BEST PRACTICES OF CSOs WORKING ON IMMUNIZATION AND MCH IN SINDH, PAKISTAN

DEC 2012
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### Abbreviations

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<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ASWA</td>
<td>Azad Social Welfare Association</td>
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<td>AKHSP</td>
<td>Aga Khan Health Services, Pakistan</td>
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<tr>
<td>BCG</td>
<td>Bacille Calmette-Guérin</td>
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<td>BHU</td>
<td>Basic Health Unit</td>
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<td>BWDA</td>
<td>Bhittai Welfare Development Association</td>
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<tr>
<td>CBA</td>
<td>Child Bearing Age</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<td>CHIP</td>
<td>Civil Society Human And Institutional Development Programme</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>DDF</td>
<td>Dharti Development Foundation</td>
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<td>DPT</td>
<td>Diphtheria-Tetanus-Pertussis</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme Of Immunization</td>
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<td>GAVI</td>
<td>Global Alliance For Vaccines And Immunization</td>
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<tr>
<td>GGGRDS</td>
<td>Green-Globe Research &amp; Development Society</td>
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<td>HANDS</td>
<td>Health And Nutrition Development Society</td>
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<td>HBIG</td>
<td>Hepatitis B Immunoglobulin</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Vaccine</td>
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<td>HELP</td>
<td>Health, Education And Literacy Programme</td>
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<td>HMC</td>
<td>Health Management Committee</td>
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<td>LHV</td>
<td>Lady Health Visitor</td>
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<td>LHW</td>
<td>Lady Health Worker</td>
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<td>LSO</td>
<td>Local Support Organization</td>
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<td>MCH</td>
<td>Mother And Child Health</td>
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<td>MCV</td>
<td>Measles Containing Vaccine</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>NID</td>
<td>National Immunization Day</td>
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<td>OPV</td>
<td>Oral Polio Vaccine</td>
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<tr>
<td>ORS</td>
<td>Oral Rehydration Solution</td>
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<tr>
<td>PAB</td>
<td>Protection At Birth Against Tetanus</td>
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<td>PAVHNA</td>
<td>Pakistan Voluntary Health And Nutrition Association</td>
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<td>PDHS</td>
<td>Pakistan Demographic Health Survey</td>
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<td>PMRC</td>
<td>Pakistan Medical Research Council</td>
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<td>PVDP</td>
<td>Participatory Village Development Programme</td>
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<td>SNID</td>
<td>Sub-National Immunization Day</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Assistant</td>
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<td>THF</td>
<td>The Health Foundation</td>
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<td>TT</td>
<td>Tetanus Toxoid</td>
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<tr>
<td>UC</td>
<td>Union Council</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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<tr>
<td>VHC</td>
<td>Village Health Committee</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Pakistan CSOs Coalition for Health and Immunization came into existence in 2011. At the time it had 15 members who had been working in coordination with GAVI Alliance, Federal Ministry of Health and UNICEF on different health care projects. The dedicated initiative on ‘Strengthening CSOs Engagement in Health’ was offered to CSOs Coalition in July 2012 which has started its interventions from Sindh Province through a Pakistani CSO ‘CHIP’. The Coalition focuses on directing its efforts towards different health projects such as to reduce neonate, infant and maternal death rates. It basically strives to increase safe deliveries and immunization coverage rates.

Civil Society Organizations (CSOs) have been recognized to play a significant role in strengthening health delivery systems in the country. The GAVI Alliance strategy for “strengthening CSO engagement in the health sector” has focused on selected CSOs in Sindh. These CSOs have been working extensively in hard-to-reach areas and with marginalized communities. The theme for GAVI Partner’s Forum for 2012 on immunization advocacy goals has been Results, Innovation, Sustainability, and Equity (R.I.S.E).

The CSOs engaged in Sindh to increase immunization coverage rates identified barriers to immunization, implemented strategies to overcome these challenges, documented best practices, and monitored the resultant improvement in immunization coverage. The barriers faced can be broadly categorized into:

**Barriers at policy level** – such as drafting policies, decision-making, reviewing and feedback.

**Barriers at service level** – such as access, logistics, cold chain maintenance, skills training, delayed salaries, political interference, safety and security of health service providers, inadequate communication, ineffective documentation and reminder system.

**Barriers at community level** – such as myths, fears, misconceptions, lack of awareness, religious influences, gender inequity, socio-cultural factors, and language barriers.

The best practices¹ implemented by the CSOs is to some extent, generally applicable to other regions, but, are also specific and appropriate to the particular area. The best practices included establishing strong networking and good working relations with key stakeholders, advocacy campaigns, community mobilization and participation, imparting skills training, increasing awareness about the importance of immunization, stringent monitoring and accountability, building trust and confidence in healthcare providers, effective communication through innovative means (interactive theatre, role plays, tableaus), sensitizing religious leaders, logistic support, gender equity, accurate documentation and data collection, motivating staff and parents/caregivers, consistency in follow-up, and integration of services.

The CSOs provided figures on immunization coverage of BCG, DPT1-DPT3, OPV, and measles in children as well. These have been presented in tables as an annexure. The dropout rates from DPT1 to DPT3 are used as a measure of the strength of a health and immunization system. A strong system ensures high coverage rates of DPT3; whereas a weaker system can reach a child with the first dose in the series, but not the third. Additionally, DPT vaccine is being given in routine immunization schedules rather than campaigns.

To conclude, this documentation of best practices implemented by CSOs in Sindh is compelling evidence that there is much to be gained in engaging CSOs to strengthen the existing health system in increasing effective immunization coverage in mothers and children.

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¹ Best practices as defined by WHO, is “knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts”: Guide to Documenting and Sharing Best Practices, WHO Regional Office for Africa, 2008.
Chapter 1 BEST PRACTICES ESTABLISHED BY HANDS IN MATIARI

1.1 TEAMING UP AND NOT PARTING WAYS

Walo Kolhi was shaking, his head spinning in turmoil with a sea of emotions. He gazed at the lifeless body of his young son, “who and what is responsible for this?” the poor farmer thought to himself. Someone in the village made a suggestion, “it could be because of a vaccine he was given by the Lady Health Worker a few weeks back.” Fuming with anger he spun round and went in search of the LHW, wanting to hand her over to the police. Timely intervention by village elders and the Department of Health officials averted an unnecessary crisis. As a result though, over two thirds of the villagers refused immunizations for their children and women, and viewed interventions from the health department with suspicion. This is where a local Civil Society Organization (CSO) can play a pivotal role in influencing and persuading the community to dispel misconceptions on immunizations.

The Health and Nutrition Society (HANDS) is one such organization that with an innovative approach achieved success in convincing this reluctant village, under the GAVI project, which began in 2009. HANDS has over 30 years’ experience and expertise of working in the province of Sindh, on health related projects. Amongst its many achievements, HANDS specializes in community mobilization, capacity building, advocacy, and promoting sustainability of its projects. HANDS project on addressing barriers to immunization was undertaken in District Matiari, comprising of 19 Union Councils. The targeted areas were rural and many hard-to-reach villages, consequently being underserved by primary health services and under-immunized.

HANDS overcame barriers to immunization in District Matiari by implementing best practices and achieved:

- Children 12-23 months of age fully immunized increased by 21%
- Mothers given TT vaccine increased by 50%
1.2 **Barriers to Immunization**

The major obstacles faced by HANDS included planning and policy-making decisions at the district level not being shared with the CSO, such that valuable inputs at the grass root level from HANDS were not incorporated into the policies. Inaccessible areas were repeatedly ignored for routine immunization coverage due to lack of vaccinators or resources; and there was inadequate availability of transport to remote areas. Several underserved regions have poor or non-existent roads, and access is only possible by 4x4 vehicles.

The EPI center was not given the required time and attention by the healthcare provider; in addition there was poor motivation of vaccinators and Lady Health Workers (LHW) to achieve immunization targets. This was partly due to delayed salaries and insufficient per diem allowance for travel.

Awareness and knowledge on health related matters in the community were poor, with misinformation on the benefits and risks of immunization commonplace. Additionally many refusals were based on religious grounds. Internal conflicts and feudalism among the local people also compromised the safety and security of field health workers, adding to the reluctance on reaching the unreached.

1.3 **Interventions**

The focus of intervention by HANDS in Matiari, was to:

1.3.1 Increase immunization coverage of < 2 year olds in the selected areas.

1.3.2 Increase in TT (Tetanus Toxoid) coverage of women of Child Bearing Age (CBA)

To achieve these objectives, the following strategy was adopted: HANDS built a strong networking system and established excellent relations with Government health officials at provincial and district levels. Regular meetings and awareness sessions were conducted with principal stakeholders to discuss and overcome these barriers to immunization. HANDS also conducted baseline surveys and shared this data both internally and with Government officials, to plan evidence-based policies for effective immunization coverage.

HANDS extended practical support to the Government health department in maintaining the cold chain for the vaccines and in accessing hard-to-reach villages. This was achieved by donating refrigerators to BHUs (28 refrigerators so far), training and giving per diem allowance to ten vaccinators to widen the immunization coverage by approaching new and “untouched” areas. In addition, transport vehicles (4x4) were provided for routine immunization and immunization campaigns.

Choosing respected members from within the community, including religious leaders, formed health Management Committees (HMC) and Village Health Committees (VHC) and awareness trainings on the importance of the EPI were conducted. Refresher training on immunization was given to the healthcare provider in the BHU, and this knowledge was then imparted to the local people. Counseling sessions on vaccinations were given to mothers and caregivers especially. Involving the local community in this manner ensures sustainability and ownership of the project, thus creating a demand for provision of the health services and immunization in particular.
National Immunization Days (NIDs), Sub National Immunization Days (SNIDs), Mother and Child Health (MCH) week were celebrated in the community health facility by arranging walks, rallies, tableaus and role-plays. This latter form of interactive theatre effectively communicates the message to the local community in an easily understood way. HANDS successfully increased immunization coverage in District Matiari, of children between 12-23 months of age fully immunized from 61% to 82% (an increase of 21%). Mothers receiving two or more injections of TT during last pregnancy increased greatly from 40% to 90% (an increase of 50%).

Participation in policy development, strengthening and supporting the existing health facilities, community mobilization and effective communication are some measures that HANDS consider can increase immunization coverage even further.

Correcting misinformation on vaccine safety using a novel approach of communication with families is illustrated by the story of Niymat, a Lady Health Worker, working in village Pharsi, District Matiari. Niymat says, “I have been providing natal care and vaccinations to the village for eight years. But over the last five years the vaccination rate for children has steadily declined such that, now, all the parents have refused to have their children vaccinated.”

The reason is fear of the risks of vaccines, because five years ago a child from the village died due to a diarrheal illness three days after being vaccinated. Despite senior healthcare providers reassuring the community that the death was unrelated to immunization, the villagers remained unconvinced. The local people also disappointingly rejected Niymat’s efforts on awareness sessions. The HANDS-GAVI team identified this ‘all-refusing’ village, and intervened by conducting awareness activities through the Village Health Committee, and interactive theatre sessions (role play, dramas, tableaus) in which benefits and risks of immunization were covered, with question answer sessions clarifying doubts and misgivings, thus sensitizing the community effectively. Persistent efforts have paid off, and Niymat excitedly says, “The villagers call me themselves now, and ask for vaccinations for their children as soon as possible!”

This success story is part of the role CSOs can play in addressing and overcoming barriers to immunization.

1.4 BEST PRACTICES BY HANDS

1.4.1 Maintaining a Strong Working Relationship with Government Health Officials at Provincial and District Levels

By providing data and other ground realities to the health officials, HANDS actively participated and collaborated in evidence-based policy planning, decision-making and review. Sharing of information was only possible due to strong networking and confidence established between HANDS and relevant district and provincial health officials. HANDS effectively bridged the gap between the community and health officials in a coordinated manner by teaming up and working closely to increase immunization coverage. Establishing Health Management Committee (HMC) and Village Health Committee

This created a platform for awareness sessions regarding immunization campaigns within the
community at all times that could be conducted at both door-to-door level and on a larger scale. The members of the committees are respected, reputable local leaders who can exert an influence on the knowledge, attitude and practices of the community regarding health matters. They can create a demand for better health and immunization services, and it gives a sense of ownership to the community thus ensuring long-term sustainability of the project or programs. The committees are also involved in community mobilization by selecting and training capable and enthusiastic individuals from the local people as social mobilizers.

1.4.2 Providing Refresher Skills Training on Immunization

HANDS provided refresher skills training to the healthcare providers at the BHU and to LHWs on routine immunization practices, accurate data collection and entry, new vaccines and administrative protocols, as well as other skills regarding immunization. This capacity building exercise keeps the staff up to date, confident, and well equipped to answer immunization concerns of mothers and care givers.

1.4.3 Ensuring Effective Communication through Innovative Means

It is important to convey to the community the risks and benefits of immunization in an easily understood way. Since the literacy level is low, effective communication is possible by using puppet shows, role-play and interactive theatre. In a fun and - way that engages individuals of all ages, backgrounds and education levels, this dispels myths and false health beliefs regarding vaccines and immunization. HANDS, together with the GAVI team, thus successfully convinced a reluctant and ‘all-refusing’ village to allow immunization of all the children.

1.4.4 Extending Logistic Support to NIDs, SNIDs and MCH Week Activities

HANDS provided refrigerators to BHUs thus making them functional and maintaining the cold chain for vaccines. Appropriate transport (4x4 vehicles) was arranged for immunization staff to access hard-to-reach and remote areas for routine immunization coverage and for special campaign days and weeks. These activities by HANDS therefore strengthened the health care facilities provided in the area.
Chapter 2 Best Practices Established by HELP in Karachi

2.1 Knowing Someone Cares - Makes Mothers Happy

Health, Education and Literacy Programme (HELP) is a non-governmental, non-profit community based primary health care and education program working in Karachi and District Sanghar, Sindh Province, since 1991. With GAVI support, HELP has worked in Tharparkar from 2009 till 2011 and is currently working in Taluka Shadadpur of District Sanghar. The areas targeted by HELP for their immunization project were Khuda Ki Basti, Neelum Colony and Lower Gizri. These are impoverished urban slums; housing both skilled and unskilled workers, low socio economic status families, with high illiteracy rates. Sanitary conditions are poor, and average family size consists of at least five children.

2.2 Barriers to Immunization

Awareness on the importance of immunization is lacking, and false health beliefs and misconceptions about vaccines are common in the community. In addition, the dynamics of the community are continuously changing due to the frequent relocation of residents. Consequently, keeping accurate records of vaccinated children and mothers, tracking and following-up on under-immunized or missed immunizations is a challenge. Absenteeism of government employed vaccinators and ensuring the safety and security of HELP’s field workers were additional barriers to effective immunization coverage. Policies on health related matters and EPI
were not discussed with the CSOs on national level and seemed to lack evidence – based decisions.

2.3 INTERVENTIONS
The focus of intervention by HELP was to:

2.3.1 Increase immunization coverage of < 2 year olds in the selected areas.

2.3.2 Increase in TT (Tetanus Toxoid) coverage of women of Child Bearing Age (CBA)

To improve immunization rates, HELP engaged and sensitized reputable community leaders on the importance of mother and child vaccination through male social mobilizers. Multiple group discussions were held with community stakeholders. They also established community-based groups to ensure viability of the project.

By selecting and training local women as Community Health Workers (CHW), HELP also ensured sustainability of the immunization program. Regular skills refresher training sessions of CHWs are conducted, to keep them updated on new vaccines and other administrative protocols. Furthermore, trained Lady Health Visitors (LHVs) are involved in supervising the CHWs, who in turn provide field doctors with the necessary data on under-immunized children, referrals, and refusal rates. Weekly meetings with field workers including field coordinators and social mobilizers are held. The Project Manager obtains weekly reports from the CHWs during these meetings and discusses the problems faced during the week. The chairperson of the organization also reviews monthly reports on immunization coverage.

To deal with refusals, HELP Program Manager Dr. Amara explained, “Either the field doctor, or a trusted and reputable social mobilizer approaches the mother and attempts to convince her on getting the child, or herself, vaccinated.” With effective communication, this strategy usually has success, with the added result of “making the mothers happy that someone cares” she further stated. This stringent monitoring and evaluation system helps gauge the success of, and, identify gaps in the immunization coverage of the urban slum areas.

Linkages and liaising with the Government health sector officials on Expanded Programme of Immunization (EPI) have been established, thus strengthening the delivery of health services being offered in the area.

After implementing these best practices, HELP successfully increased EPI coverage of children less than 5 years of age in Khuda Ki Basti from 30% to 97% (an increase of 67%). The coverage rates in Neelum Colony and Lower Gizri increased from 23% to 98% (an increase of 75%). Children who are fully immunized in these areas currently stands at 68%. Over a quarter of the children are in the process of immunization; and the refusal rate has been kept low to 3%. Similarly increased coverage of TT vaccination of women of CBAs was seen in Khuda Ki Basti where rates went up from 10% to
Together for a difference

85%. In Neelum Colony and Lower Gizri the coverage area has increased from 9% to 89% (an 80% increase).

HELP strongly believes that for future coverage of immunization to increase, and to achieve its targets, the role of CSOs can be effectively used in community mobilization and capacity building trainings of vaccinators. Additionally, support should also be obtained from dedicated local individuals, including religious leaders. Birth attendants if equipped with the necessary knowledge can influence parents or care givers to initiate immunization soon after birth.

They also suggested that the health policy and EPI policy should be evidence-based, and if shared with CSOs on national basis could bring about a more integrated health service delivery system and thus accomplish complete immunization coverage of children and mothers.

2.4 BEST PRACTICES BY HELP

2.4.1 Conducting Weekly Meetings with Field Workers and Health Providers to obtain Immunization Updates and Compile Weekly Reports

A stringent system of accountability and responsibility was enforced by HELP, in which each worker provided data on under-immunized, missed, or refusal cases that was effectively addressed, and follow-up was ensured. Regular scrutiny of tracking cases was essential because of the migratory nature of the community. It also created a close and caring working environment between HELP field workers and the community. The monthly reports compiled by the project manager were also shared with the Chairperson in regular meetings, once again reinforcing a strict monitoring and evaluation system.

2.4.2 Establishing Linkages and Liaising with EPI Workers

Since HELP has a strong relationship with both the community and EPI workers, HELP coordinated health and immunization activities between the two. A demand for quality health services and provision of adequate immunization coverage of under-served and under-immunized areas was achieved.

2.4.3 Selecting and Training Local Women as Community Health Workers (CHWs)

Capacity building of the CHWs selected from within the community is essential to ensure viability and sustainability of the program. Due to socio-cultural norms, the majority of mothers and care givers prefer women health providers. Skills training of local women on accurate data collection, quality standards and protocols, and health related activities were conducted by HELP.

2.4.4 Sensitizing Community through Selecting and Training Reputable Members from Community as Male Social Mobilizers

Community mobilization and awareness sessions on the importance of immunization were possible through training of dedicated individuals from the community. Male social mobilizers were selected as Pakistan has a patriarchal society and health—the male head of the household usually undertakes related decisions. Furthermore, with female field workers there are safety and security concerns.
Chapter 3 **BEST PRACTICES ESTABLISHED BY PAVHNA IN LARKANA**

3.1 **CONCERTED EFFORTS BRING RESULTS**

“Measles outbreak claims 154 lives in Sindh,” screams the headlines in a daily national newspaper. This is not ‘breaking news’ from twenty to thirty years ago, on the contrary, it is the tragedy of today - December 2012 (The News). Heralding in the New Year, this should make health officials, policy-makers, and key stakeholders sit up and take notice. Immunization must take higher priority in healthcare responsibility. Public-private partnerships can play a significant role in ensuring effective immunization coverage of children and mothers.

Sindh province has the highest concentration in the country of Non-Governmental Organizations (NGOs) working in the development sector, including health. The GAVI Alliance under its business plan 2011-2015 wishes to strengthen the capacity of integrated health systems delivery of immunization initiatives by, amongst other factors, “strengthening Civil Society Organization (CSO) engagement in the health sector.”

A leading CSO, Pakistan Voluntary Health and Nutrition Association (PAVHNA) programs on primary and reproductive health services where immunization is an essential and important factor. PAHVNA has worked under the GAVI project of 2009, in the remote, rural areas of District Larkana, Taluka Naudero and Baqrani to address and overcome barriers to immunization.

3.2 **BARRIERS TO IMMUNIZATION**

The target area includes 8 Union Councils in hard-to-reach regions of the district. The community consists of poor, uneducated farmers working on smallholdings, raising livestock or employed on a meagre salary by landlords. Living conditions and sanitation is poor; families with up to ten children live in inadequate housing, with an estimated literacy rate of only 34% in Larkana. Awareness on
Together for a difference

Health related matters, especially immunization is lacking; misconceptions on health beliefs are common and influenced by village elders and religious leaders. For example it is generally perceived that only polio drops are necessary – while other vaccines are of no use. Due to socio-cultural constraints, women prefer lady vaccinators and healthcare providers. Home births supervised by unskilled birth attendants (dais) are widespread. The dais lack the necessary information and training to advise women on the importance of immunization.

Health facilities, the Basic Health Unit (BHU), and EPI centers are inaccessible to the community for immunization due to lack of transport, inflexible clinic timings, and shortage of trained staff (Lady Health Workers, vaccinators), disinterested health providers, and a general “fatigue” for routine immunization as resources are diverted towards polio campaigns. Furthermore, due to the migratory nature of the community there is a lack of accurate documentation, tracking, referral and recall system, thus the community is underserved and under-immunized. Ensuring the safety and security of field workers, logistic support and maintaining the cold chain for vaccines are additional challenges.

3.3 INTERVENTIONS

The focus of intervention by PAVHNA in District Larkana was to:

3.3.1 Increase immunization coverage of < 2 year olds in the selected areas.

3.3.2 Increase in TT (Tetanus Toxoid) coverage of women of Child Bearing Age (CBA)

These objectives were achieved by PAVHNA using the following strategy. PAVHNA established strong networking and close coordination with the District Health Department and EPI team to improve the health status of women and children in particular. National Immunization Days (NIDs), SNIDs and Mother and Child Week (MCW) were fully supported by PAVHNA; the latter also gave Government vaccinators performance-based financial incentives. An advocacy campaign was initiated that included government officials, community leaders and the media. As a result, PAVHNA received appreciation letters from the Government Health Department, encouraging PAVHNA to continue and sustain its efforts in improving immunization coverage rates.

PAVHNA conducted awareness sessions on the importance of immunization in the community by involving all-important stakeholders; including village elders, religious leaders and family members. The community was mobilized to create a demand for accessible and effective health services. A door-to-door campaign was implemented to create an environment conducive to access immunization services and set up an effective referral network system. PAVHNA also conducted knowledge, attitude and practices surveys to assess the impact of their interventions.

By adopting these best practices PAVHNA successfully increased immunization coverage in District Larkana, Taluka Naudero and Baqrani. Overall immunization coverage in the selected areas increased from 69% to 91% (an increase of 22%). Children aged 12-23 months fully vaccinated in the area increased by 19%. Mothers who had received two or more TT injections during last pregnancy
increased from 55% to 64%. A measure of the awareness on the importance of childhood immunization increased by 68% and 47%; in Naudero and Baqrani respectively.

PAVHNA believes that policy making and decision-making should be shared with CSOs and policies must have a robust implementing, monitoring, and evaluation system in place. PAVHNA also strongly recommends a greater emphasis on routine immunization and not just concentrated efforts on the polio campaign. This neglect of immunization with other vaccines has resulted in sporadic, fatal outbreaks of measles in Sindh. The role of CSOs in enhancing immunization coverage rates in interior Sindh has not been utilized to its full potential. PAVHNA hopes to continue in its endeavor to improve the health status of mothers and children.

3.4 **BEST PRACTICES OF PAVHNA**

3.4.1 Networking and Coordinating with District Health Department and EPI Team

By working closely with the Governmental health officials and EPI team and having accurate data on the community it served, PAVHNA was able to identify under-served and under-immunized areas, which were then targeted in the immunization coverage plans. Routine and campaign immunization days were fully supported by PAVHNA field workers.

3.4.2 Advocacy Campaigns with Key Stakeholders

PAVHNA actively lobbied for improving quality health services for both mothers and children. They campaigned to health officials, community leaders, and the media with the focus on advocacy of improved and increased immunization coverage.

3.4.3 Accommodating and Motivating Parents/Care Givers by Door-To-Door Campaigns

As access to health services was a major barrier for the community, PAVHNA’s efforts on a door-to-door campaign met with considerable success. This kind of ‘personalized’ service was relatively easier to achieve by PAVHNA as they have close links with the community and have built a strong trust and confidence relationship with the local people.

3.4.4 Establishing Effective Referral and Recall System

The close contact with the community, as well as accurate data and record keeping established by PAVHNA on missed, under-immunized or refusal cases allowed for setting up a robust referral and recall system. Following-up on cases was also essential.

3.4.5 Conducting Research on Knowledge, Attitude and Practices on Immunization in Community to Measure Impact of Awareness Campaigns

PAVHNA conducted awareness sessions on immunization within the targeted community. To assess the impact of these sessions pre- and post- information on the knowledge, attitude and practices towards immunization was collected. This provided evidence-based figures so that groups could be identified for further or more intensive sessions as necessary. In this way resources were maximally utilized and repetition was avoided.
Chapter 4 BEST PRACTICES
ESTABLISHED BY THE THF IN KARACHI

4.1 CHANGING PERCEPTIONS IN MADRESSAS OF KORANGI

Hepatitis B is a viral infection of the liver that causes acute and chronic liver disease, which can later develop into liver cancer. Hepatitis B can be prevented by the Hepatitis B Vaccine (HBV), and in 1992 WHO recommended global against Hepatitis B. In Pakistan though, it was not until 2002 that the Hepatitis B vaccine was introduced as a part of EPI, with the support of GAVI Alliance. The WHO further recommends “all children and adolescents younger than 18 years old and not previously vaccinated should receive the vaccine.” According to the Pakistan Medical Research Council (PMRC) an estimated 2-3% of the adult population in Sindh is thought to suffer from Hepatitis B.

The Health Foundation (THF) is a non-governmental, non-profit organization established in Karachi focusing on creating awareness, prevention, screening and treatment of Hepatitis B and C. The area selected by THF, under the GAVI project of 2009, for Hepatitis B immunization of school going children (5-15 year old), and infants born to Hepatitis B positive mothers was Korangi, Karachi. Korangi consists of nine Union Councils and a cantonment area.

4.2 BARRIERS TO IMMUNIZATION

Korangi is a densely populated industrial area with numerous factories and small industries. It has a diverse multi-ethnic community; with large families living in tightly packed housing units. Socio-economic status and literacy level is low, furthermore awareness on the importance of immunization as a preventive measure against disease is also lacking. Religious leaders exert a considerable influence on the health beliefs of the community, and immunization in particular is viewed with suspicion.

Additionally, Dr. Kashif Riaz, Project Manager lamented, “...for mothers‘ taking care of several small
children and household duties, health is not a priority”. Korangi is known to have a volatile security location, with frequently occurring ethnic and politically motivated conflicts, causing a real threat to healthcare providers and community mobilizers.

THF focused on schools and madressas within the Korangi area, and it was during the initial identification process that they noticed an inequity of access to health services in the ‘madressas’—which are religious learning centres. Furthermore, many of the schools in Korangi were charity funded, so attendance was patchy and lax, with absenteeism common; therefore tracking and capturing missed or incomplete immunization in the children was an additional barrier to effective immunization.

4.3 INTERVENTIONS
The focus of intervention in Korangi, by THF was:

4.3.1 Hepatitis B vaccination of school going and madressa children (5-15 year old)

4.3.2 Hepatitis B (HBV) vaccination of babies; those born to Hepatitis B positive mothers given HBV and Hepatitis B Immunoglobulin (HBIG) within 24 hours of birth to prevent mother-to-baby transmission of disease

THF liaised and established a good rapport with the Union Council Education Officer; the latter issued a letter strongly recommending the schools to allow not only Hepatitis B immunization of the students, but also awareness sessions on the modes of acquisition and prevention of both Hepatitis B and C. Permission was sought from Principals of schools, and informed consent was taken from parents to conduct immunization of the children. Accurate documentation was maintained allowing for an easy tracking, follow-up and reminder system. THF took the opportunity to educate and include into the project mothers of vaccinated students. A significant drawback to the immunization campaign was follow-up and referral after school vacations (long summer breaks, shorter winter and spring holidays). As mentioned earlier, keeping track of missed or under-immunized children in charity-funded schools was problematic. “We have our own vaccinators, and plan to start a door-to-door vaccination campaign to counteract missed opportunities during school holidays, and expand coverage,” explained Dr. Riaz. Children in ‘madressas’ (religious learning centres) presented a marginalized group. Many health beliefs on the safety, efficacy and risks of immunization were religion-based. Convincing the community otherwise required working closely with religious leaders, “with tact, patience and sensitivity,” stated Dr. Riaz.

Madressas are known to ‘keep to themselves’ and gaining access to conduct any interventions was tantamount to an invasion of privacy. THF approached the madressa clinical officer and even “provided a vial of HBV so it could be laboratory tested by them,” Dr. Riaz elaborated. THF then proceeded by conducting awareness seminars, and obtaining a written ‘fatwa’ (religious ruling) from a respected and renowned Mufti (religious leader) endorsing the use of immunization as both beneficial and safe. Once the students of the larger madressas were successfully vaccinated against
Hepatitis B, the smaller institutions followed suit. A minority of the madressas persistently refused immunization for its students, and in these institutions THF conducted awareness sessions on Hepatitis B. THF spokesman stated positively, “we will keep trying with these madressas, and hope to build trust and confidence in our activities, such that, a demand for vaccination is created in the community.”

By implementing these strategies, THF successfully immunized 40,000 students in madressas, and an estimated overall 50% of school going children in Korangi. THF believes that focusing on school children especially in madressas; and involving parents; obtaining a written religious ruling on the benefits of immunization; conducting awareness sessions on Hepatitis B; and support from the Local Town Health Office were instrumental in successfully and effectively increasing immunization coverage of Hepatitis B in Korangi, Karachi.

4.4 **BEST PRACTICES BY THF**

4.4.1 Approaching School and Madressa Administrators with Formal Letter issued by Education Officer

This was essential for THF to have a written statement from the Government official to gain access to the schools and madressas. THF was allowed to conduct awareness sessions on Hepatitis B and also carry out vaccinations of the school children.

4.4.2 Obtaining Informed Consent from Parents, and take opportunity to include Mothers in Awareness Campaign

It was crucial to get informed consent from the parents, and THF seized the opportunity to include the mothers in the awareness sessions. This integrated approach increased the immunization coverage with a greater impact. CSOs are usually viewed favorably and with less suspicion than international NGOs.

4.4.3 Obtaining Written Fatwa (Religious Ruling) from Mufti Endorsing Immunizations

As THF focused on the marginalized group of children studying in madressas who thus held strong religion-based health beliefs, it was important and vital to obtain a written proof of endorsement for the benefits of immunization and the safety of vaccines.

4.4.4 Maintaining Accurate Documentation of School children for Tracking, Follow-Up, Referral and Recall System

Accurate data and record keeping by THF provided a strong system to administer appropriate and timely immunizations for the school children. THF was also consistent with follow-up and reminders.
Chapter 5 **Best Practices Established by PVDP in Tharparkar**

5.1 **Old Habits Die Hard**

For over a decade, sixty-year-old Saroo Kheto, an unskilled traditional birth attendant (known as Dai) in the village of Veal, in the district of Tharparkar, would deliver babies bending awkwardly over the mother lying on the floor.

5.2 **Barriers to Immunization**

Veal, with a population of just 2,000, with a majority belonging to the Kolhi tribe, following the Hindu faith, lies in the heart of the desert in Tharparkar, Sindh province and poses a challenge quite different from other parts of the country for provision of health services. The nearest town of Nagarparkar is located 30 kilometers from it. It has one primary school but no healthcare centre with the nearest basic health unit almost 15 kilometers away. The people are herdsmen who delve in subsistence farming.

"We’d cover the floor with a layer of sand and spread a sheet of cloth over it and asked the woman to lie down on it,” said the TBA. “The sand would absorb the discharges during delivery making it easier for us to clean up afterwards,” she said.

Not only that, she said she would apply “pressure” on the abdomen of the pregnant woman to help assist in delivery and would even ask her push with “full force” during her contractions. But Kheto is not the only one employing harmful and

PVDP overcame barriers to immunization in District Tharparkar by implementing best practices and achieved:

- Children 12-23 months fully immunized increased by 35%
- Mothers given TT vaccine increased by 40%
unsafe methods to deliver babies. There are thousands of TBAs across Pakistan that help in delivering babies by putting both the life of the mother and her baby in jeopardy.

According to the latest Pakistan and Demographic Health Survey (2006-07) the Maternal Mortality Ratio (MMR) is estimated to be 276 deaths per 100,000 live births. But these figures mask disparities between urban and rural areas. With an estimated population of 180 million, this translates to roughly some 30,000 maternal deaths in the country annually.

In Pakistan, two in three women deliver their babies at home, usually at the hands of unskilled traditional birth attendants (TBAs). These home births, in addition to being a leading cause of maternal complications, also carry a high risk of the newborn dying.

Kheto said she also ensured the baby was not breastfed for at least three days and considered the first milk, or the colostrum, unclean which was therefore discarded. “The baby was given unpasteurized goat milk as it is considered lighter than cow and buffalo milk because it is believed the new mother cannot produce enough milk.”

Other harmful practices still prevalent in villages include putting a paste made of kohl (antimony), oil and cow-dung, which is put on the baby’s umbilical cord supposedly to make it heal faster. The baby is given honey mixed with some herbal concoction, even butter or ‘kheer’ (milk cooked with rice and sugar). To clean the vagina after birth, a small ball made of gur (clarified sugar cane) and some herbs is put inside the vagina and replaced after two days with another ball of misri (sugar crystals) and removed after five days. With such dangerous practices then it is little wonder that a newborn baby dies every four minutes in Pakistan.

According to a study spanning 20 years, conducted by the World Health Organization, Save the Children and the London School of Hygiene and Tropical Medicine – and published in the medical journal PLoS Medicine, in August 2011, Pakistan, with a newborn death rate of 42 per 1,000 live births, is among the five countries with the lowest newborn survival rate. The other four are India, Nigeria, China and the Democratic Republic of Congo.

But all this has changed. Kheto, a widow, who has delivered hundreds of babies and who picked up the trade from a relative is today horrified to learn she put so many mothers and babies at risk.

5.3 INTERVENTIONS

She and two other TBAs in her village are among the 300 women who have been trained by the Participatory Village Development Programme (PVDP), a civil society organization, established in 1997, working for mother and child health and immunization, in the two districts of Tharparkar and Sanghar, in Sindh, under the GAVI project of 2009. PVDP has vast experience in community mobilization, capacity building and conducting awareness campaigns in these districts.

Due to some of the villages being so remote, Dr. Ramesh Kumar, Health Coordinator of PVDP, says it poses a challenge quite different from other parts of the country for provision of health services.

“In these villages sending a girl to school is still not widely acceptable and with such widespread illiteracy it is difficult to find young women to train as community midwives. Lack of transportation is another issue. Most of the villages are so far from health centres that TBAs are the only solution
to saving a mother,” pointed out Kumar.

To bring the mortality figures of both the mother and child down, it is imperative to train the TBAs, said the PVDP spokesperson, adding: “Changing old ingrained habits is not easy!”

“Illiteracy of the TBAs makes our job all the more challenging,” he said adding: “The training includes counselling women regarding immunization, breast-feeding practice, hygiene-related diseases, virtues of child spacing and safe delivery methods. We have put a lot of emphasis on early referral to the nearest hospital in case they are able to detect birth complications.”

But with an absence of public transport, it takes a minimum of 5 to 6 hours of steady, uninterrupted walk for a young sturdy man to reach the nearest town of Nagarparkar from their village. So they often use camel if there is no motor vehicle available.

According to Kheto, women are shy of giving birth in a strange place, and home-births are the norm in their village. In addition, she said, “It would be very expensive to deliver at a healthcare facility. The only way to reach the town would be on a 4x4 vehicle, which is far too expensive for a poor villager, and the delivery would cost additional RS. 4,000 to 6,000 (U.S. $ 40 to 61). On the other hand, delivery at home would cost no more than RS. 500 ($5) and at times not even that. “I sometimes get a goat, at times just fabric; it all depends on the family’s economic status,” she says.

PVDP also encourages TBAs to visit pregnant women for antenatal care and advise them for dietary needs, preparedness for delivery, and immunization.

Family planning is also an important component of their training. With almost 84 percent of Pakistani couples not using any modern family planning (FP) methods, bringing down the population figures is indeed a gargantuan task, concedes Kumar.

The TBAs are provided with safe delivery kits with sterilized birthing supplies that include gloves, a plastic apron, a plastic sheet, soap, clamps, a new razor, and sterilized string and cotton balls.

PVDP has also brought about another important change in families with regards to immunization through their TBAs. Kheto and many other TBAs who were clueless about importance of vaccination before are now the ones advising pregnant women to get vaccinated against Tetanus and are actively involved in promoting routine immunization of children against childhood diseases said the PVDP spokesperson.

“For the first time women are getting anti-tetanus vaccination and refusal to get their children vaccinated for has dropped significantly,” said Kumar. He said parents refused to get their children vaccinated because they developed fever after that. “But once the various myths surrounding the vaccines were broken and they were explained why their children became slightly feverish, many accepted that it was an important step for their children’s health.” Additionally, Village Health Committees (VHCs) have been established to create a demand for health services within the community.
Efforts by PVDP to increase immunization coverage of children less than 2 years of age have been successful, increasing from 41% to 76% (an increase of 35%). The TT vaccine coverage of mothers has increased by 40%, in District Tharparkar. While Kumar believes dais should be replaced by skilled birth attendants, but for now it is best to arm the TBAs with knowledge to change their practices. “We cannot ignore TBAs and neither can we do without them; in the absence of a proper hospital facility in the remote villages, they are the real life savers,” said Kumar.

But Dr. Shershah Syed, a leading Karachi-based Obstetrician and Gynecologist, insists the only way to bring down newborn deaths is to replace TBAs with skilled birth attendants (SBAs). “Indonesia and Malaysia have done so successfully,” he quoted.

5.4 **BEST PRACTICES BY PVDP**

5.4.1 **Imparting Skills Training to Traditional Birth Attendants (TBAs)**

Capacity building and refresher training of TBAs was conducted by PVDP. These were essential to make sure the TBAs unlearned harmful practices and were now knowledgeable on safe health practices. The TBAs were equipped to give advice on immunization of expectant mothers and of babies at birth. They were also provided with basic safe birthing equipment.

5.4.2 **Establishing Village Health Committees (VHCs)**

By involving the community in forming health committees, the project was sustainable and it created a demand for quality health services.

5.4.3 **Raising Awareness on Benefits of Immunization to Mothers/Care Givers by TBA**

Due to inaccessibility of larger health centres and family preference, home births supervised by TBAs is very common. The TBAs use this opportunity to conduct awareness sessions on the importance of immunization and maintain records for referral and tracking missed individuals.

5.4.4 **Initiating Routine Immunization at Birth by TBAs**

The TBAs have a responsibility to initiate routine immunization at birth. They have been mobilized and involved in process of vaccination like encouraging pregnant women for TT and new born for routine immunization.
Chapter 6 Best Practices Established by AKHSP in Tando Allahyar

6.1 A Changing Landscape

When Naseem Begum stepped out of her house for the first time as a CHW, she knew very well how limited her mobility was. Having lived in a conservative society like Sheikh Moosa, she realized that the cultural norms did not allow her to visit other people's houses freely. She had decided to step out of the house with the sole purpose of earning some money and contributing to the family income in an attempt to fight back her poverty stricken life style.

Naseem has shown some remarkable results ever since. She has registered 571 children under 5 years of age and 108 expecting mothers, identified 352 malnourished children and ensured that approximately 82% of the children are being monitored for growth and vaccination as per protocol. Furthermore, according to recent quarterly reports, she has been able to help 62 malnourished children to become normal weight, which she has been able to maintain during the three months of their follow up visits.

But these statistics alone do not do her justice: she has developed the confidence to undertake an even

AKHSP overcame barriers to immunization in District Tando Allahyar by implementing best practices and achieved:

- 100% registration and BCG, first and third DPT, Polio and Measles vaccination in children
- 13.2% increase in TT coverage for pregnant mothers in the three UCs
bigger objective, that of women empowerment. She believes that she has opened doors for other girls to come forward and participate in the community building activities. She is now ready to embark upon a much broader role as a woman leader. Furthermore, her drive to learn has extended beyond her role and she is currently undergoing community midwifery training.

6.2 **BARRIERS TO IMMUNIZATION**

District Tando Allahyar, with a population of 563,018, comprises pockets of highly poor communities. The problems posed by poverty are exacerbated by low rates of literacy in these areas even though literacy rates and levels of awareness are relatively higher in the more urbanized areas. In contrast to this, however, it is one of the rich districts of the province in terms of agriculture and the farms in the district supply fruit and vegetables in markets from Sultanabad to Hyderabad and Karachi.

Despite this, baseline figures of immunization in children less than two years of age and mother TT before any interventions reveal that only 69.5% of children aged 0-23 months received BCG; 61.9% received first dose of DPT; 96% received at least one dose of Polio; 56% children have received third dose of DPT; 60% children have received Measles vaccine; and only 35% mothers who have received two or more TT doses during last pregnancy. MMR, in 2009, in the district was 254 deaths per 100,000 live births and according to government reports, EPI coverage, in 2008, in the three UCs Miradabad, Dad Jarwar and Sheikh Moosa was 56%.

Initial needs analysis highlighted that low rates of immunization were largely due to lack of community understanding and parental awareness about the importance of the process. There was negative propaganda and myths about immunization that had to be shattered before the community could be convinced of its importance. Some people disregarded vaccines because „there was no such phenomenon as a vaccine in Islam” while others regarded it as a tool for infertility. Lack of acceptance of male vaccinators in a community marred by extreme poverty with limited financial resources, patriarchy and gender disparities also added to the challenges.

At services level, there was lack of availability of the required trained staff such as LHWs and vaccinators, lack of resources for transportation, weak management and low morale amongst staff due to delay in incentives coupled with excess workload. The BHUs and EPI centers were also far away; hence, accessibility was also an issue. This became a particularly stark issue when coupled with the fact that the people were extremely occupied in farming particularly at times of sowing and harvesting which made keeping up with vaccination doses a challenge.

At policy level, a comparatively greater focus on the Polio campaign as compared to the routine immunization was also identified as a barrier.

6.3 **INTERVENTIONS**

Aga Khan Health Services Pakistan (AKHSP), with funding from GAVI Alliance, accepted the challenge of enhancing access to immunization in difficult to reach communities. Community Health Workers were selected by the local CBO from each of the three UCs. The requirement for the selection of a CHW was: they should belong to the same area or a nearby village, affiliated with a CSO; male or female; aged between 20 years and above (preferably below 60 years); able to read; have respect in the community; and preferably those with previous experience in a similar role or those who have
any professional experience and/or certificate course in health.

Villages in the three UCs were mapped out. The project team made ocular visits to each of these areas with each CHW and health committee members. Each CHW was then assigned a package of responsibility and trained accordingly. The package included registration of families with a child below the age of 5, promotion of routine immunization in children and pregnant women, identification and management of malnourished children and promotion of family planning, skilled birth delivery, antenatal and postnatal care and social mobilization. Wherever there was a BHU present, CHWs were responsible for referring children to the nearby BHU for vaccination. Besides sensitizing the community, CHWs were also responsible for ensuring updated records of their assigned villages. For immunization, vaccination houses were established in hard to reach areas with a vaccinator visiting once a week.

The package of service designed was selected very carefully keeping in mind the monitoring of outcome indicators and denominators for measuring the progress of the program. Contracts were developed with each of the CHWs and with CBOs, clearly stating the terms and conditions of payment. Separate contracts for pay for performance were developed with the health care providers. Three cycles of trainings were conducted in counseling techniques and health education on importance of vaccination (EPI for children and TT for women of childbearing age), birth preparedness, community IMNCI (not clinical) and malnutrition rehabilitation. This was important not only to mobilize the community but also to ensure that the correct message was being communicated.

A process was developed which not only built the capacity of local community as monitor of the service and on the other hand, verified the performance from the data source (client registration form, ANC cards, delivery record signed by the skilled provider). Under the Pay for Performance scheme, once a CHWs performance was audited, the designated health committee member and the project team representative signed compensation issuance note. The incentive is a fee-for-service scheme with monthly or quarterly performance payments paid to the CSOs and CHWs based on the total number of incentivized interventions delivered in a month or quarter. After completion of the first stage of the program, the package of incentives was changed to only output-based indicators simplifying the payment to CHWs.

The project showed notable results in 18 months period. Out of a total of 49 CHWs, 36 were female. Separate targets and areas were allocated to men and women CHWs but they were also given the flexibility to work together. Working together as a team, male and female community health workers were able to cover a large area and influence male and female members of the household and the community. Analysis showed that in most cases male and female CHWs worked together in manner, which complimented each other’s roles. While men were able to take care of most of the documentation work, the female CHWs were able to reach out to women in the community and convince them of the importance of vaccination.

In comparison to 2008, routine EPI increased by 44% in the three UCs by December 2012 and 39,697 doses had been given at vaccination points or during vaccination campaigns by March 2013. Significantly, 100% of the children in the project area were registered and received BCG, first doses
of DPT, at least one of Polio, third doses of DPT and Measles vaccines. TT coverage for pregnant mothers in the three UCs had increased by 13.2% when compared to the baseline; around 21.6% of the children with severe malnutrition showed signs of improvement in terms of their nutritional status; and skilled birth delivery increased by 25.3%.

6.4 **BEST PRACTICES BY AKHSP**

6.4.1 **Sensitizing Community Leadership to Overcome Barriers at a Community Level**

As Tando Allahyar has a very conservative culture, it was important to engage the community leadership including religious leaders in the mobilization process. The community leadership was reluctant at first to allow women to go from home to home. However, when it was explained that women would be able to reach out to the women in the households to motivate them to vaccinate their children, a sense of responsibility erupted in their minds.

6.4.2 **Identifying and Training CHWs**

AKHSP team entered with the stakeholders in the community to develop mutually agreed criteria for selection of the CHWs. Identification of additional female CHWs participation was kept as a desirable target for the health committee. A training program was designed and implemented to educate the identified CHWs on community mobilization around immunization, skilled birth, malnutrition prevention and management of sick child at home.

6.4.3 **Bringing Male and Female CHWs Together to Work as a Team**

The project catchment area comprised community’s set against a background of patriarchy and restrictive cultural norms. The project was unique as it managed to empower women by not simply providing them with a source of income but also by changing the community’s perception about women being able to move freely within the society. Furthermore, the inherent flexibility of the project encouraged team approach, which in turn led to male and female CHWs coming together as agents of change and synergizing each other’s efforts.

6.4.4 **Incentivizing CHWs to take More Responsibility**

In the initial discussion, project team assumed that CHWs would be willing to take the responsibility of approximately 800 to 1000 of the population in line with the LHW program under Pakistan’s Primary Healthcare Initiative but this was not the case. However, as soon as the Pay for Performance concept was understood, CHWs were very keen to have larger areas assigned to them. Some of the CHWs took this task up as a full-time job. On an average 1,000 to 1,500 of the population was covered by each CHW.

6.4.5 **Mobilizing CBOs to fundraise in order to Ensure Continued Financial Support**

The project model is replicable in the context of rural Sindh and mobilizing CBOs to fundraise to ensure continued financial support for CHWs after the end of the project can ensure its sustainability. CBO RAHE, in Sheikh Moosa, is one of the examples of successful fundraising, which was able to bear the cost of two C-section deliveries that perhaps would not have been possible otherwise. Conversely, the Pay for Performance system is quite cost efficient and brings accountability in the system. If designed with care and carefully monitored, this approach can be implemented in a variety of settings.
Chapter 7 CONCLUSION

All the members of Pakistan CSOs Coalition for Health and Immunization want to make use of their full potential in order to improve the conditions of immunization in Pakistan. To overcome geographic shortcomings it is important to first strategize and then implement steps to improve upon the issue of immunization and mother and child health care.

It has been brought into notice that other CSOs besides the members of Pakistan CSO Coalition are working towards the goal of immunization as well and have proved themselves to be a success. These CSOs ought to be mapped and profiled in order to integrate them to the system based on their core skills.

To achieve the above mentioned objective strong governance structure and a transparent decision making system is required. It is also important to register the Pakistan CSOs Coalition which has been working informally and calling meetings on need basis so far. But all these efforts must be on country level. To maximize the working of the Health Department and the CSOs it is crucial to minimize the gap between the two. The areas of cooperation and potential of each stakeholder should be laid down in order to increase the effectiveness of work and chances of success.

It is also essential to clarify the role of CSOs in the provincial planning commissions and also engage them at all levels including review, monitoring and coordination meetings at district, provincial and federal level. This will help in joint efforts for common goals and will improve coverage of immunization and mother and child health care. It will also bring forward a balanced perspective from both the public and civil society. Although CSOs have been working independently and in joint coalition with the government on several occasions but it is important to set up a pilot project as examples of CSO-public partnership. This would allow us to refine and upscale for larger areas.

Joint efforts need to be recorded and documented for wider sharing. This would not only shed light on how important it is to integrate CSOs in our system but also promote a cost effective analysis.
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