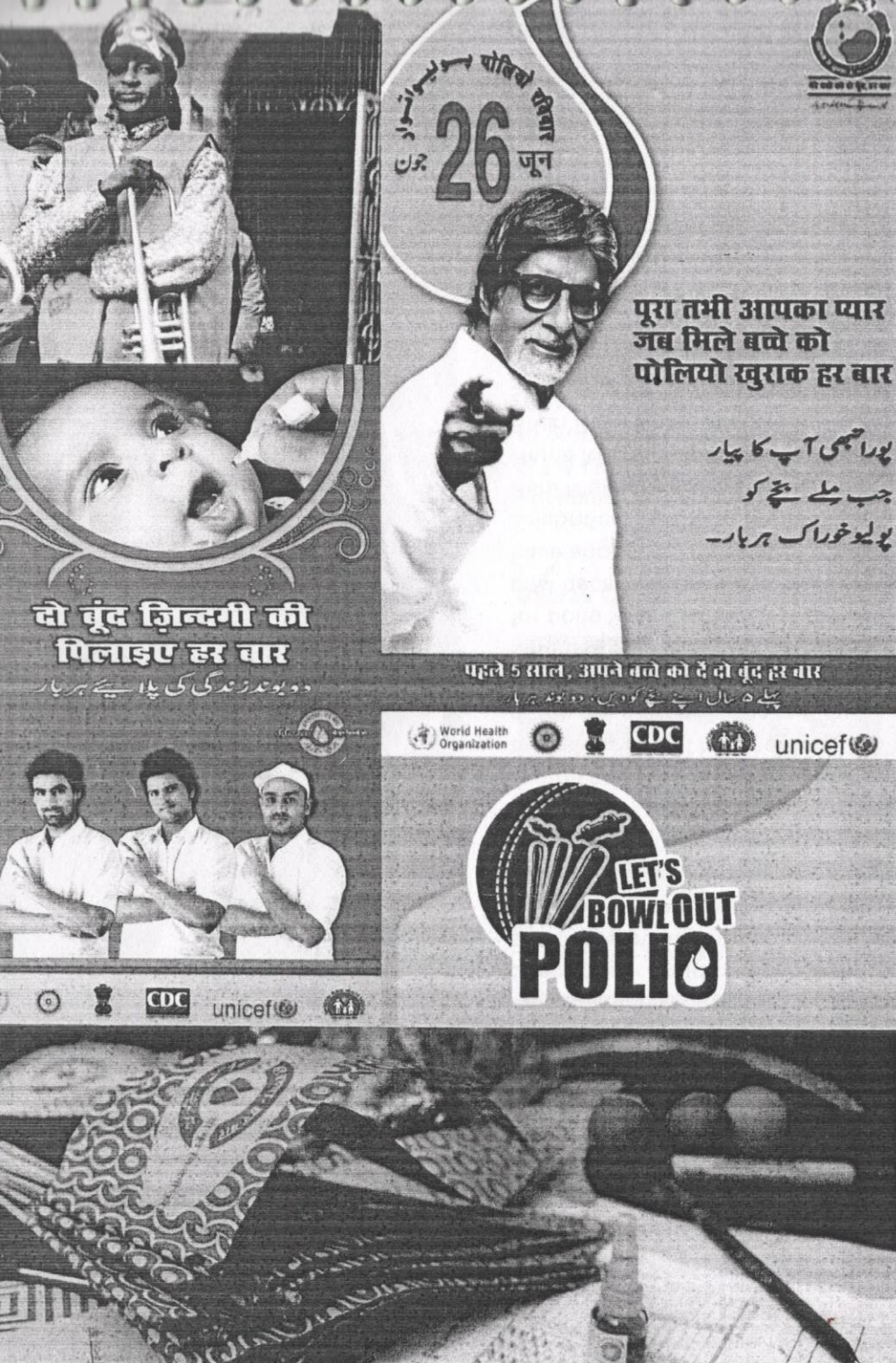
जून २६ शरिते ३०
उच्च स्वास्थ्य समिति, बिकर
unicef

पोलियो उन्मूलन अभियान
आपनि कि आपनार ०-५ বছर
बाकाके पोलिओ टिका खाईयेछन?
उच्च स्वास्थ्य समिति, बिकर
unicef



पोलियो उन्मूलन अभियान
जल्म देखि ५ वर्ष सम्म को सबै बाल बालिका
लाई पोलियो को बूंद अवश्य दिनुहोला
उच्च स्वास्थ्य समिति, बिकर
unicef

जून २६ देखि ३०
जन्म देखि ५ वर्ष सम्म को सबै बाल बालिका लाई पोलियो को बूंद अवश्य दिनुहोला



IEC materials

Branding of polio

communication material – To distinguish the polio campaign from other programmes, a polio-specific brand has been developed utilizing bright colours – yellow, magenta and blue – supported by catchy taglines and logos. The robust outdoor campaigns ensure strategic visibility for the programme, generating attention and interest. Polio posters are recognized by one and all and across the country. The tag line has evolved with the programme needs from ‘do boond zindagi ki’ (two drops of life), adding ‘har bachcha har baar’ (every child, every time), to ‘mere bachche ko

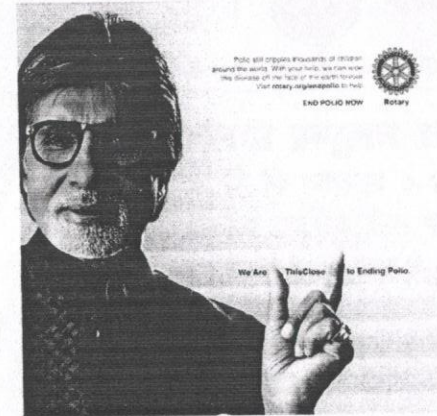
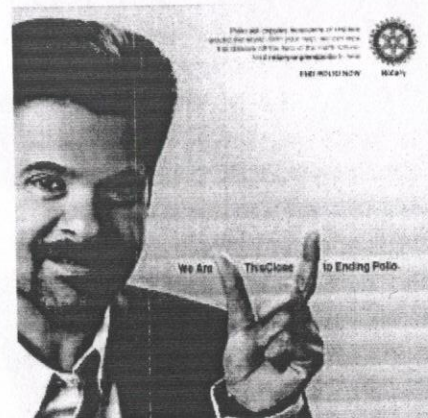
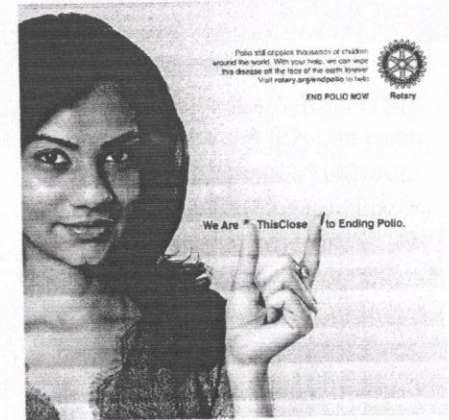
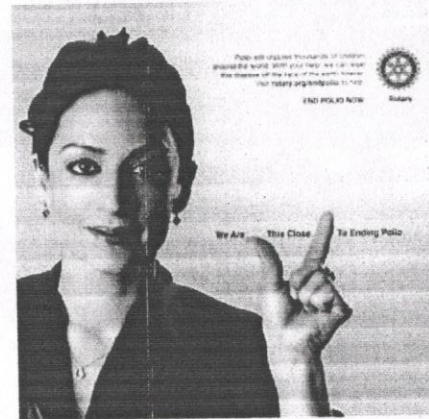
do boond har bar’ (for my child, two drops every time), placing the onus on parents to ensure the well-being of their children.

Special IEC for migrants – In order to reach out specifically to the most vulnerable migrant population, special IEC has been designed with catchy lines such as “jahan bhi jao jahaan bhi raho, polio ki khurak avashya pilao” (wherever you go, wherever you are, ensure polio vaccination for your child up to 5 years). These messages are placed on hoardings, posters, banners, buses, auto rickshaws, cycle rickshaws and even at international border posts.



Brand Ambassadors and celebrities – Amitabh Bachchan, one of the most popular Bollywood stars, has been the UNICEF brand ambassador for polio for a decade, appearing annually on mass media campaigns. The mass following of the celebrity and his endorsement of the polio programme is widely recognized as being a key generator of community support for polio vaccination. Over the past decade, Rotary and UNICEF have engaged a number of other celebrities, including Preity Zinta, Rani Mukherjee, Jaya Bachchan, Hema Malini, Aishwarya Rai, Shah Rukh Khan, Amir Khan, Soha Ali Khan. Popular national and regional celebrities such as Farooq Sheikh and an actor/singer from Bihar – Manoj Tiwari – visited and interacted with communities in the toughest refusal areas to garner support for the vaccination programme.

Celebrities



Rotary's 'This Close' campaign

Cricketers

For the past decade, India's cricketers have been key players in the country's fight to stop polio. In this cricket-crazy country, the impact of cricketers publicly calling on

parents to immunize their children has ensured that the polio eradication programme has enjoyed widespread community support. The **Bowl Out Polio** campaign has been a key pillar

of the success of India's battle to end polio. This collection of photographs is a tribute to the contribution of cricketers over the years to polio eradication.

Inzamam-ul-Haq and Rahul Dravid



Saurav Ganguly and Donna



Anil Kumble



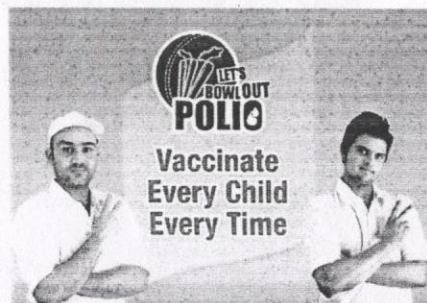
M. S. Dhoni



Brett Lee



V. Sehwag and S. Raina



Yusuf Pathan



Harbhajan Singh





Fundraising, advocacy and partnerships

Fund-raising – To date, Rotary has contributed more than US\$1 billion (Rs. 5,000 crores) worldwide for polio eradication. In India alone, Rotary's contribution stands at US\$158 million (Rs. 790 crores). In India, the Aditya Birla Group, with its patron Mrs Rajashree Birla, an honorary member of Rotary Club Mumbai, has contributed US\$6 million. Rotarian Harshad Mehta has contributed more than US\$3.5 million to the polio eradication effort, while Ms Usha Mittal has donated US\$1.5 million.

High-level advocacy – Since the launch of the programme, Rotary has been garnering support for

polio immunization by meeting the Prime Minister, Chief Ministers, Health Ministers, local politicians, Cabinet Secretary, Chief Secretaries, Principal Secretaries, District Magistrates and other health officials for the polio campaign.

Ulemas Committee – Engaging key religious leaders to get community support for polio eradication, Rotary formed an Ulema Committee in Uttar Pradesh comprising of senior Muslim scholars and religious leaders to address issues of resistance.

Advocacy with media – National, state and local media, vernacular press; print, TV and radio are

being partnered with to spread messages on the importance of polio immunization and polio eradication, address myths, rumours and fear in the community and accurately position the polio programme in the all-important local media. Media workshops are ongoing to engender long-term advocates for polio eradication.

India Unite to End Polio Now campaign – Partnering with the private sector, the India Unite to End Polio Now' (IUEPN) campaign launched by AidMatrix Foundation and UNICEF garners support from companies under their corporate social responsibility budgets

for contributions in kind to support polio awareness among the highest-risk populations. These partnerships have tapped innovative communication channels across the polio-endemic and high-risk states, such as polio booths at major transit locations, mobile vans displaying communication materials, SMS and voice messaging services, public service announcements on polio in cinema halls and local theatres, magic shows, and wall paintings, etc. Public spaces like railway stations, buses, bus stops, markets, dairy booths, banks and schools have been successfully negotiated for maximum visibility of messages.



Two-year-old Rukhsar, from Panchla Block, Howrah, West Bengal, was paralyzed by polio on 13 January 2011.

Will she be the last case in India?

This booklet has been put together for the Polio Summit 2012 organized by the Ministry of Health and Family Welfare, Government of India and Rotary International, to mark India's remarkable efforts and progress in polio eradication.