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PAKISTAN

**RAPID ASSESSMENT
SOCIAL MOBILISATION IN UCI**

24 September-12 October 1989

UNICEF - Evaluation Office



ACKNOWLEDGEMENT

The team members gratefully acknowledge the valuable assistance of all those with whom they met during the mission. In particular, our warm thanks go to the National Institute of Health, the Federal Ministry of Health, and their partners at federal, provincial and local levels for their hospitality and insight. We owe Col. Mohammad Akram Khan special appreciation for his dedication and substantive knowledge shared with us. Our admiration goes to those who made substantial progress and those who are trying to make positive changes. The collaboration of the UNICEF Representative to Pakistan and his staff in Islamabad, Lahore, Quetta, Peshawar and Karachi offices and the intensive briefings organised for the first phase of the mission and provincial visits greatly facilitated the accomplishment of the mission.

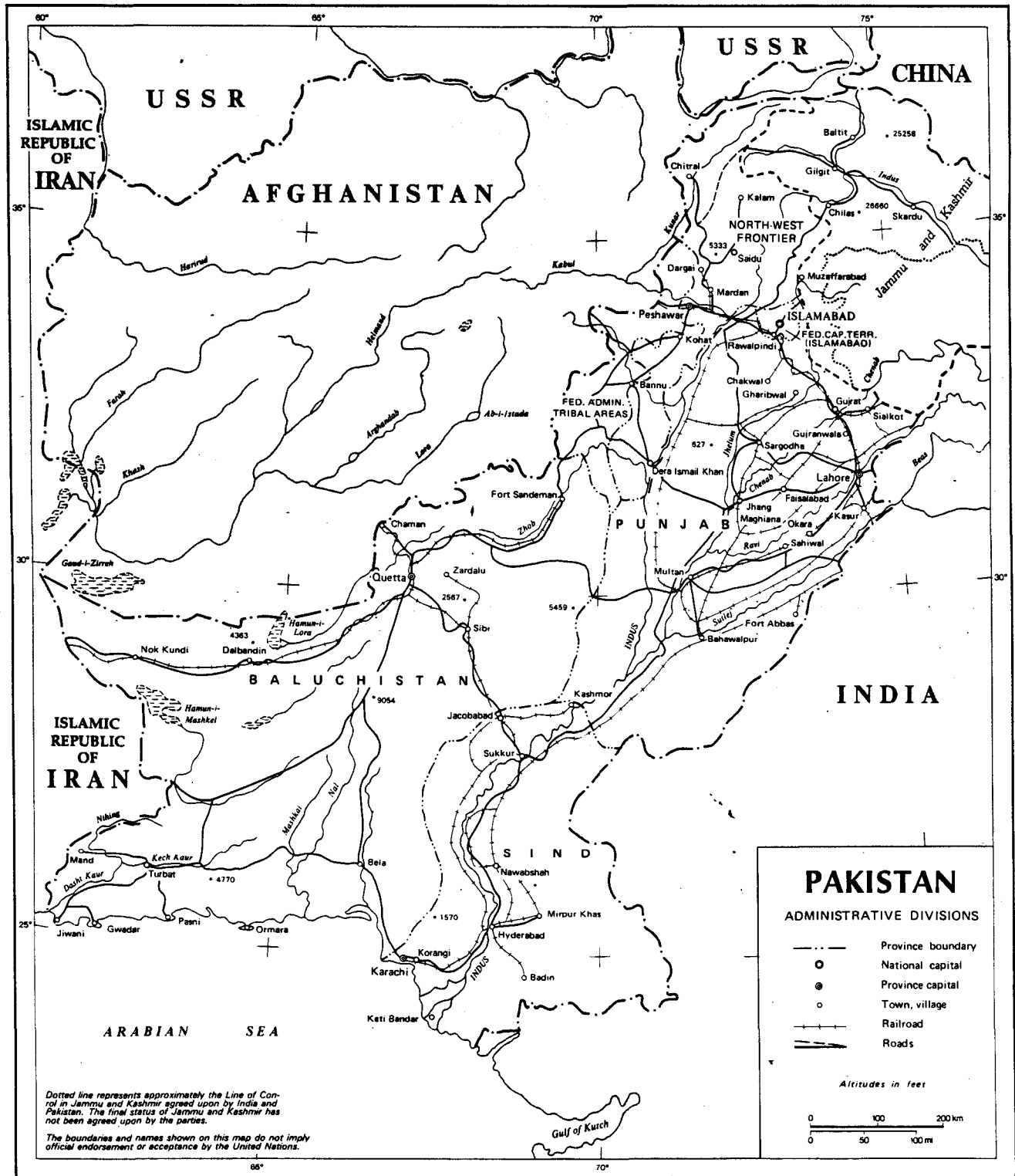


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EXECUTIVE SUMMARY

From 24 September to 12 October 1989, a UNICEF evaluation team conducted an evaluation of the accelerated EPI in Pakistan. Their mission was to assess the current status of the programme, determine how close Pakistan is towards reaching coverage targets set by UCI 1990, and to learn more about how the country has used various social mobilisation strategies to maximise coverage.

The evaluation team consisted of Steve Woodhouse, Chief, Training Section, M.L. Wickramasinghe, Communications Officer, Kampala, John Richardson, Consultant on media, and Ibrahim Jabr, Senior Programme Officer, Evaluation and Team Leader. After initial briefing in Islamabad, the team divided into two groups and each travelled with staff from UNICEF offices and representatives of the National Institute of Health (NIH) to assigned provinces. All provinces except the northern areas were visited. There, group members interviewed various health officials, TBAs, private physicians, government representatives, religious and traditional leaders, members of the media, and mothers and fathers of children. Prior to and during their field travels, team members read a wide range of relevant documentation, including previous coverage surveys, the current Plan of Operations, annual reports, and recent reports on immunisation activities. Briefing on the results of the mission was carried out in UNICEF-Islamabad and then at NIH in the presence of health, WHO and UNICEF federal and provincial staff.

Provincial performances varied considerably. Punjab, with the largest population of the five provinces, has maintained the most notably consistent levels of coverage, and employed a series of social mobilisation strategies that other provinces have not yet followed to the same degree. Sindh, the second largest of the provinces, has achieved a steady rise in coverage, but by its own most recent survey data still has a long way to go to reach full immunisation. The Northwest Frontier Province, one of the highest mountain regions in the world to the north, has experienced difficulties extending coverage to much of the province for political and geographical reasons. And Balochistan, with a thinly scattered population and weak infrastructure, has progressed very little on either coverage or social mobilisation. Coverage surveys conducted in 1988 estimated the national coverage for under-two year olds at 78 per cent, with all antigens above the 80 percent mark. But when measured by coverage of children under one, the national level is much lower, not exceeding 40 percent.

The main factors behind reaching these high coverage rates were:

1. Understanding cultural barriers: In order to minimise the impact of female seclusion (purdah) on service acceptability, it was decided from the outset to provide outreach vaccination services to those residing within 8-10 km from a health unit and send mobile teams to more remote areas. During the period 1982-1988, the number of fixed and "mobile" vaccination points increased to 1,876 and 3,752, respectively;
2. Translating political commitment into resource mobilisation: In 1982, federal and provincial authorities sought funding for the vaccination teams and incorporated it in the regular budget;

3. **Building on the experience of smallpox:** The approach to setting targets for vaccinating teams, supervising results, monitoring performance and instilling in the vaccinators the spirit of tracking beneficiaries has paid dividends, particularly in Punjab and recently AJK. This could be traced on several occasions to EPI personnel at provincial and district level who had been in the field operation of smallpox in Pakistan and abroad and who had previously used similar techniques in the eradication of smallpox.

The inability to reach the set targets was attributed to the following causative factors:

1. **Linking strategy to targets:** When the target age group was changed in 1986 from under-twos to infants, many children still received their vaccinations, and particularly measles vaccine after their first birthday. This stems from the fact that neither the frequency of visits of vaccination teams was increased, nor messages to parents modified to avoid delay in completing vaccination;
2. **Vaccination outside existing channels:** Vaccination services are not available in all BHUs, MCH centres, RHUs and hospitals. When available in curative centres, children are not routinely screened for immunisation when they seek curative care;
3. **Follow-up on dropouts:** Regardless of the coverage level, the team could not identify an existing system for tracing defaulters. Records are not consulted regularly to identify dropouts. Instead, outreach teams arrive in the village and wait for the clientele to come voluntarily.

With the exception of a mass media campaign conducted between 1983-85 at the initiative of the federal government and its international aid partners, social mobilisation has been inconsistent and limited largely to the initiatives of individual district health officers. Those efforts have been important, and have contributed significantly to the coverage levels that have been reached so far -- particularly in Punjab and Sindh. Punjab went further than any of the other provinces in its attempts to enlist the support of the traditional health sector, private physicians, non-health partners, and union councils. But even those efforts were characterised by appeals to a mass public to bring children for immunisation. Very little has been done to target messages to those who have proved hardest to reach, and there has been equally little in the way of education for parents. The concept of social mobilisation that has guided both UNICEF and the various health authorities has been too narrow to include enough of the kinds of innovations -- such as making social and religious leaders full partners in the campaign, or fully involving those from either the traditional or private sectors in an effort to expand coverage -- that will be needed if coverage is to increase much more and EPI is to be sustained.

The team concluded that while there have been signs of progress everywhere, they have not added up to enough to reach UCI 1990. This target may be reached if the health service seeks and receives an injection of support from non-health partners. Those include the federal government and social and political leadership at all levels.

What progress has been made is increasingly imperiled by current austerity measures and the changing priorities of international donors. A serious effort needs to be made to

broaden the health service's network of support and include other health practitioners, such as TBAs and private physicians, who already have access to significant parts of the population that the current government services do not reach. These measures would help ensure long-term sustainability of the programme.

That effort must be coupled with a systematised and targeted effort to identify those who have not had their children immunised and those who have defaulted. A strategy for early immunisation against measles is urgently needed to achieve UCI 1990. The health services have already provided services to a good percentage of those who can be reached through conventional channels with broad messages. Now they must concentrate on the much smaller percentage of people who have so far proved resistant to such efforts.

I. INTRODUCTION

Since the setting of the global target of Universal Child Immunisation by 1990 (UCI-1990), several countries have already implemented their plans and made progress in increasing immunisation coverage and reducing the incidence of vaccine-preventable diseases. The various programmes implemented have led to the development of a large reservoir of experiences. The Executive Director of UNICEF decided in late 1988 to review these experiences and focus attention on the role played by mobilisation in successful immunisation efforts. Six countries have been selected for this thematic evaluation. Two countries, Nigeria and Senegal, were assessed in May-July 1989.

One of the countries selected is Pakistan, which undertook a thorough review of its health services in the late 1970s and early 1980s. As a result, priority was given to development of preventive services. Funds were re-allocated from building one hospital to low-cost health interventions. Limited projects in the early 1980s led to an accelerated health programme (AHP), which was launched in 1983 in all provinces. It consisted of three major components: immunisation, control of diarrhoeal diseases through oral rehydration and training of TBAs. After 1985, the programme was integrated into the health delivery system. Extensive programme reviews were conducted in 1984, 1987 and 1988 which included immunisation coverage surveys in all provinces.

Pakistan has accumulated knowledge and experience from various accelerated activities in its promotion of immunisation in different geographical and socio-cultural environments. This assessment focuses on this activity and draws lessons that can be derived for subsequent similar activities. It focuses specifically on the role of mobilisation in increasing coverage and assesses to what extent the lessons derived were internalised and systematised. (Appendix 1 gives the terms of reference of the task force for the countries under study). The scope of this study was kept broad in an effort to look at immunisation from both historical and cultural perspective, and to derive lessons which may have applicability to other PHC components.

II. METHODOLOGY

The rapid assessment procedures (interviews, observation, focus group discussions) were the guiding principles for this evaluation. The team took as a point of departure the results of the comprehensive surveys conducted in 1984, 1987 and 1988, and vaccination reports in 1989 when available. The National Institute of Health (NIH) and UNICEF provided the team with a rich set of documents on the programme since its inception. Field visits were made to allow direct observation and establish contacts with administrators, providers, communities and users.

The selection of sites for field visits was based on the following:

- Due to the decentralised structure of the administration, the team had to establish contact with as many provinces as possible. Given the time limitation, the team spent about 5 days in each of the four provinces of Punjab, Sindh, NWF and Balochistan. A one-day visit was made to AJK province;
- An effort was made to cover urban and rural areas and when applicable tribal areas;
- An average of three districts were selected from each of the four provinces. The district is an important operational and administrative level of health service delivery.

Appendix 2 gives the detailed timetable of the mission. The team had intensive briefing sessions in Islamabad at NIH and UNICEF offices during the first two days. The team then divided in two groups, each of which visited two provinces for 10 days. During this period, each group had briefings from provincial authorities, visited tehsils, union councils, villages, urban neighborhoods, and spoke with local leaders, health providers and families (see Appendix 3 for the administrative structure in Pakistan). Before leaving the province, the group held a briefing session with the provincial Health Secretary and officials on the findings and recommendations. An exception was made in Balochistan where this meeting was chaired by the Chief Minister in the presence of the two Chief secretaries, the Minister of Health, Secretary of Finance and senior health officials. Appendices 4 and 5 give the composition of the team and field groups and the list of key persons met. The team reconvened in Islamabad during the last week to prepare the draft report and hold briefing sessions at NIH and UNICEF.

To make the report useful to federal and provincial authorities, it was decided to divide it into sections that deal with:

- thematic and common issues on service delivery and impact, and mobilisation;
- provincial summaries on achievements, shortcomings and recommendations. No summary was prepared on AJK due to the short exposure of the group to the province;
- conclusions and recommendations focusing on common issues, policy implications and sustainability.

III. FINDINGS

This section of the report aims at analysing the achievements and constraints in the programme's pursuit of Universal Child Immunisation (UCI) and its effort to reach national and provincial targets. It is important to note how provinces were or were not able to accommodate the strict standards set after 1985.

A. Achievements

Pakistan achieved substantial progress towards reaching UCI. Its strategy consisted of three phases:

- 1982-1985: immunising under-fives and pregnant women by implementing the programme in a vertical manner;
- 1985-1987: focusing on the immunisation of under-twos and married women of child-bearing age (MWCBA) and integrating immunisation in health services;
- 1988-1990: ensuring full immunisation of infants, and covering the backlog of children of 12-23 months of age while maintaining its target for women.

The survey conducted in 1984 showed that the coverage in Punjab province increased from 2 to 80 percent. Similar surveys in 1987 and 1988 reconfirmed the high performance of Punjab and estimated the national coverage in 1988 at 78 percent for under-twos, with all the antigens higher than 83 percent. All provinces except Balochistan had their coverage per antigen above 80 percent. Figure 1 shows the coverage trend for each province during the period 1982-1988.

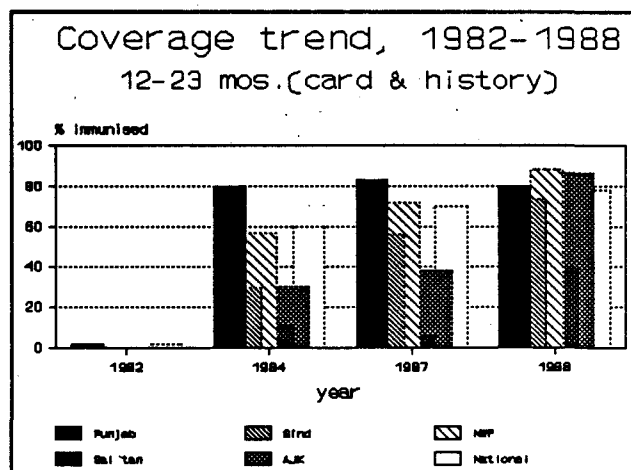


Figure 1

Another important development has been the drastic reduction in dropout rates between DPT1 and DPT3 which decreased nationally from 31 percent in 1984 to 8 percent in 1988. As depicted in Figure 2, the most dramatic decreases occurred in Punjab, North-Western Frontier (NWF) and Azad Kashmir (AJK) provinces reaching around 5 percent. Sindh province followed the same path but its dropout rates did not go below 16 percent. There was a minimal decrease in Balochistan.

Similar achievements were made in relation to Tetanus Toxoid. Coverage rose sharply in 1984, underwent minor increases during the period 1984-1987 and picked up momentum again in 1988. Figure 3 shows progress at provincial and national level. It is

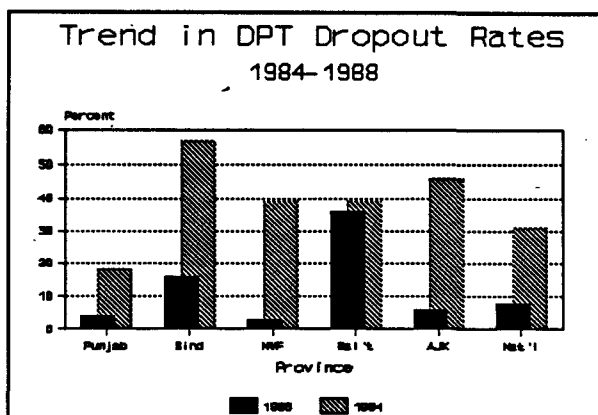


Figure 2

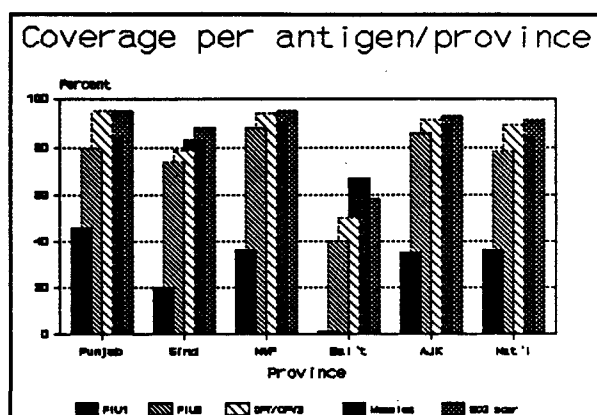


Figure 3

worth noting that while the target group was MWCBA's, coverage surveys conducted to date were limited to mothers of target infants.

Tables 1-4 (Appendix 7) give the breakdown of targets by antigen, province, year and age group. Since these were calculated on the basis of fully immunised children, it can be concluded that NWF, Sindh and the country as a whole met the 1987 targets set for children of 12-23 months of age.

With regard to TT, while targets set for 1988 nationally and for A.J.K, Punjab, and Sindh were met, results should be treated with caution for the following reasons:

- the 1988 figures based on vaccination cards are slightly more than one half those based on card and history;
- since there is no specific TT card for women, those vaccinated prior to or during pregnancy have their vaccination recorded on a vaccination card for children. Those who get vaccinated after delivering have the information noted on the vaccination card of their infant. Since coverage surveys checked the vaccination status of mothers of target infants, it may be possible that percentages were calculated with many MWCBA's as part of the numerator while the denominator was pregnant women.

B. Present Status of Coverage

It is important to point out major discrepancies between the very good results of the coverage surveys mentioned above and more recent statistics provided by provincial health departments in some provinces, notably Sindh and NWF. The observations made by the team fully support and are consistent with the findings of the provincial authorities that

coverage is presently substantially lower than the survey results showed. In Sindh, the figures reported for the period July 1988-June 1989 (see Table 5, Appendix 7) give a coverage of 50.9 percent for the best antigen (DPT3) in the best district, while others are much lower. One of them, Thatta, showed only 17.3 percent coverage for the best antigen (BCG). In NWF province, nearly all senior officials, including the Governor and the Commissioner of Peshawar and tribal areas spoke frankly of the real difficulties in reaching 50 percent of the province. This was attributed to geographical, political and socio-cultural constraints.

C. Contributing Factors to Progress

The team identified several key factors which contributed to these achievements. Some of these were common to all provinces while others were province or district-specific.

1. Understanding cultural barriers

It is estimated that, prior to 1983, less than 20 percent of the population was using public health services, particularly those at peripheral level which offer preventive care to children and women. This stems from the tradition of purdah (female seclusion) which does not encourage women to leave their houses except for normal chores and emergencies. In order to minimise the impact of such attitudes on service acceptability, it was decided from the outset to provide outreach vaccination services to those residing within 8-10 km from a health unit and send mobile teams to more remote areas. During the period 1982-1988, the number of fixed and "mobile" vaccination points increased to 1,876 and 3,752, respectively. The increase in the number of lady vaccinators and their recent deployment in outreach and mobile teams also helped make the service more socially acceptable. It is estimated that in 1988 44-66 percent of urban and 75-98 percent of rural population received vaccination from outreach or mobile teams.

2. Translating political commitment into resource mobilisation

In 1982, the federal and provincial authorities conducted an extensive programming exercise for EPI which identified the most viable strategy for service delivery, staff requirements and relevant budget forecasts. Based on these, it was decided to seek funding for the teams and incorporate it in the regular budget. Provincial health officials presented their proposals to their counterparts from Finance and Planning and obtained a commitment (PC-1) for the plan period. It was then necessary to follow up on the annual budgetary allocations to ensure the continuity of funding.

3. Building on the experience of smallpox

The dynamic approach to accelerated EPI could be traced on several occasions to similar techniques previously used in the eradication of smallpox. The team met EPI personnel at provincial and district level who had been in the field operation of smallpox in Pakistan and abroad. Their approach to setting targets for vaccinating teams on monthly and sometimes daily basis, supervising results, monitoring performance and instilling in

the vaccinators the spirit of tracking beneficiaries has paid dividends, particularly in Punjab and recently AJK.

4. Individual initiatives involving the private sector

Some provinces succeeded in attracting the private sector. In Punjab, the Ministry agreed with private hospitals and practitioners to supply them with vaccines and related supplies. In return, the private sector was required to report periodically on the number of children and women vaccinated and the incidence of vaccine-preventable diseases. The replenishment of stocks depended upon receipt of reports on the previous period.

5. Individual initiatives for sustaining coverage

While Punjab managed to maintain its coverage on annual basis, review of monthly records of 1988 and 1989 shows that increases in dropout rates and failure to meet monthly targets were corrected by launching mini-campaigns. This is a clear indication of the high quality of management and supervision in the province. However, such an approach raises some doubt about the value and affordability of this technique to ensure sustainability on a permanent basis.

D. Shortcomings and Constraints

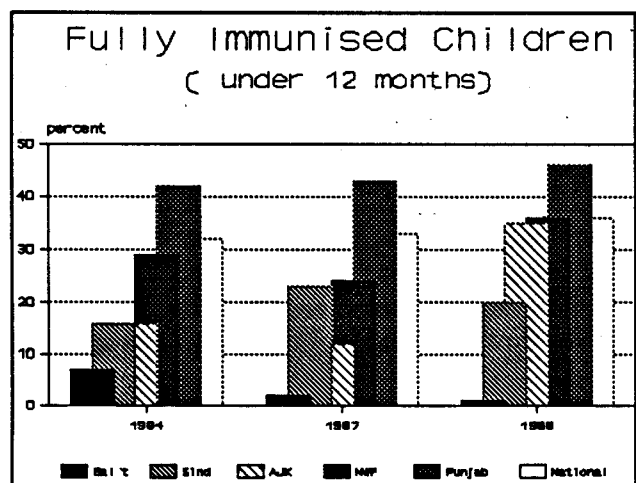


Figure 4

While Pakistan was successful in meeting the targets set nationally per antigen for the under-twos, these targets could not be met in some provinces. The programme also fell short of reaching national targets after the target group was limited in 1986 to infants. Figure 4 shows that, despite acceleration, coverage of the under-ones never reached 50 percent even in the most promising provinces. Balochistan dropped to pre-1983 levels. Sindh did not maintain its 1988 level. It was estimated that not more than 36 percent of infants completed their vaccination in 1988 before reaching their first birthday. The situation becomes more serious if data is based on vaccination

cards. The provincial and national target will not be met by the end of 1990 if conditions remain unchanged.

Review of existing documentation supplemented by discussions at federal, provincial and local level and field observation helped to identify the following causative factors:

1. Linking strategy to targets

The strategy of outreach and mobile services was originally selected when the target group was children of the 0-2 years age group. During 1982-1985, teams had ample time to administer the 6 vaccine doses to children before completing two years of age. Each team visited the village once a month. It was therefore highly probable, barring any accident or active resistance from parents, that these visits would result in vaccinating the child against the target diseases, including measles, before completing 2 years of age. However, with the focus on infants starting in 1986, it became necessary to administer measles vaccine during one of the three visits made when the child was 10-12 months old. When asked about reasons for defaulting, parents cited minor sickness, physical weakness, and lack of knowledge on the need to vaccinate the child by one year of age. Some of the vaccination teams were not aware of the necessity to complete measles vaccination before the first birthday. It was clear that neither the frequency of visits was increased, nor the messages to parents modified to avoid delay in completing vaccination. The low proportion of fully immunised infants was caused by this misunderstanding. However, examination of health centre records showed that few children had received their BCG and DPT/OPV doses late but results of the 1987 and 1988 coverage surveys as presented could not support or contest this observation.

2. Vaccination outside existing channels

Vaccination services are not available in all BHUs, MCH centres, RHUs and hospitals. When available in curative centres, children are not routinely screened for immunisation when they seek curative care.

3. Follow-up on dropouts

The team could not identify an existing system for tracing defaulters. While records of fixed, outreach and mobile teams are well kept, these are treated as archives rather than reference. Instead of preparing a list of potential children for vaccination and defaulters prior to reaching the village, outreach teams arrive in the village and wait for the clientele to come voluntarily.

4. Province-specific issues: administrative and managerial problems

The overlap of managerial responsibilities in Balochistan and an inability to secure annual financial allocations for the recruitment and mobility of outreach teams are dealt with in the provincial summary.

IV. MOBILISATION FOR EPI

TRYING TO REACH A MASS AUDIENCE

A. Initial Efforts

While Pakistan's experiences with social mobilisation differ from province to province, there have been two major efforts that have had national impact. It is generally agreed that the most significant factor contributing to increased coverage was the introduction of outreach services and mobile teams, mentioned earlier in the report. The other major initiative was a campaign to inform the public about the availability of services.

Shortly after the start of the accelerated health programme in 1983, a federally initiated media campaign was launched that generated an enormous number of radio and television spots. While it is difficult now to quantify the impact of the campaign, it is agreed that it contributed greatly toward making immunisation part of a basic social literacy for many educated people. Just how many it reached and how well the messages were understood and retained are not clear.

The bulk of the funding for the media campaign was spent between 1984-1986 -- over three years ago. But since then there has been no campaign of similar magnitude. If the original initiative had been sustained and aimed at Universal Childhood Immunisation by 1990, it has been argued, a mass media campaign and an accompanying mobilisation of political, social, and religious leaders would have been scheduled to reach a peak sometime toward the end of this year or the beginning of next. But this has not happened.

B. Limitations of Media Outreach

While the media campaign was helpful in increasing awareness, it was a general approach that was not tailored to particular audiences. It reached those who had no particular objection to being offered immunisation services. It was neither accompanied nor followed by any particular effort to identify and reach those sectors of the population which because of social custom or educational level were not responding. There was no systematic mobilisation of the religious and social leaders and civic organisations that had access to these sectors and could lend greater credibility and meaning to EPI.

As channels of communication, the media are limited. Newspapers cater to the understanding and interest of an educated, literate minority. While television and radio reach a larger audience, among whom are many who are illiterate, there is no way to control the response with any certainty. As a means of reinforcing a more targeted mobilisation, experience has shown that media campaigns can be very productive. In this case, it helped prepare the ground but was not followed by any real refinement of the process on a national basis.

C. A Narrow Concept of Social Mobilisation

Much of the difficulty now seems to lie with the original concept of social mobilisation. Too many of those interviewed by the team did not look beyond basic attempts to reach an undifferentiated, mass audience. Many seemed to equate the term 'social mobilisation' with mass media campaigns. While this may be changing in some places, there is little evidence that it is happening either quickly or on a wide scale. Communication on immunisation to date has been one-way. Messages have been amplified in the public arena, but not enough interpersonal work has been done.

TARGETING MESSAGES

D. Passing Messages Through Other Channels

Notable efforts have been made by some health officials to promote immunisation in their communities. They have concentrated for the most part on finding ways to pass on information about when and where immunisation services would be offered. Those outside the health services whom they have enlisted to help have tended to be message carriers, but there is little evidence that they have been encouraged to be much more than that. In both Punjab and Sindh, these efforts have been essential to a gradual increase in coverage, but go only part of the way towards reaching those groups that are hardest to reach.

In one district in Sindh, mobilisation efforts went beyond the use of media. Information on immunisation was distributed at railways stations, in banks and through the mail. Literate children were sent home from school with messages for their parents, and school medical officers were asked to devote time at school to education. Parent meetings were held. But the same people who initiated such efforts also noted that there is still a considerable lack of motivation among certain parts of the population that has not been overcome.

In Punjab, health officials relied on other channels to spread word of immunisation - including village elders, religious leaders, and teachers. They have recently begun to use traditional birth attendants (TBAs) and female school teachers to tell mothers to come for TT immunisation. This is one of the first concrete examples of an effort to use a communication channel that is particular to its intended audience. But health authorities have not reached out to the traditional sector, nor have they put enough importance on explaining to those whom they want to pass on messages why immunisation is so important.

There are encouraging signs that in some places the health services have begun to find ways to target hard-to-reach audiences. Female vaccinators are being used around the country to reach women whom social custom prevents from being vaccinated by men. In Karachi, the introduction of female vaccinators is being coordinated with media and non-governmental outreach. There are other provinces -- NWF and Balochistan -- where such coordinated campaigns have not yet been done.

It was clear to the team that for much of the public, immunisation is still not a top priority. Other more immediately tangible concerns -- such as sanitation, diarrhoea control,

in one case respiratory and eye problems from air pollution near a cement plant -- take priority. Preventive measures are much harder to grasp, particularly for people who are given no particular reason to believe in them. People need to be convinced, and for those that have so far been unconvinced by standard techniques of passing on information from a government agency, they need to be convinced by people they respect and trust.

E. 'Person-to-Person' Communication

But there is uncertainty as to how to move from addressing a mass audience to addressing the more individualized needs of families -- the only level at which most are likely to be ultimately convinced. Most of those who were asked about this by the team said that 'person-to-person' communication was ultimately the only way to convince people, but it was often unclear what that meant. Very few were willing or able to decide whose responsibility this would ultimately be.

In the end, it is the health worker -- in this particular case the vaccinator -- who is the ultimate bearer of the message. His interaction with the parent and child is precisely the time at which they are most vulnerable and in need of explanation and support. But evidence suggests that the large majority of vaccinators are ill prepared for this task. They have been trained to perform a technical skill, not to be communicators.

So far the health service has not turned to TBAs and private doctors, both of whom service many of those who do not use government health services. TBAs are among those in the traditional health practices who have an understanding of and credibility among those living in villages and remote areas, as are many private doctors. With proper orientation, they represent an existing army of health workers who could contribute enormously to the spread of immunisation.

They also have not done enough to understand health care users. Sufficient effort has not been made to understand who these people are, why they have not had their children immunised, and what their understanding of health is. They have not been the object of a special set of inquiries. Nor have health workers been trained or encouraged to develop an ability to elicit such information when they come in contact with parents and children.

V. PROVINCIAL SUMMARIES

This section is intended to provide information to provinces that can be useful for programme development. Summaries have been prepared for Punjab, Sindh, NWF and Balochistan.

SUMMARY REPORT-PUNJAB

I. Introduction

Punjab is the second largest province geographically. According to the 1981 population census, it has 56.5 percent of the country's population, of which 28 percent live in urban areas.

The team visited the province during the period 25-30 September 1989. During the visits, discussions were held with the senior health officers at the provincial ministry and visits were made to the three districts of Gujranwala, Okara and Sahiwal. There, team members talked with health providers, local administrative and traditional bodies and families of beneficiaries. A meeting was also held with the Lahore immunisation council, which was interested in TT immunisation in urban areas.

II. Achievements

Achievements during the period 1982-1989 can be summarised as follows:

1. Trends in coverage

Impressive coverage results were achieved in a short period. Coverage rates for under-twos rose from 2 to above 80 percent in 1984, thus reaching UCI targets. High coverage rates have been maintained to date. Similarly, coverage rates of infants have steadily increased.

2. Service accessibility

Services became easily accessible through outreach activities from fixed centres and mobile teams.

3. Involvement of private sector

An agreement was reached with the private sector, including private hospitals and those run by NGOs and missions. The health directory provides vaccines and the private sector reports periodically on children vaccinated and incidence of vaccine-presentable diseases.

The private sector also contributed to health education. One matchbox company sponsored the printing of posters on EPI. One of the leading publishing houses in Urdu covered the costs of a workshop on child care to orient journalists on child care practices with particular emphasis on immunisation.

4. Awareness of services

The team saw evidence of widespread awareness in the province. In all interviews with citizens and villagers, the team felt that health services were well known, and that people were aware of vaccination services and their location.

5. Involvement of traditional health providers

The recent involvement of TBAs as promoters of TT vaccination in particular and child immunisation in general is an important development. In a community where 80 percent of deliveries are attended by TBAs, their credibility in their community surpasses by far that of a formal health worker. Their potential role as communicators and motivator has recently been acknowledged by public health services. After completing their training, TBAs can play a vital role in their communities in promoting immunisation.

III. Underlying Causes of Success

1. The smallpox spirit

The management comprises a number of persons who served during smallpox eradication. Their previous experience in dynamic service delivery and their vision of EPI as a similar challenge are favourable factors in the present programme.

2. Management: linking progress to targets

Management has successfully instilled the notion of target population and coverage on annual and monthly basis to its vaccinators and supervisors. These two sets of data were frequently referred to. Difficulties in meeting targets led to mini-acceleration activities, particularly in May-June 1988.

3. Addressing cultural problems: mobilisation of providers

Pakistan has socio-cultural values which discourage women from leaving their homes except for emergencies. Consequently, a strategy was adopted from the outset to move the service closer to the target population through outreach and mobile teams. This early action played a vital role in increasing service acceptance.

4. Institutionalising outreach: resource mobilisation

Punjab Province made political commitments to UCI similar to those of the Federal authorities. Unlike other countries which usually provided temporary material and financial support to additional personnel for UCI, Punjab translated the political commitment into resource mobilisation by building in the regular budget funds required for outreach and mobile teams.

5. Interplay of mass and inter-personal communication channels

It was not possible at this stage to accurately assess the impact of mass media on coverage during the initial period of the acceleration. Nevertheless, the RS. 20 million spent from the provincial budget on education through press, radio, TV advertisement, posters, leaflets and billboards undoubtedly attracted the attention of those who had no basic objection to immunisation being made available at their doorstep. Fathers interviewed considered the broadcasting of messages over the radio as an indication that immunisation is nationally accepted as beneficial to children. Others said that while radio is a propaganda organ, the neutral nature of health allows these messages to retain credibility.

During the visits to the three districts, mothers in health units, villages, and urban neighborhoods identified inter-personal channels as their immediate source of information on immunisation. The same applied to a group of fathers interviewed for the same purpose. These channels can be divided into two categories:

- "localite" channels: informal channels of village elders, religious leaders and TBAs who enjoy the trust of the community;
- "cosmopolite" channels: personnel from the formal sector, such as vaccinators, lady health visitors, and sometimes teachers who normally are outside the immediate communication environment but possess technical knowledge necessary for informing and educating the user.

The ability to integrate the two channels in a harmonious manner helped families acquire basic information and consider immunisation a socially acceptable practice.

The mass media was first used to saturation. Inter-personal channels then came to the forefront while mass media has been playing a supportive role.

6. Promising beginnings: involving non-health personnel

Recent acceleration of TT saw the introduction of a new dimension to mobilisation. In Gujranwala district, female school teachers were immunised against tetanus and had their children fully immunised. This well planned and conceived approach reached the different hierarchies of the education department and led to the involvement of the school system in communication and motivation. This approach appears to have good potential for replication in other districts.

IV. Shortcomings

1. Vaccine shortage

There were occasional vaccine shortages during previous years. These were particularly reflected in the drop in BCG coverage in 1988.

2. Synchronisation between strategy and target group

Since 1982, UCI has had several revisions of the target groups. Originally, the project focussed on under-fives. In 1985, the age group was narrowed down to under-twos. In February 1988, it was decided to focus on infants. But this did not lead to a change in the vaccination strategy. Outreach and mobile teams which used to visit villages once a month did not increase the frequency of their contact with their target population. This meant that in cases of illness or poor follow-up, there was a greater chance for an infant to miss his measles vaccine before his first birthday.

3. Availability of vaccination services

Vaccination services are not available in all service delivery units. All MCH centres and BHUs do not offer such services. This raises a question about the kind of child services in MCH centres.

4. Integration of services

While vaccination teams were found in outpatient clinics to cover non-immunised children and women, they did not motivate the families to get vaccinated. Checking of vaccination records is not practiced.

5. Follow-up on dropouts

There is no established system of follow-up on defaulters. Outreach teams do not review their records upon arrival in a village and prepare a list of children who need to be vaccinated and those who defaulted during the previous visits. Village leaders, TBAs and chokidars are not involved in contacting the target children.

6. Creating a sense of dependency

The outreach approach in urban and rural areas was a major factor behind achieving high coverage rates. But, in the long run, this may help encourage an attitude among the population that services should always come to their doorstep.

7. EPI, an exclusivity of the Health ministry

During the period 1982-1988, the project was designed, co-ordinated, funded and implemented by the Health Ministry. The role of other bodies was not perceived.

8. User problems and message targeting

Messages to date have focussed on providing general information to the public such as EPI diseases, dates and venue of vaccination sessions, news about teams, vaccine doses. With progress in acceleration, the content and type of messages remained unchanged. Messages specifically addressed to dropouts to result in behavioural change were not developed.

The necessity for a change in the approach is governed by the quality of the knowledge of mothers on immunisation. None could name the 6 preventable diseases. Most knew that immunisation saves lives but could not link immunisation to disease prevention. Some women accepted immunisation as a result of pressure brought about by inter-personal channels.

V. Recommendations

1. Success can be sustained and consolidated through the following measures:
 - taking a more aggressive approach to integrating immunisation in curative services: children and women should produce a vaccination card before receiving curative services; patients falling in the target group should not be discharged from hospital before having their vaccination status updated;
 - broadening the scope of outreach by having LHVs visiting the village with the vaccinator and providing pre-natal and post-natal care and nutrition education, and establishing contact with the TBA;
 - shifting EPI services carefully and gradually from outreach to fixed centres through mobilisation and communication.
2. Much more can still be achieved with existing resources. By implementing the following, more frequent contacts can be made with each village or more villages can be covered by the same team:
 - improving information on target groups at village level: the starting point should be new pregnancies and births available with the TBA and chokidar, and dropouts obtained from records;
 - using the village leader for motivating users: this method is expected to reduce dropout rates, increase measles coverage and shorten the time spent by the team in each village;
 - involving union councils: reporting to them during the meeting on achievements, identifying problems and agreeing on the type of support required from the council members. Giving responsibilities to the council in problem solving will get them more actively involved in EPI acceleration.
3. The acceleration strategy should now move from the stage of creating awareness (information) to changing attitudes. The communication content and strategy should be:
 - responsive to specific knowledge gaps, concerns and problems of users. This can be accomplished through simple KAP studies on the community, feedback from health providers such as vaccinators, LHVs and TBAs, consultations with influential persons like village leaders and teachers, and through more informal channels;

- designed to educate the family on the importance and benefits of immunisation, and its role in preventive health. This will help develop positive attitudes and make prevention an integral component of the health of the family. This can be made possible by a conscious shift in the strategy of message design to accommodate feedback from users through the channels described above.

SUMMARY REPORT - BALOCHISTAN

I. Introduction

The province is the largest geographically. According to the 1981 population census, its population is mainly tribal, rural and nomadic. It constitutes 5.1 percent of the national population, with 15.6 percent residing in urban areas.

The team visited Balochistan during the period 30 September-5 October. It held extensive discussions with the Additional Chief Secretary- Development, senior officials in Health, TV, radio and printed media, visits to Quetta slums, and districts of Moslembagh, Loralai, Ziarat and Mustung. The roundup meeting was held with the Chief Minister, the two Chief Secretaries, the Health Minister, Secretary of Finance and senior health officials.

II. Present situation

The status of immunisation is characterised by high dropout rates, coverage which reached 40 percent for the under-tuos in 1988 but has recently decreased substantially, and an absence of acceleration activities outside expansion of services. Despite this grim picture, the province has a strong tribal and cultural structure which can play a positive role in mobilisation. As a result, the team decided to quickly identify the contributing factors but devote its attention to demonstrating methods of mobilising providers, leaders and users and assist in outlining the strategy for the coming 9 months.

III. Contributing factors

Several factors behind this low immunisation status were identified. These can be summarised as follows:

1. UNICEF's passive role in the past: the project was conceived as a standard EPI activity. There is no clear indication of active involvement in project implementation and follow-up, particularly at district and local level;
2. Lack of motivation at the top: the duality of responsibility between the Deputy Director-PHC and the EPI project manager led to practical neglect of the project. Plans were not made, budgets were not prepared, submitted in due time or followed up. As a result, additional personnel required for outreach and mobile teams could not be recruited, and existing teams made limited field visits due to delay in the release of travel and subsistence allowance. Both senior officials seldom went on supervisory visits.
3. Role of the district health officer (DHO): In the absence of guidance, the performance of DHOs varied depending on their own interpretation of their role. Some were under the impression that EPI was still run in a centralised manner as in the period 1982-1985, with outreach and mobile teams directly attached to Quetta. Others saw in the decentralisation process in 1985 a move giving them authority over cold chain and transport and keeping responsibility in Quetta. None felt that they had a supervisory and training

role vis-a-vis vaccination superintendents and vaccinating teams. The concept of mobilising local leadership and communities was non-existent.

4. **Role of service providers:** While vaccination was a responsibility of several categories of health workers, the following problems were identified:

- MCH services were not involved in vaccination;
- Curative services did not systematically check the vaccination status of children and mothers and ensure that the required doses were given before discharge;
- EPI services, whether static, mobile or outreach , were perceived as passive, consisting of services made available to users who were left on their own to decide whether or not to take advantage of such services;
- Outreach teams and LHVs go separately to the same village and there is no information exchange between them;
- There is notable neglect of follow-up, resulting in dropout rates of 60 percent in some cases;
- The target groups and vaccination schedule were sometimes not clear to vaccinators;
- Vaccinators did not see a supportive and promotive role for non-health personnel in immunisation.

5. **Poor understanding of users:** Those in the delivery system had limited awareness of the beliefs and attitudes of their communities. The following were not incorporated or addressed:

- traditional misconceptions, such as that vaccination harms children, interferes with pregnancy, or is a form of birth control;
- the decision-making process at village and household level, particularly the important roles played by males and mothers-in-law in conveying information and reaching decisions;
- use of the mass media to address problems and speak to decision makers and message conveyors;
- misconception about when to vaccinate a child: some mothers believed that the child should be strong in order to qualify for vaccination.

IV. Recommendations

Despite the difficulties described above, the team felt that there was potential for inclusion of the top administration and the strong tribal structure in helping to redress the situation in the next 9 months. The following actions might help in this regard:

1. **Revise the concept and re-structure the management of EPI services. This includes:**
 - assigning responsibility for the project to one person: he will be responsible for preparing, submitting and following up on the annual budget and its distribution among DHOs; he will report monthly to the executive committee on status and progress of the project; he will identify problems and determine what support is required from the committee;
 - adopting a field-oriented approach in management: he should spend a major portion of his time on field visits, supervising DHOs, and providing guidance in mobilisation and training;
 - broadening the base by involving non-health sectors in the co-ordinating committee and political and religious leaders in mobilisation;
 - ensuring a more active partnership from UNICEF, particularly in assigning specific districts for staff to visit and participate in mobilisation and monitoring;

2. **Train the DHO to become a manager, promoter and communicator. He is required to play a pivotal role in mobilisation and management of immunisation:**
 - as a manager, by planning district activities, supervising and training DSVs and vaccination teams; integrating curative and preventive activities in static health units, completing the recruitment of teams and deploying existing vaccinators to outreach and assigning new recruits to static centres; synchronising the outreach work of vaccinators, LHVs and TBAs; reviewing the schedule and results of vaccination teams while taking into consideration the seasonal movement of semi-nomadic groups, monitoring dropout rates;
 - as a communicator, by establishing contact with traditional and religious leaders to introduce the team, agree on a strategy for achieving full coverage and identify how they can provide support; to monitor progress in their community and help vaccinators gain confidence and acceptability; to identify causes behind defaulting to help target messages;
 - as a mobiliser, by mobilising providers, leaders and users; establishing a rapport with union councils, the school system and other non-health sectors; training vaccinators and their supervisors in mobilisation techniques, and establishing contact with the local leadership;

3. Select the target population. To ensure optimum results in the light of existing and expected resources, the project should concentrate through June 1990 on the following:

- Urban areas (about 8 percent of total population) and large rural agglomerations (about 50 percent of the population). The remote areas and hamlets could be reached when additional resources become available;
- Under-twos and married women of child-bearing age. Providers and users should be persuaded to vaccinate their infants at an early age.

4. Ensure the mobility of vaccination and supervisory teams. Vehicles which were originally provided for mobile teams and are either off-road or misappropriated should be returned. In areas where transport cannot be secured by the DHO, local communities can be approached to transport vaccination teams to and from the village based on a pre-determined schedule.

5. Optimise the use of media. While inter-personal communication is the primary channel, mass media - especially radio and in urban areas TV - can play a supportive role by re-enforcing messages given through traditional channels. In view of the large radio audience, particularly among males, the following guidelines need to be taken into account:

- Messages should be targeted to fathers/husbands in particular and parents in general. This takes into consideration that female mobility for purposes other than traditional chores is decided by male members of the family;
- Programmes should address the respective ethnic groups in their own language, using their own idiom, other salient features of their culture and perhaps one of their leaders;
- Programmes on immunisation should address the concerns of people regarding immunisation, rather than providing general information on vaccination. An effective programme would directly address the father on his obligation to ensure full immunisation of his children.

SUMMARY REPORT - SINDH

I. Introduction

Sindh is the second most heavily populated province in Pakistan, with approximately 23 percent of the country's population. It has a larger percentage of urban population than any of the other provinces, most of which is clustered on the banks of or in the irrigation areas near the Indus River. It also has a widely dispersed rural population, which lives in approximately 68,000 small settlements. The province's largest city, Karachi, has a population of well over seven million, which account for at least a fifth of the country's urban population.

The evaluation team visited three of the province's four major urban areas between September 26-30. They spoke with various representatives from provincial and district health services, non-governmental organizations, the media, and private medical practitioners. They also visited villages near two of the urban areas -- Sukkur and Larkana -- where they talked with teachers, a dai, and representatives of a newly formed village health committee near Sukkur.

The team found that the basic health infrastructure was generally sound and met some very committed and competent health officials. But it also found that the current system is limited in its access to the population, particularly those who have proved themselves unresponsive to government services or too isolated to take advantage of them. Recent efforts to increase coverage in urban areas, which had been neglected earlier in the decade when the focus of the EPI was on rural areas, have only recently begun and are difficult to assess with anything beyond speculation.

II. Positive Features

The successes of Sindh's EPI to date can be attributed largely to the following factors:

1. High Awareness of EPI

There is a high level of awareness of the EPI programme among senior health officials in the province. Much of the success of the programme has been due to the efforts of committed district health officers and EPI managers.

2. Good Infrastructure and Outreach

There appears to be a good health care delivery infrastructure in Sindh. The cold chain is generally well maintained, the supply of vaccines and syringes is adequate, and monitoring of targeted achievements is good.

3. The significant increase in coverage that occurred in the mid-1980s was due largely to the introduction of outreach and mobile teams. There was also a media campaign during

those years, which helped raise awareness of immunisation as a preventive health care practice - particularly among the more educated, urban population. Both of these have given EPI the opportunity to reach out to its target populations.

4. Good Use of Targeting/Monitoring as a Management Tool

Establishment of targets at provincial, district, and health center levels has allowed for reliable monitoring and supervision of coverage.

5. Attempts to Reach Communities

The recent emphasis put on the use of female vaccinators to reach women whom social custom prevents from being vaccinated by men is a sign that one of the most serious shortcomings of the programme is now being addressed.

6. Vaccinators have been using village leaders and local religious figures to inform population of availability of immunisation.

III. Major Shortcomings

Nonetheless, there are a number of factors which appear to limit maximum performance of the health delivery system and particularly EPI. Unless a number of them are addressed quickly and creatively, it will be difficult not only to increase coverage, but to maintain an optimum level of service delivery.

1. Virtually No Social Mobilisation

There has been virtually no social mobilisation of political leaders, non-governmental organisations, traditional health practitioners, private doctors, or other governmental agencies. That has prevented EPI from going beyond the normal limitations of the province's health delivery system. Because the media campaign that was conducted earlier in the 1980s was not accompanied by any such mobilisation, its impact was limited. It was not reinforced by the support of respected authorities in religious and social life.

2. No Emphasis on Family Education

There has not been any accompanying priority -- except in a few cases at district or health centre levels -- put on educating parents about why immunisation is important and how it is relevant to their concerns.

3. Low TT Coverage and high Dropout

TT coverage for women is still very low. This is due in large part to social customs which prevent many women from receiving immunisations from men. The recent emphasis being placed on the use of female vaccinators is a step in the right direction, but there is still a very long way to go.

4. There has been evidence of a significant dropout problem in Sindh. This is undoubtedly the result of a number of factors, but among the most important are the lack of service orientation to the total needs of the mothers and children. There is no evidence of a follow-up system that would obligate vaccinators to track down mothers whose children need further immunisation. Nor has there been sufficient effort made to educate mothers about the importance of full immunisation.

5. Health System is Too Centralised

The health delivery system is centralized and vertical. This prevents its managers from using complementary resources from other parts of the health delivery system in any regular or systematic way, and limits decisions for change and innovation to those at the top. When those at the top -- most notably the district health officers -- do not make EPI a priority, coverage is low. While there was a decision to integrate EPI more fully at the district level in 1985, it has not yet gone far enough.

6. No Merit System or Sanctions/Rewards

Many of the posts that are filled in the health care system are done so as political appointments, not on the merits of the person hired. This results in the presence of many in the health care system who may have neither the experience nor the commitment to do an exemplary job.

7. There is no system of sanctions and rewards in the health delivery system. This deprives vaccinators and other health workers of tangible incentives for good work, and allows for the possibility that the system's resources and obligations will be abused.

8. Urban Bias and Problems of Transport to Rural Areas

Many of the vaccinators are from urban areas. This limits their knowledge of and willingness to serve in remote, rural areas. It is a particular problem for mobile teams, members of which may not be prepared to work with local health practitioners like the dais.

9. Because more than half of the population is scattered among widely dispersed settlements in remote, semi-desert, access on a regular basis has been and will probably continue to be limited under the present system. A shortage of POL funds, vital to steady maintenance of a working vehicle fleet, has made transportation to such areas unreliable. There have also been reports of vehicles that are broken down and have not been repaired.

10. Poor Training

Training of vaccinators has been poor. They have not been shown how to be effective communicators who can interact with mothers and children at a health centre or to approach village leaders. They have been given technical information relevant to the administration of vaccinations, but it appears they have been given little more.

11. Too Much Reliance on UNICEF

There has been an excessive dependence upon UNICEF for financial and material support to EPI. This has left health authorities without much in the way of resources or ideas for sustaining the programme after 1990.

IV. Recommendations

With such shortcomings in mind, the evaluation team makes the following recommendations for action in EPI in Sindh. They are intended to encourage both a short term rise in coverage and increase the potential for sustaining it.

1. Mobilise Leaders and Traditional Sector

UNICEF and other international partners (such as USAID) should mobilise political leaders, non-governmental organisations, and the media to promote full immunisation among those groups that have not been covered. That group includes poor and illiterate families in urban areas, women whom social custom prevents from being vaccinated by men, and those in remote, rural villages.

2. The health services should work closely with other government agencies -- including education and religious affairs -- in their effort to inform and educate community and religious leaders about immunisation.

3. The health services should involve both traditional practitioners of health and private doctors in provision of immunisation. Traditional birth attendants should be trained to educate mothers in villages about immunisation, and private doctors should be encouraged to increase immunisation coverage in urban areas. While both of these strategies have been somewhat controversial, they do propose that the health authorities take full advantage of other health care systems that already exist and have credibility among key sectors of the target population -- and should cost them virtually nothing.

4. Learn More About Target Population

Health service officials should learn more about their target populations by conducting KAP surveys, focal groups, or any other systematized methods of collecting information about community perceptions and health priorities. This will enable them to plan in response to community needs, rather than risk the possibility that the services they are offering are not fully appreciated by their users.

5. Screen Mothers and Children for Immunisation

All health facilities should screen mothers and children as a matter of routine to determine who has been immunised and who has not. This will contribute a great deal to the reduction of dropout rates and missed opportunities. TBAs should also be turned to as a source of information on children in their villages who are eligible for vaccination.

6. Recruit Staff Who Are Competent and Willing

More of an effort should be made to recruit health staff on the basis of their experience and willingness to do the job.

7. Develop Systems of Rewards/Sanctions

Systems of reward and sanction should be developed that will reward the achievements of devoted health staff and provide some guarantee that the system will not be abused or neglected. Possibilities might include a performance appraisal system which links exemplary work to promotion.

8. Provide More Support for Female Vaccinators

To provide greater flexibility to urban vaccination teams, they should be provided with a transportation allowance rather than be dependent upon vehicles which may often not be available or have broken down.

9. After 1990 the job descriptions and training of female vaccinators should be broadened to include CDD, malaria control, ARI, and other childhood diseases.

SUMMARY REPORT -- NORTHWEST FRONTIER

I. Introduction

The Northwest Frontier (NWF) Province has less than 15 percent of the country's population. Much of it, perhaps up to a third of the total, is difficult to reach for either geographical or political reasons. The northern third of the province is mountainous, eventually becoming one of the highest mountain ranges in the world. The western third, bordering Afghanistan, is composed of tribal agencies that are not under the firm control of the Pakistan government. Many of the people living in this area have resisted outside government for centuries, and do not easily welcome even the best intentions of the Pakistani authorities.

The population in the province is widely dispersed, with many families living high in the hills and often several days by foot from the nearest road. This has presented health authorities with a very unusual set of circumstances which are difficult to meet with conventional forms of health care delivery. For these reasons it is clear that while sincere efforts to immunise children have been made in those parts of the province that are easily accessible, it will take some time to reach those who are not near roads or are living in politically inaccessible regions.

The team visited the NWF province between 1-5 October. They met with EPI officials, district health officers, vaccinators, some district council leaders and other community notables, a traditional birth attendant and a private doctor, health staff at a private mission hospital, a former Health Minister and the current Health Minister, and the governor of the province.

II. Current Situation

Provincial health authorities have realised that the only way to reach those who are far from health centres -- and particularly women who are restricted by purdah from receiving vaccinations from men -- is to employ male and female outreach and mobile teams. The recent hiring of female vaccinators is one positive step in that direction. Within the more accessible part of the province -- communities situated along the main trunk road from Peshawar to Islamabad -- coverage has been much better than in outlying areas. Even in the more accessible areas, according to some health authorities and community leaders, there is still room for improvement. The team noted a discrepancy in some places between reportedly high immunisation coverage and evidence of a lack of reduction of disease incidence.

The limits of geography, politics, and social custom in the NWF present health authorities with a built-in set of obstacles that will be very difficult, but not impossible, to overcome. The percentage of the population that is very hard to reach is the percentage that must be reached if coverage levels are to increase substantially.

III. Major Shortcomings

There are still a number of serious limitations to the current immunisation programme in NWF. If these are not made a high priority for immediate action, there is little likelihood that there will be any dramatic rise in coverage in the immediate future.

1. Lack of Mobilisation/Awareness of EPI

There is little evidence that any major social mobilisation has taken place. Inaccessibility has left many parts of the province unaware of EPI. More disturbing, however, was the lack of awareness of EPI among some community leaders in the areas visited. This has deprived the health service of the extra push it needs to stimulate a wider awareness of immunisation.

2. Uneven Motivation

Some EPI workers seemed short on motivation. There was evidence of this among some of the vaccinators the team met, but it was also noted by some of the officials the team interviewed. The majority of them have clearly not been selected or trained as communicators, and often neither understand the details or importance of explaining the concept of full immunisation to mothers they see. Problems of access -- of long journeys to remote villages -- may discourage some of them.

3. Much of the motivation problem may be attributed to two important factors. One is that many of the appointments to the health staff, as elsewhere in the country, are made out of political consideration. This does not guarantee the presence of committed, experienced individuals. The second is that monitoring and reporting in some areas is clearly not very strong. This is often the case if the district health officer has not made EPI a sufficient priority.

4. Dropout and Low TT Coverage

One consequence of low motivation, the general lack of communication skills among vaccinators and insufficient supervision, is a significant dropout rate. There appears to be no coherent or reliable system for ensuring that mothers return with their children to complete the full round of immunisations.

5. There is also a very low coverage for TT among women. Much of this may be attributed to the institution of purdah, which prevents male vaccinators from immunising women. While there are teams of female vaccinators that operate out of Peshawar to complement district outreach, they are not at present likely to be sufficient to meet the need. There is also some danger that women from Peshawar may not be eager to go to remote areas which demand a great deal of fortitude and time. The decision by UNICEF to offer 500 rupees to each female vaccinator who performs 750 TT vaccinations in a month is regarded by the team as inappropriate. The temptation for those who do not reach the target to exaggerate their actual achievement is too great.

6. Poor Equipment and Shortage of POL Funds

There are problems of cold chain management due to the absence of electricity or fuel in remote areas, and reports of vaccines that had lost potency. Most of the vaccine carriers which the team saw were old and needed to be replaced.

7. A shortage of POL funds is a major handicap to outreach and mobile teams.

8. Poor Training

The training of vaccinators is poor. The technical training manuals are not appropriate. The Urdu translation is difficult to absorb, and the examples are taken from Africa. This further compounds the problem cited earlier of vaccinators who are not properly equipped to communicate effectively with those they are serving.

IV. Recommendations

The team recommends the following for immediate action. Some involve changes that will take some time to produce significant results, but they are among the steps that will need to be taken if current difficulties are overcome with any real success.

1. More Social Mobilisation is Needed

High level officials, starting with the current Health Minister for the province, should devote more time to talking about EPI to other community leaders. If immunisation is to be sustained in the long term, it is essential that community leaders understand it.

2. To help reach remote areas and be more responsive to local customs, the health service should make the training of TBAs a priority. Their relationship to the official health delivery system should be carefully defined, and done so in recognition of their value as a means of communication with village communities. Other traditional practitioners in many village communities, should also be included.

3. The formation of village health committees should be encouraged to help support both community outreach and traditional health structures.

4. Learn More About Target Population

To orient health care delivery more closely to the actual needs and priorities of communities, the health care system should undertake KAP studies and engage in other, systematised means of gathering important economic and anthropological information about the communities it serves.

5. EPI Needs to Be Decentralised

Much of EPI should be decentralised for practical reasons. The current priority on localised recruitment and assignment of posts should be upheld.

6. Better Monitoring and Co-ordination are Needed

The existing system requires much better co-ordination for follow-up of dropouts. Individual teams need to be responsible for full coverage of specific areas.

7. The current system of monitoring and supervision also requires greater attention. Procedures for village outreach and mobile teams need more careful supervision if immunisation is to be fully effective.

8. More Practical Training is Needed

Greater emphasis should be put on practical training of vaccinators that puts as high a priority on their roles as communicators as on their assumption of technical skills. Training should be based on what the vaccinators already know.

9. Educate Parents

Every available channel must be used to spread not just information about where and when immunisation is offered, but on why it is important and what the potential benefits to family and community life will be. Koranic schools are an obvious channel, but perhaps no less important are grocers, shopkeepers, and barbers, who know individuals in the community and have time to talk to many of them during the course of a day.

10. More Female Vaccinators

Given the considerable need, health authorities should expand their hiring of female vaccinators. The policy of offering an additional 500 rupees for 750 TT injections per month should be discontinued.

VI. CONCLUSIONS

A. Signs of Progress Everywhere, but Targets Have not Been Reached

While much distance has been covered since the start of the EPI in Pakistan, current achievements do not measure up to the government's own targets of coverage for children under one year of age. Principal reasons for this include the following:

1. The health system has not included other, non-health partners in its promotion of immunisation.
2. UNICEF and the health authorities have operated under a very narrow and restrictive concept of social mobilisation rather than an inclusive one.
3. There has been a widespread failure to appreciate the importance of educating families about the impact of immunisation on their lives.
4. There has been an insufficient follow-up of defaulters.

B. Progress That Has Been Made is Not Likely to Be Sustained

The question of sustainability is an important one. For the following reasons, it is doubtful that without considerable change in the current strategy, even current levels of coverage may not be sustainable in the future.

1. Priorities change in both government and international agencies, and financial and political support for EPI may diminish as a result.
2. The lack of a serious education campaign has not created a sustainable demand from the public.
3. Because it has not reached out to other existing health care structures -- in both the traditional and private sectors -- the health system has not succeeded in weaving immunisation into the fabric of village life.
4. Mobile teams, which have been responsible for substantial increase in immunisation coverage over the past few years, are limited in the amount of the population they can actually cover on a sustainable basis, and may be the victims of budget cuts.
5. Current and future restraints of IMF terms and various adjustment policies will more than likely contribute to a reduction in available support for social programmes.
6. The current strategy of taking health care to the people may encourage a culture of dependency upon government outreach.

VII. RECOMMENDATIONS

Given the previously stated conclusions, the team recommends the following:

SOCIAL MOBILISATION

I. UNICEF Needs to Broaden Its Contacts

UNICEF needs to work more closely than it has on broadening its understanding of social mobilisation for EPI by including political parties, other ministries (such as education and religious affairs), the private sector, and more of the traditional sector (TBAs, others). It must play a role in cultivating support and leadership for the programme at federal and provincial levels.

II. Health Agents Need to be Effective Mobilisers

1. District Health Officers need to acknowledge the potential contributions of other partners who are not in the health field and work with them at village and district levels to educate and mobilise the public.
2. Vaccinators should liaise more closely with imams and TBAs in an effort to better understand the communities which they serve.
3. Both District Health Officers and vaccinators need to devote time to educating others in their communities -- from civic leaders to village mothers -- about immunisation and why it is important for their family and communal welfare.

III. Providers of Immunisation Need to Learn More About Their Targets

EPI managers need to find out who has not been immunised and why, and build an education campaign around the answers to these basic questions. There are many ways this can be done, from formal KAP studies and focal groups to informal conversations at village levels. Only then can they design a delivery system that is directly responsive to the particular needs of the communities they serve.

IV. A More Comprehensive Understanding of Mobilisation is Needed

Mobilisation needs to be a collaborative effort between various social, political, and media leaders and institutions. Communications about immunisations should be tailored to the particular features and limitations of different target groups. Mass media should be one important part of an overall strategy, but it will not be sufficient to rely on it as the ultimate means of communication.

SERVICE DELIVERY

I. A Change in Strategy is Needed to Reach Children Under One

Now that the health services have revised their target to children under the age of one, measles vaccinations must receive particular attention. The following must be done:

1. The frequency of outreach visits must be increased.
2. There must be a more dynamic approach to the follow-up of defaulters by identifying who they are and by utilising local contacts with TBAs and village leaders to convince parents to bring their children for vaccination.

II. Ways Must Be Found to Guarantee Transport to Health Staff

Transport problems were cited by virtually all the health officials the team visited, and must be resolved. Possible innovations include:

1. Ensure reliable transport budget by allowing greater flexibility between budget lines.
2. A transport allowance should be provided male vaccinators in urban areas to make them less dependent upon vehicles that may be unavailable or have broken down.
3. Seek new methods of maintaining motor bikes such as selling them at higher purchase to vaccinators and supervisors.
4. Better supervision of vehicle use is needed to avoid misappropriation and ensure efficient and reliable maintenance.

APPENDICES

- Appendix 1 - Terms of Reference**
- Appendix 2 - Timetable**
- Appendix 3 - Administrative Structure in Pakistan**
- Appendix 4 - Composition of the Team & Field Groups**
- Appendix 5 - List of Persons Met**
- Appendix 6 - Literature Reviewed**
- Appendix 7 - Coverage Data**

Appendix 1

TERMS OF REFERENCE UNICEF Task Force on Evaluation of Social Mobilisation and UCI

I. Evaluation objectives

Social mobilisation has been widely acknowledged to play an important role in the acceleration of immunisation programmes in many countries. However, the process has, to date, been little studied and evaluated, and indicators of what constitutes successful mobilisation are meager. As programmes around the world are increasing emphasis on sustaining high levels of coverage, and on using social mobilisation for other interventions, there is a need to learn more about this social mobilisation process and its institutional framework.

During the last Regional Directors meeting and during the UCI Quarterly Monitoring Review, questions were raised regarding the role of social mobilisation in explaining diverse achievements and maintenance of coverage in countries or in different areas of the same country.

An Evaluation Task Force, consisting of staff members from different divisions of UNICEF Headquarters and from field offices, has therefore been set up to undertake "Rapid Assessment" in 1989 and 1990, in a number of countries which have been characterised by various types and degrees of social mobilisation activities, including "campaign efforts".

For the purpose of this review, social mobilisation is defined as a process for engaging people in action and redirecting existing or creating new human and material resources for the achievement of a society's or community's social goals. To that end, it aims at understanding and modifying people's behaviour, attitudes and beliefs through a communication process.

The objectives of these rapid assessments are:

1. to extract lessons regarding social mobilisation, with particular attention to sustainability and expansion of programmes, and to identify potential indicators of social mobilisation;
2. to examine the role of social mobilisation in explaining different levels of achievements in UCI across country and within country, in coverage gains and drop-out rates;
3. to identify ways to improve the immunisation and the communication systems, especially from a user's perspective, and to optimize the use of social mobilisation in regard to both the achievement and sustainability of UCI and other programme efforts;

4. to identify lines of action to be taken by UNICEF, the governments concerned, other donors, and the private sector (e.g. private physicians and the media), for immediate follow-up; and
5. to identify common strengths and weaknesses of the social mobilisation interventions, as well as country specific initiatives.

The rapid assessment should conclude with the formulation of practical recommendations regarding strategies and phases of activities, alliances, institution building, legislation, identification of local skills and expertise, priority target groups, message focus, dissemination plan including agreement with media, channels of communication, mobilisation of financial and human resources.

II. Evaluation sites

The countries to be covered have gained significant cumulative experience. Countries which have been selected for this year, at the Executive Director's suggestions, are: Colombia, India, Nigeria, Pakistan, Turkey and Senegal.

Areas of study within countries will be selected in consultation with the UNICEF field offices.

III. Design and methods

There are a number of factors that contribute to why UCI acceleration efforts succeed or fail to expand or be maintained. They can be grouped in three main categories:

1. the immunisation system's ability to provide services and attract users. What is the extent of access to availability, and acceptability of services? What are the functional linkages of immunisation with other services? What is the degree of integration and synchronisation of the communication, education, demand creation and mobilisation efforts with the EPI programme?
2. the communication/education system and its capacity to support and also influence the immunisation system by conveying a user's orientation. What is its capacity to understand the unreached or the hard-to-reach audiences, to carry out strategic planning, investigation, message design, training, co-ordinated dissemination, and monitoring? What policy or legislation exists to back-up or institutionalise these activities? What incentives or feedback systems help motivate health providers, communicators and users? What were the past communication experiences? What is the degree of involvement of politicians, religious leaders, NGOs, and the formal education system?

Other operational issues of the communication process to be examined will include the following questions: Has the sequence of analysis, planning, implementation, co-ordination and evaluation of information, motivation and education activities been followed? Has the institutional capacity in a country

for social mobilisation been assessed? Has social mobilisation been based on an in-depth and comprehensive understanding of the people and users concerned? Has the feasibility of the demand created through the mobilising process, as regard the preparedness of service delivery, and its sustainability been studied?

3. the user's profile and its characteristics. What is the socio-economic status of the population? Which social network is dominant in the community? What disease-specific beliefs, vaccine-related fears are demonstrated by the population? What is the population's knowledge of the vaccination schedule and perception of the EPI programme? What is the degree of satisfaction with medical services?

The rapid assessments need to use multiple data collection in order to understand the role of these factors in each country.

The immunisation system can be analysed through review of documents, in-depth interviews with EPI managers and other providers at various levels (national, regional and point of service), semi-structured observation of vaccination sessions in various settings (urban and rural, fixed and mobile), and group discussions with health providers.

The communication system will be scrutinized through review of planning documents, content analysis of educational/promotional materials and programmes, in-depth interviews with media and community development personnel, NGOs, non-formal/formal education staff, market research agencies, and group discussions with communication specialists.

The users characteristics will be examined through the review of existing anthropological and sociological studies, such as recent KAP studies, and available data from focus group research.

III. Manpower and logistics arrangements

A working group at Headquarters has been designated to draft the terms of reference and the suggested field protocols. It includes Mr. Samir Basta, Dr. Susi Kessler, Mr. Ibrahim Jabr and Ms. Hanan Hammam of the Evaluation Office, Mr. Terrel Hill of the UCI Unit, Mr. Luis Rivera and Ms. Sylvie Cohen of the Programme Communication Section of the Programme Division.

The assessment teams will include staff members from different UNICEF divisions, field offices and a selected number of national counterparts or consultants. Priority will be given to in-house resource persons. Multiple skill teams, ideally, should include: communication/social marketing specialists, programme planners, EPI specialists, and anthropologists/social researchers.

Participants should be knowledgeable about country situation and sensitive to local conditions. Team members will cover more than one country to ensure consistency and continuity in analysis. The Evaluation Office will ensure the selection of team leaders to provide strong leadership. Contacts will be made with regional and field offices for their participation in the mission. The identification and finalisation of teams will be completed in January/February 1989 in consultation with the field offices. The Evaluation Office will help cover the mission costs.

Field offices are expected to assemble documentation, outline country specific issues for the team to consider regarding social mobilisation in the context of sustainability, contact local government, make appointments, arrange for the team's accommodation and local travel, provide administrative support and accompany the Task Force during the field visits.

V. Reporting and timetable

A country report will be prepared under the guidance of the team leaders, and with the assistance of a rapporteur, after preliminary synthesis and discussions with field offices. The reports will contribute to the documentation for the UCI 1991 Board Paper regarding the impact of the UCI effort.

The assessment is expected to lead to a better understanding of how social mobilisation can be evaluated and improved in support of UCI and for all CSD/PHC efforts.

Appendix 2

TIMETABLE

23 September

Arrival in Islamabad

24 September

09:00 - 12:30 Briefing at UNICEF Office
12:30 - 13:30 Lunch by Staff Association
14:00 - 14:30 Courtesy call on the Director-General of Health
15:00 - 17:00 Review of field visit arrangements and documentation
20:00 Dinner at residence of UNICEF Representative

25 September

11:00 - 13:00 Briefing at NIH (MOH, NIH, WHO, CIDA, USAID, PRITECH, UNICEF)
13:00 - 14:00 Lunch at NIH
19:30 - 21:00 Groups A and B depart for Lahore and Karachi

GROUP A

26 September

09:00 - 10:00 Briefing at UNICEF office
10:30 - 13:00 Briefing at office of Director-General of Health Services
13:00 - 15:00 Lunch with Secretary of Health
15:00 - 18:00 Review of documentation
18:00 - 20:00 Panel discussion "Jang Forum"

27 September

07:30 - 09:00 Travel to Gujranwala
09:00 - 10:00 Meeting with DHO
10:00 - 13:00 Visits to OPD of DHQ Hospital, RHC (Dukur), BHUs (Jora, Borakatima), interviews with Community, TBA, interview with mobile team (Yusufkot village)
13:00 - 15:00 Lunch
15:00 - 17:00 Meeting with Union Council
17:00 - 18:00 Meeting with member of Parliament
18:00 - 19:30 Return to Lahore

28 September

07:00 - 09:00 Travel to Okara
09:00 - 10:00 Meeting with DHO
10:00 - 12:00 Visit to BHU, RHC (Chack 85 - 5L)
12:50 - 13:30 Travel to Sahiwal
13:30 - 15:30 Lunch with DHO and discussions
16:00 - 18:00 Return to Lahore

29 September

20:00 Dinner by Director-General, Health Services

30 September

10:00 - 11:30 Briefing with Secretary of Health on results of field visit
11:30 - 13:00 Meeting with Lahore Immunisation Council
14:30 Departure for Quetta
21:00 Dinner by Director-General of Health Services

1 October

08:00 - 09:00 Briefing at UNICEF office
09:00 - 10:00 Briefing with Additional Chief Secretary (Development)
10:00 - 11:00 Briefing by Director-General of Health Services
11:00 - 12:00 Meeting with Chief Secretary
12:00 - 13:00 Meeting with Mayor of Quetta City & Municipal Council
13:00 - 14:30 Lunch by Mayor of Quetta City
15:00 - 17:00 Preparation of position paper for Chief Secretary
17:00 - 18:30 Meeting at TV station
18:30 - 22:00 Dinner at residence of Res. Programme Officer

2 October

07:30 - 09:30 Travel to Muslimbagh
09:30 - 10:30 Discussions with DHO - Zhob
10:30 - 12:30 Visits to RHC and Municipal Council BHU
12:30 - 14:00 Visit to Argus Village and meeting with tribal chief
14:00 - 15:00 Lunch
15:30 - 16:00 Meeting with Imam of Mosque, Nassai Village
16:00 - 18:00 Travel to Loralai
18:00 - 20:00 Meeting with DHO and staff and dinner

3 October

09:00 - 10:00 Visit to RHC Sunjavi and discussion with tribal chief
10:00 - 11:30 Travel to Ziarat

11:30 - 12:30 Visit to RHC and MCH
12:30 - 13:30 Meeting with Union Council and tribal chiefs
13:30 - 14:30 Lunch
16:00 - 19:30 Travel to Quetta; visit to urban areas of Quetta and discussions with radio officials

4 October

08:30 - 09:30 Travel to Mustung
09:30 - 10:30 Discussion at hospital
11:00 - 12:00 Visit to urban area during outreach
12:00 - 13:00 Return to Quetta
13:00 - 14:00 Lunch
17:00 - 18:00 Briefing Chief Minister on objectives and results of mission
20:00 Dinner at residence of Res. Programme Officer

5 October

08:00 - 09:00 Briefing at UNICEF office during staff meeting
11:25 Departure for Islamabad

6 October

Free

7 October

06:30 - 10:30 Travel to Muzaffarabad
10:30 - 11:30 Meeting with Director-General of Health Services, AJK
11:30 - 12:00 Visit to radio station
12:00 - 13:30 Visit to MCH Chinar, BHU Garhi Dopata and meeting with TBAs
13:30 - 14:30 Lunch
14:30 - 18:30 Return to Islamabad

GROUP B

25 September

19:05 - 21:00 Departure for Karachi

26 September

08:30 - 10:00 In-house briefing
10:30 - 12:30 Briefing Sindh government
12:30 Lunch
15:30 - 16:30 Departure for Sukkur

27 September

Field visit
Sukkur and outskirts
Drive to Larkana

28 September

19:10 - 21:05
Field visit to Larkana
Departure for Karachi

29 September

Free

30 September

Field visit to Karachi Metropolitan
Meeting Karachi Municipal Corporation
Meeting Newspaper "Star"

1 October

06:30 - 10:15
11:00 - 12:30
13:00 - 15:00
15:00
Departure for Peshawar
In-house briefing
Briefing with Secretary of Health
Review of documentation

2 October

09:00
10:30
Field visit
C.B. Hospital Peshawar
Pabbi town
Meeting with Commissioner
Meeting with Governor

3 October

09:30
11:30
Field visit
M.C. Charsada
Village Baghdada, District Mardan

4 October

09:00
13:00
15:30
Field visit to Abbottabad
Akora Khattak Health Centre
Civil Hospital, Hari Pur
BHU Nawanshehr

5 October

09:00 Field visit : C.H. Qalandarabad
11:00 DHQ Hospital Mansehra
13:00 BHU Shinkiari
15:00 Meeting with Minister of Health
17:00 Depart for Islamabad

6 October

Free

ALL TEAM

7 - 10 October

Report writing (incl. meetings with Fed. authorities
and international agencies)

11 October

11:00 - 12:00 Meeting with Federal Secretary of Health
12:00 - 13:00 Meeting with UNICEF Representative

12 October

09:00 - 11:30 Debriefing at UNICEF Office with UNICEF staff
12:00 - 14:00 Debriefing at NIH with Government, WHO and other agencies
14:00 - 15:00 Lunch by Chairperson, Staff Association
19:00 Departure from Islamabad

Appendix 3

ADMINISTRATIVE STRUCTURE IN PAKISTAN

General Administration

Chief Minister
Commissioner
Deputy Commissioner
Assistant Commissioner
Administrative Officer
Chairman
Councilman

Administrative level

Province
Division
District
Tehsil
Markiz
Union Council
Neighborhood, village

Health

Minister/Secretary
Director of Division
DHO
Assistant DHO
Medical Officer
BHU Officer
Dispensary worker

Appendix 4

COMPOSITION OF THE TEAM & FIELD GROUPS

UNICEF HQ

John Richardson	Consultant (Media)
Steve Woodhouse	Chief, Training Section, UNICEF, New York
M. Wickramasinghe	Programme Communications Officer, UNICEF Kampala, Uganda
Ibrahim Jabr	Senior Programme Officer, Evaluation-HQ and Team Leader

UNICEF Islamabad

Pirkko Heinenon	Officer-in-Charge, Health & Nutrition Unit
Nassim ur Rehman	PCI Officer
Raana Syed	PCI Officer
Rik Peeporkorn	Programme Officer, Health & Nutrition Unit
Martine Berger	Programme Officer, Health & Nutrition Unit
Ahmed Zubair	Chief, FOC
Ramzan Azhar	Chief, PCI and local co-ordinator of the assessment

National Institute of Health (NIH)

Lt. Gen. Azhar Ahmed
Dr. Col. M. Akram Khan
Q.I. Siddiqui
Abdul-Sattar Chaudhary

Group A

I. Jabr
M. Wickramasinghe
Naseem ur Rehman
A. Khan
R. Peeporkorn (B'tan)
P. Heinenon (Punjab)

Group B

J. Richardson
S. Woodhouse
R. Syed
M. Beyer
Q.I. Siddiqui

Appendix 5

LIST OF PERSONS MET

During visit to Islamabad

Mr. Syed Sadek Ahmed

Lt.General Azhar Ahmed (retired)

Abdul-Sattar Chaudhary

Col. M. Akram Khan

NIH,

Dr. Zakat-Al-Rahman

Dr. Ali Idris

Robert Karam

Debbie Goldman

Secretary of Health,

Federal Ministry of Health

Executive Director, NIH, Islamabad

Advisor on Health Education, Islamabad

Gen. Manager, EPI Programme,
Islamabad

Acting Executive Director, NIH

WHO Adviser EPI, Islamabad

Communication Adviser, CIDA, Islamabad

Health & Population Division, USAID

During visit to Azad Kashmir

Dr. Abu Wafa

Dr. M. Akram

Ahmed Razi

Dr. M. Shabdir

Hanif Lang

Shamshad Akhtar

Syed Nassim-Uddin

Director-General of Health Services

EPI Manager

Health Education Officer

DHO

WHO Operations Officer

LHV

Director, Radio Services

During visit to Balochistan

Key officials

Nawab Mohammad Akbar Khan Bugti

Dr. Abdul Malik Baloch

S.R. Poonegar

Ata Mohammad Jaafar

Maqbool Ahmed Lehri

Dur Mohammed Kasi

Chief Minister

Minister for Health

Chief Secretary

Additional Chief Secretary (Development)

Mayor, Quetta Municipal Committee

General Manager, Pakistan TV, Quetta

Health Department

Dr. Mohammad Iqbal Khan
Dr. Gul Mohammed Khan
Dr. Abdul Sattar
Zaidi

Director-General, Health Services
Deputy Director, PHC
Deputy Director, EPI
WHO Operations Officer, Quetta

District Officials

Dr. Saeed Ullah
Dr. Abdul Rehman
Sultan Mohammed
Molvi Abdul Salam
Elders & School Teacher
Dr. Ajmal Latif
Dr. Mohammed Shah
Imam Majid Musa Khel
Ghulam Qadir
Abdul Mannan
Akhtar Mohammad
Wali Mohammed
Haji Abdul Hameed Dumar
Dr. Anita Davidson

Babar Sharif
Abdul Haq
Malik Taj Muhammad
Dr. Sami Khan
Kausar Farooqi
Robina Tajeen
Dr. Nawaz

DHO, Zhob District
M.O, Civil Hospital, Mustung
DSV, Mustung
Imam Masjid, Nassai Village
Village Argus, Zhob District
DHO, Loralai
Assistant DHO, Loralai
Loralai
Teacher from Duki Tehsil
Councillor, Town Cttee, Loralai
DSV, Loralai
Vaccinator, RHC Sunjavi
Village elder, Sunjavi
Medical Officer, District
Hospital, Ziarat
Vaccinator, EPI Centre, Ziarat
Khatib Jama-E-Masjid, Ziarat
Village elder, Munnaywala, Ziarat
DHO, Kalat
LHV, Tehsil Hospital, Mustung
M.O, Civil Hospital, Mustung
M.O in-charge, Civil Hospital,
Mustung

During visit to NWF

Key Officials

Retd. Brig. Amir Gulistan Janjua
Shahzada Gushtasip Khan
Sardar Haider Zaman

Sardar Mehtab Ahmed Khan Abbasi

Governor
Minister for Health
Minister of Labour & Chairman
District Council
Ex-Minister of Health, serving
member of Provincial Assembly

Other Officials

Dr. Tariq Nishtar
Ejaz Rahim
Dr. Alam Khan
Dr. Nadir

Dr. Mohammad Shah
Dr. Zor Talab Khan
Dr. Mohammad Rafiq
Hanif Lange
Rodney Stent

Dr. Hella Loyd

Secretary of Health
Commissioner, Peshawar
Director, EPI/CDD
Dep. Director, Health Services,
Abbottabad
DHO, Mardan
DHO, Mansehra
Assistant DHO, Mansehra
WHO Operations Officer for NWF
Administrator, Bach Christian Hospital
Qalandarabad
Physician

During visit to Punjab

Dr. Mohammad Mazahir Ali Hashmi
Ismatullah Chaudhry
Dr. Fayyaz Ahmad Ranjha
Dr. Khurshid Ahmad Khan
Dr. Ashek Hussain
Dr. Altef Hussain
Dr. Shawkat Reza Khan
Dr. Fahmida Jahil

Secretary of Health
Director-General of Health Services
WHO Operations Officer
DHO Gujranwala
DHO Sahiwal
BHU Jora (Gujranwala)
BHU Borakatima (Gujranwala)
)
) Lahore Immunisation Council

During visit to Sindh

Dr. Farkhunda Mumtaz
Dr. Panwar
Dr. Noor Ahmed Abbasi
Dr. Nadira Subhani
Dr. Muqueet Qureshi
Dr. Abdullah Katpar
Dr. Imtiaz Mughal
Dr. Khalid Masood
Dr. A.R. Bugti
Dr. Ali Nawaz
Dr. Sharif
Ghazi Salahuddin

Director, Health Services, Karachi
Municipal Corporation
Deputy Director, Karachi
Municipal Corporation
Director, PHC, Agha Khan Health Services
Health Officer, Sindh Employees Social
Security Institute
Asst. Project Director, EPI/CDD
DHO, Sukkur
Assistant DHO
Rotarian Sukkur
Dep. Director, Health Services, Larkana
DHO, Larkana
Assistant DHO
Editor "Star" Evening Newspaper

UNICEF officials

Kunio Waki
Steven Allen
Ahmed Zubair
Ramzan Azhar
Philippe Heffinck
Birgitta Anderfelt
Rima Salah
Haidar Zaman
N.R. Jafri
Pirkko Heinenon
Martine Beyer
R. Peeperkorn
Naseem ur Rehman
Raana Syed
Shamshad Qureshi
Abdul Ahad Khan

Representative
SPPO
Chief, FOC
Chief, PCI
RPO, Karachi
RPO, Lahore
RPO, UNICEF Quetta
OIC, Peshawar
PO, Karachi (Health & Nutrition)
OIC, Health & Nutrition Unit
PO, Health & Nutrition Unit
PO, Health & Nutrition Unit
PCI Officer
PCI Officer
PO, Lahore
PO, Quetta

Appendix 6

LITERATURE REVIEWED

1. Quarterly UCI Monitoring Reports, 1988-89
2. Nationwide Immunization Coverage Evaluation and Survey on selected EPI targetted diseases and diarrhoea including ORT Management at household level, March-April 1987, NIH/WHO
3. Review of Accelerated Health Programme and Primary Health Care in Pakistan, 7 February-6 March 1988, MOH/WHO/USAID/UNICEF Programme review (incl. prov. report on Punjab, Sindh, NWFP, Balochistan, AJK)
4. Articles of Understanding- National Plan of Action for EPI, 1986-88 (GOP/WHO/UNICEF/USAID), June 1986
5. Situation Analysis of Children and Women in Pakistan, June 1987
6. Master Plan of Operations, Draft Agreement 1988-92 (Nov. 1987)
7. Inter-provincial Immunization Coverage Evaluation and Disease Survey - Results (1987)
8. UNICEF Annual Report - 1987
9. From Campaign to Integrated Programme: EPI in the Punjab (Pakistan) E.S. Trainer, Ph.D
10. EPI Pakistan - Mid-year Progress Report, 24 Sept. 87 (memo from J. Lambert)
11. EPI Pakistan - Annual report for 1987
12. UCI 1990 for Pakistan
13. UNICEF Annual Report - 1988
14. EPI in Punjab - An analytical Report, UNICEF Pakistan, July 1987
15. Pakistan, EIU Country Report No.1, 1989
16. Country Profile - Pakistan, Afghanistan, EIU 1988-89
17. Review of the AHP and other selected PHC activities in Pakistan, 10 Nov. - 6 Dec. 1984 GOP/WHO/UNICEF/USAID/CIDA review team.

18. Review of the AHP and PHC in Pakistan, 7 Feb. - 6 March 1988 (incl. prov. reports) MOH/WHO/USAID/UNICEF Programme Review
19. Briefing kit prepared by UNICEF Quetta
20. Brief for Task Force on Balochistan by Dr. Mohammed Iqbal Khan, DHS Balochistan
21. District of Sahiwal, 1989 Health facilitators (EPI) by Dr. Khurshid Ahmad Khan (DHO)
22. Brief EPI District Gujranwala
23. Brief on EPI in Punjab, Directorate of Health Services
24. Brief on EPI in Okara
25. Annual Development Programme 1989-90, Azad, Government of the State of Jammu and Kashmir, Planning & Development Department
26. Brief folder on Azad Kashmir prepared by the Health Department
27. Azad Kashmir at a glance - 1988, Azad Government of the State of Jammu and Kashmir, Planning and Development Department
28. Polio Study in Quetta District, Vol. I & II, by Innovative Development Consultants (PVT) Ltd. Lahore - Karachi
29. Community Health Survey, Muzaffarabad District, AJK - 1987, December 1988, Planning and Development Department, AJK, UNICEF Islamabad
30. Summary of Findings -- Awareness, Attitudes and Decision-Making, based on a survey in Rawalpindi City, Feb. 1988 (Vol. I & II), by Gallup Pakistan for NIH/CIDA Communications Project
31. Literature Review and Bibliography -- Awareness, Attitudes and Decision-Making, based on a survey in Rawalpindi City, Feb. 1988 (Vol. III), by Gallup Pakistan for NIH/CIDA Communications Project
32. Health Education and Communication Plan of Action, by NIH/CIDA Communications and Motivation Unit, July 1988
33. Training Report, by Richard Wrott (August 1988)
34. Review and Training Needs Assessment, by NIH/CIDA Communications and Motivation Unit (July 1988)

35. Health Educators Workshop Final Report -- Evaluation of Health Education Materials (Sept. 1988) by Communications and Motivation Unit, NIH/CIDA
36. Report on National Seminar on Child Survival & Development and the Media - 1986, by UNICEF, Islamabad
37. Child Survival and Development -- Proposal for an Integrated Motivational Workshop for rural-based Medical Officers
38. A Communication Approach for Accelerated Health Programme (EPI/CDD/TBA) in a Pilot Area (November 1982), by Ramzan Azhar
39. A Communication Strategy for EPI (May 1982), by Jane Bunnag/David Mason/Ramzan Azhar

Appendix 7

COVERAGE DATA

Table 1 : Coverage per antigen per province
1984, 1987 and 1988

Year	Province	BCG Scar	DPT/OPV			Measles	FI	FIU1	TT2
			1	2	3				
1984	Punjab	91	97	93	85	88	80	42	40
	Sindh	40	75	48	15	62	29	16	2
	NWF	91	95	77	58	93	57	29	5
	Bal't	12	39	30	23	34	11	7	1
	AJK	42	76	52	41	42	30	16	7
	NAT'L	74	88	76	65	79	61	32	24
1987	Punjab	95	98	97	96	88	83	43	39
	Sindh	65	85	75	67	69	56	23	27
	NWF	80	87	82	74	76	72	24	22
	Bal't	9	18	13	10	12	6	2	3
	AJK	52	83	73	60	45	38	12	13
	NAT'L	81	89	85	81	76	71	35	39
1988	Punjab	95	99	98	95	84	80	46	74
	Sindh	88	93	84	79	83	74	20	42
	NWF	95	97	95	94	90	88	36	64
	Bal't	58	88	65	50	67	40	1	31
	AJK	93	97	96	91	89	86	35	75
	NAT'L	92	97	93	89	84	78	36	63

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**Table 2 : Coverage by antigen and province
1984**

<u>Province</u>	<u>Set'lmnt</u>	<u>BCG</u>		<u>DPT/OPV</u>		<u>Measles</u>	<u>FI</u>	<u>FIU1</u>	<u>TT2</u>
		<u>Scar</u>	<u>1</u>	<u>2</u>	<u>3</u>				
Punjab	Urban	85	97	89	79	88	74	40	48
	Rural	93	98	94	87	88	82	43	37
	Total (*)	91	97	93	85	88	80	42	40
Sindh	Urban	60	65	52	40	50	39	18	4
	Rural	24	82	45	23	72	21	14	1
	Total (*)	40	75	48	30	62	29	16	2
NWF	Urban	83	86	74	67	81	65	47	8
	Rural	93	96	78	56	95	56	26	4
	Total (*)	91	95	77	58	93	57	29	5
Bal'tan	Urban	36	58	44	32	48	25	46	1
	Rural	8	35	28	21	32	8	0	0
	Total (*)	12	39	30	23	34	11	7	1
AJK	Total	42	76	52	41	42	30	16	7
National	Total (*)	74	88	76	65	79	61	32	24

FI: fully immunised
 FIU1: fully immunised under 1 year of age
 Bal'tan: Balochistan

**Table 3 : Coverage by antigen and province
1987**

<u>Province</u>	<u>Set'lmnt</u>	<u>BCG</u> <u>Scar</u>	<u>DPT/OPV</u>			<u>Measles</u>	<u>FI</u>	<u>FIU1</u>	<u>TT2</u>
			<u>1</u>	<u>2</u>	<u>3</u>				
Punjab	Urban	96	97	95	94	83	81	55	58
	Rural	94	99	98	97	90	84	39	32
	Total	95	98	97	96	87	83	47	49
Sindh	Urban	62	80	68	61	61	51	23	34
	Rural	68	88	80	72	75	60	24	21
	Total	65	84	74	67	68	56	23	30
NWF	Urban	90	92	90	82	79	80	25	34
	Rural	78	86	80	73	75	70	24	20
	Total	84	89	85	78	77	75	25	30
Bal'tan	Urban	-	-	-	-	-	-	-	-
	Rural	9	18	13	10	12	6	2	3
	Total	9	18	13	10	12	6	2	3
AJK	Urban	-	-	-	-	-	-	-	-
	Rural	52	83	73	60	45	38	12	13
	Total	52	83	73	60	45	38	12	13
National	Total	81	89	85	81	76	71	35	39

**Table 4 : Coverage by antigen and province
1988**

<u>Province</u>	<u>Set'lmnt</u>	<u>BCG</u>		<u>DPT/OPV</u>			<u>Measles</u>	<u>FI</u>	<u>FIU1</u>	<u>TI2</u>
		<u>Scar</u>	<u>1</u>	<u>2</u>	<u>3</u>					
Punjab	Urban	95	99	98	95	81	76	46	74	
	Rural	96	99	99	96	85	81	46	75	
	Total (*)	96	99	98	95	84	80	46	74	
Sindh	Urban	84	94	85	81	86	75	21	73	
	Rural	91	93	84	77	81	74	20	19	
	Total (*)	88	93	84	79	83	74	20	42	
NWF	Urban	95	97	95	93	92	88	52	67	
	Rural	96	97	96	95	90	89	33	63	
	Total (*)	95	97	95	94	90	88	36	64	
Bal'tan	Urban	-	-	-	-	-	-	-	-	
	Rural	58	88	65	50	67	40	1	31	
	Total (*)	58	88	65	50	67	40	1	31	
AJK	Urban	-	-	-	-	-	-	-	-	
	Rural	93	97	96	91	89	86	35	75	
	Total (*)	93	97	96	91	89	86	35	75	
National	Total (*)	92	97	93	89	84	78	36	63	

(*) Explanation note: Basis for calculating provincial/national figures

<u>Province</u>	<u>% of national population</u>	<u>% urban</u>	<u>% rural</u>
Punjab (incl. Islamabad)	56.6	27.7	72.3
Sindh	22.6	43.3	56.7
NWF	13.1	15.0	85.0
Bal'tan	5.1	15.6	84.4
AJK	2.6		

**Table 5 : EPI Coverage report for the province of Sindh
July 1988 - June 1989**

City	BCG	OPV/ DPT- I	OPV/ DPT- II	OPV/ DPT- III	Measles	Fully Immunised	TT. I	TT. II
Badin	32.4	33.4	31.9	30.9	27.8	28.7	5.4	3.6
Dadu	25.3	31.0	27.8	28.2	25.1	25.0	13.2	10.9
Hyderabad	47.0	42.7	39.3	47.4	33.6	44.7	26.7	20.2
Sanghar	32.9	33.8	34.9	37.1	30.4	36.8	11.7	9.8
Therparkar	36.2	37.0	31.8	31.2	29.2	28.4	18.9	16.2
Thatta	17.3	16.4	13.5	12.9	12.0	11.6	6.4	4.4
Jacobabad	38.1	35.9	32.2	29.2	27.1	27.4	20.7	17.8
Khaipur	45.2	39.6	41.4	41.3	33.6	38.3	13.4	12.2
Larkana	49.7	50.0	32.3	42.1	33.8	30.4	18.4	14.3
Nawabshah	46.6	50.2	48.9	50.9	45.4	53.0	17.4	15.7
Shikarpur	22.9	24.4	20.3	19.9	18.7	19.1	9.6	8.8
Sukkur	49.2	44.8	41.6	45.8	41.2	48.4	18.2	15.5
Karachi Central	23.2	22.6	20.5	21.7	21.0	23.4	15.6	13.0
Karachi East	30.2	35.5	43.1	41.6	39.0	47.0	19.5	13.0
Karachi West	28.0	28.3	25.5	31.8	31.7	36.0	17.1	14.7
Karachi South	36.0	29.1	24.7	25.0	24.1	27.8	33.6	20.1



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External ID **EVL/03.09.07/ PAK 89/800**

Title

Rapid Assessment - Social Mobilisation in UCI

Date Created

1/1/1989

Date Registered

12/18/2003

Date Closed

Primary Contact

Owner Location

Home Location

Current Location/Assignee

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Document Details **Record has no document attached.**

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