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COVER PHOTO: A map developed by Community Health Volunteers (CHV) trained through Catholic Relief Services as part of the CORE Group Polio Project in Nairobi. The map breaks parts of Nairobi city down into areas where the CHV's conduct surveillance for communicable diseases like polio, measles and cholera. Any suspected cases are referred to the health clinic, and samples ultimately end up at the Centers for Disease Control in Atlanta when a polio case is confirmed. By David Snyder/CRS

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Acronyms

AFP	Acute Flaccid Paralysis
ASCOM	Associations de Santé Communautaire
BCG	Bacillus Calmette–Guérin
CDC	Centers for Disease Control and Prevention
CGPP	CORE Group Polio Project
CHAZ	Churches Health Association of Zambia
COMARESS	Coalition malagasy pour le renforcement du système de santé et de vaccination
CRS	Catholic Relief Services
CSO	Civil Society Organization
DIC	District Immunization Champion
EPI	Expanded Program on Immunization
GPS	Global Positioning System
HENNET	The Health NGOs Network
HMIS	Health Management Information System
HPV	Human Papillomavirus
MHEN	Malawi Health Equity Network
MOH	Ministry of Health
NGO	Non-governmental Organization
OCRS	Observatoires Communautaires Régionaux de Santé
POSVIT	Plateforme des Organisations de la Société civile pour le soutien à la Vaccination et à l'Immunisation au Tchad
SHATAK	Shehri Ijtamai Taraqiati Council
SPONG	Sécrétariat Permanent des Organisations Non Gouvernementales
TT	Tetanus Toxoid
UNICEF	The United Nations Children's Fund
WHO	World Health Organization



EDUCATION, COUNSELLING AND REFERRAL INFORMATION
Record special information given on Growth, Nutrition, Immunisation and fitness

DATE OF VISIT	INFORMATION	DATE OF NEXT VISIT
25/9/2010		22/10/2010
22/9/2010		21/10/2010
20/10/2010	TCA at 9 months for measles & VHA caps	
17/10/2010	completed course of vaccines at 2 months with measles & VHA caps.	
15/10/2010		At 5 1/2 yrs

A young mother looks on as a Village Health Team member reviews her child's immunization record at a school in the village of Nalugai, Uganda. David Snyder/CRS



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NATIONAL CIVIL
SOCIETY PLATFORMS
FOR IMMUNIZATION

4000+

ORGANIZATIONAL
MEMBERS

**A STRONG CIVIL SOCIETY IS
ESSENTIAL TO ACHIEVING UNIVERSAL
IMMUNIZATION COVERAGE**

**CIVIL SOCIETY ACTORS WORK IN HARD-
TO-REACH COMMUNITIES WHERE LESS
THAN 50 PERCENT OF CHILDREN ARE
FULLY IMMUNIZED**

**CIVIL SOCIETY ACTORS BRING THE VOICE
OF THE COMMUNITY TO THE TABLE OF
THE DECISION-MAKERS**

WHAT'S IN THIS PAPER?

- Innovations in community-level sensitization and mobilization for immunization services
- Lessons learned from seven years of implementing the Gavi CSO Constituency Platforms Project
- Practical guidance on applying CSO promising practices in your country and context

Introduction

Civil society and civil society organizations (CSOs) are a key partner in the Gavi Alliance, playing a crucial role in the achievement of the goal of ensuring that every child is reached with immunization. Since 2011, Gavi has been supporting civil society coordination through the Gavi CSO Constituency. This diverse group is made up of over 4000 CSOs from around the world who are all engaged in efforts to improve immunization. Members include international non-governmental organizations, national networks and organizations, local and community groups, professional associations, and academic institutions.

As a complement to this global coordination, it was also recognized that civil society in Gavi-eligible countries require support to coordinate and scale up their efforts at country level, and to support their Government to strengthen the capacity of integrated health systems to deliver immunization and increase equity in access to services. Since the start of the Gavi CSO Platforms Project, CSOs have established 24 national CSO platforms and a francophone regional network for immunization and health systems strengthening.

Over the past seven years, these platforms have played a key role in strengthening the voice of civil society both at country level and globally. CSO platforms are now actively involved in working with Governments to shape services, to reach communities that would otherwise be missed, and to counter the myths that make people hesitant to vaccinate their children. As these Promising Practices show, CSOs play an essential and irreplaceable role in the health system.

As we look to the future, it is essential that the role of civil society is not overlooked. As these Promising Practices show, we have much experience to share and learn from. Only by working together in partnership will the objective of ensuring every child is reached with immunization be realized.

— *The Oversight Advisory Group of the Gavi CSO Constituency Steering Committee*



Wonplough Weah, a community volunteer trained and managed by the Liberia Immunization Platform, spends time encouraging parents like Elizabeth Bestman to visit health clinics to get their children vaccinated against measles, polio and other vaccine-preventable diseases. Michael Stulman/CRS

PART I

Coordination and Surveillance

A. DATA COLLECTION, REPORTING, AND USE

ETHIOPIA

Newborn tracking and vaccine registers

INTRODUCTION

Newborn oral polio coverage is low in some CORE Group Polio Project (CGPP) areas of Ethiopia due to a lack of public demand and facilities that can provide the vaccine. This is a problem in pastoralist and semi-pastoralist areas, depriving newborns of their best line of defense against polio. There is a strong need to identify newborns who have not been vaccinated and to make sure that they receive the correct dosage. One of the most promising ways of doing this lies in the combined efforts of grassroots community volunteers and health extension workers. Volunteers and extension workers raise awareness among communities about the importance of immunization, help to deliver vaccinations, and track newborns through their vaccination schedules.

PROJECT PURPOSE AND CONTEXT

Community and hospital data from polio-endemic areas shows that more than three-quarters of paralytic cases occur in children under two. 70-100 percent of newborns who receive vaccination at birth will develop local immunity in their intestinal tracts and 30-50 percent will develop serum antibodies to one or more serotypes. According to studies carried out in India and Brazil, the serological response was good in infants who began immunization at birth or during the first four weeks of life. High immunization coverage is essential to ensure adequate population immunity. Until polio is eradicated, all polio-free

countries remain at risk of reimportation. Ethiopia has a history of high importation of the poliovirus due to its proximity to well-travelled borders. It is therefore essential to promote high vaccination coverage.

STEPS IN IMPLEMENTATION

Community volunteers and health extension workers in Ethiopia have taken the following steps to ensure poliovirus immunization coverage:

- Familiarized themselves with administrative bodies, influential figures, health officials and health workers at all levels, especially those working on community-based surveillance programs for acute flaccid paralysis, measles and neonatal tetanus.
- Advocated for participation of kebele-level administration and community leaders in awareness raising.
- Organized for health extension workers to train community volunteers in surveillance methods to track newborns who require vaccination and enter them into vaccination registers.
- Came together at kebele level to work on joint planning, implementation, reporting and review activities
- Traced and identified pregnant women during house-to-house visits by community volunteers.
- Referred women to nearby health facilities for antenatal care, including tetanus vaccinations to prevent neonatal tetanus.
- Reported women who did not want to attend a health facility to health extension workers for further discussion.

- Recorded all new births, including date, age and sex, in the vaccination register for health extension workers to follow-up on.
- Advised mothers on oral polio vaccination, BCG vaccination, and the benefits of breastfeeding.

POSITIVE OUTCOMES AND IMPACTS

The key positive outcomes of these combined efforts have been:

- 306,432 pregnant women were referred for antenatal vaccines between 2012–2017.
- 181,192 newborns were identified and referred for immunization.
- 71,904 children who had defaulted on their immunization schedule within their first year were identified and put back on schedule.
- Overall, newborn immunization coverage increased, and surveillance greatly improved.

LESSONS LEARNED

The community-based newborn tracking approach is cost effective and worth continuing. Communities seemed to retain information provided about the importance of vaccinations and this really helped to identify pregnant women and new mothers. Some challenges included:

- Not all women who were referred for vaccination chose to continue with the full course. Greater insight into why they dropped out would be helpful.
- Due to cultural reasons, many mothers choose a home delivery, which makes it difficult to record new births and refer these children for vaccination.
- The government made some changes to the policy on how community volunteers could operate, and this interrupted the smooth implementation of some activities. Better dialogue with national policymakers might help to forewarn of these issues and allow for advocacy in policymaking.

PROMISING PRACTICES

The main purpose of this intervention was to increase community-level participation in improving vaccination coverage, especially in relation to polio. Combining the efforts of existing health extension workers with local community volunteers really extended the reach of awareness-raising and monitoring processes. Inviting health extension workers to train community volunteers

in surveillance and recording methods helped to maintain the quality of data gathered. It also led to many women who had either not been vaccinated or missed appointments, returning to complete their course. The success of this intervention really shows the importance of building communication between official health workers and volunteers.

HORN OF AFRICA

Cross-border coordination on immunization

INTRODUCTION

The Horn of Africa is at high risk for cross-border disease transference. This threat demands focused collaboration between Horn countries. The CORE Group Polio Project specifically addresses high-risk populations who travel along, and pass over, common borders. It is vital that these nomadic groups get access to vaccines as they are most at risk of transferring vaccine-preventable diseases.

PROJECT PURPOSE AND CONTEXT

Horn of Africa countries face the challenge of fluid movement across borders. Due to insecurity in the region, many people migrate to avoid armed conflict. This constant shift of people across shared borders leads to a higher risk of diseases being carried between countries. Under-resourced health facilities mean that the wider population may not have had access to vaccinations. This leaves them with lower immunity to communicable diseases.

The frequent movement of high-risk mobile populations continues to be a significant contributing factor to the spread of vaccine-preventable diseases in the region and contributes to the ongoing transmission of wild poliovirus.

The goal of the Cross-border Health Initiative is to ensure the vaccination of all cross-border populations. It aims to link community volunteers with border health facilities to jointly investigate cases of trans-border acute flaccid paralysis and wild polio virus to synchronize immunization efforts and better contain outbreaks.

STEPS IN IMPLEMENTATION

The establishment of Cross-border Health Initiative committees was the driving force of the Initiative. Cross-border partnerships among institutions,

agencies, and communities in Horn of Africa countries is key to identifying gaps in immunization.

Cross-border forums have been established to share information and strategies. This has helped to highlight the risk of disease transfer and to coordinate collective surveillance efforts. Routine immunization and awareness-raising have been organized.

Community volunteers have been trained in surveillance methods and work with mobile border communities, conducting advocacy and sensitization activities.

POSITIVE OUTCOMES AND IMPACTS

The positive outcomes of this intervention have been:

- Improved information sharing on disease outbreak response between countries.
- Increased identification and surveillance of immunity gaps among high-risk mobile populations along border regions.
- Synchronized planning and implementation of vaccination and awareness-raising activities along border regions.

Closer collaboration between cross-border health committees has enabled the vaccination of children from high-risk mobile populations at both formal and informal border crossings. It has also led to more accurate tracking of nomadic-pastoralist communities, and improved reporting of suspected acute flaccid paralysis cases in border areas.

LESSONS LEARNED

Marginalized border areas often have inadequate health infrastructure compounded by civil insecurity. These challenges increase the cost of cross-border intervention. Effective cross-border polio eradication requires a high level of political commitment, strong coordination, and the mobilization of border communities and their leaders.

There is a need for advocacy between local governments and national health ministries. This would help to bestow a greater sense of community ownership over health services and improve resource allocation in high-risk regions.

Regional cross-border governance frameworks, such as the Intergovernmental Authority on Development and the East Africa Community, could help to institutionalize Cross-border Health Initiative and develop standardized regional immunization and surveillance reporting tools.

PROMISING PRACTICES

Countries which share borders with highly mobile populations require a coordinated effort in preventing the importation of communicable diseases. It is vital that high-risk mobile populations are reached and that they understand the importance of vaccination, as they are at risk of transferring diseases between borders. To reach these communities, a coordinated cross-border approach is required, enlisting the help of border communities and their leaders.

SIERRA LEONE

Using Knowledge, Attitudes, and Practices surveys to inform social behavior change strategies

INTRODUCTION

When the Ebola epidemic broke out in Sierra Leone in May 2014, people were terrified—so terrified that they did not know what to believe or who to trust. Quickly, and disastrously, they associated the illness with health clinics and health care workers. Many people came to believe it was the health care system itself that was infecting them with Ebola. Of all the potential dangers related to the health system they considered vaccination, with its injections and side effects, the worst.

PROJECT PURPOSE AND CONTEXT

“COMMUNITY MEMBERS BECAME SUSPICIOUS OF THE HEALTH SYSTEM AND HEALTH WORKERS, SHUNNING HOSPITALS AND OTHER HEALTH FACILITIES. CAREGIVERS OUTRIGHT BOYCOTTED VACCINATION OF THEIR CHILDREN.”—DR. ALHAJI SAYNI TURAY, DISTRICT MEDICAL OFFICER IN BO

Ebola threatened to significantly reverse immunization gains. To try and understand the scale of the problem, and the entry points for catalyzing change, the Scaling up Nutrition and Immunization Civil Society Platform conducted a Knowledge, Attitudes, and Practices survey in Bo. The results of the survey showed that more than 30 percent of children had missed a scheduled vaccination.

The reason given by their caregivers was that they were convinced that the health facilities were transmitting Ebola. Many believed that vaccination health workers were injecting Ebola into their children.

STEPS IN IMPLEMENTATION

The civil society platform sat down with the Ministry of Health and Sanitation and planned out a social behavior change campaign that was based on: 1) the results of the survey, and 2) platform members' intimate knowledge of cultural and social beliefs and practices in Bo.

They introduced the slogan "No Touch." This simple but effective message was shared through mosques, churches, radio announcements, and community events. It had a big impact on slowing the epidemic.

Then they tackled the issue of health facility stigma and immunization reluctance.

"CHANGING THE MINDSET OF THE COMMUNITY TO ACCEPT HEALTH FACILITIES IN GENERAL AND VACCINATION IN PARTICULAR BECAME OUR NUMBER ONE PRIORITY."—HAJA BAINDU, PLATFORM MEMBER

With the support and involvement of local opinion leaders and chiefs, the civil society platform went door to door providing people with the correct information about Ebola transmission and the importance of immunization. They gave drama performances in public spaces and transmitted key messages through the Kombra Media Network.

The platform also provided incentives, such as clothing, nappies, toys and food, to mothers who volunteered to take their children for routine vaccination.

INTEGRATION

It is not easy to rapidly change the beliefs and practices of half a million people. In Sierra Leone, the civil society platform was able to do it because they are not a single organization, but part of a wide-reaching coalition of disparate groups, all with their own strengths and networks, yet all united by the same vision. For example, the Agape Way Community Health Center in Bo was a crucial partner. They provided nutrition and immunization education to caregivers and guardians, conducted outreach in hard-to-reach communities, and tracked down children who had not completed all their recommended vaccine doses.

Collaborating with the UN's Scaling Up Nutrition movement really made it easier to get the word out.

POSITIVE OUTCOMES AND IMPACTS

Collaboration between civil society, community-based organizations, and local and national governments was tremendously effective.

Data indicates that:

- The September 2016 polio immunization campaign in Bo resulted in the district's highest ever vaccine coverage: 99.7 percent.
- Between 2014–2016, the vaccination rates for tuberculosis rose from 87 percent to 93 percent, and from 72 percent to 80 percent for measles.

District Medical Officer Dr. Alhaji Sayni Turay formally acknowledged the civil society platform for its critical role in community sensitization and mobilization, crediting it for the huge improvement in vaccination uptake over the past two years.

LESSONS LEARNED

Motivated by their success in increasing immunization coverage, the civil society platform is now engaged in other community-led initiatives to address the high incidence of child malnutrition.

PROMISING PRACTICES

Sudden outbreaks of disease, especially fast-spreading fatal diseases such as Ebola, can lead to panic within communities. Traditional and religious beliefs come to the forefront causing families to become suspicious of modern treatments and vaccinations. It is vital to engage religious and village leaders when tackling these beliefs and changing behavior.

SOUTH SUDAN

Independent monitoring of immunization campaigns

INTRODUCTION

South Sudan experienced a severe wild poliovirus outbreak between 2008–2009. Twenty-four cases were reported in 2008 and forty in 2009, affecting nine out of ten states. The country reported its last case of wild polio virus in June 2009 and has been polio-free for more than eight years. However, Unity State reported an outbreak of vaccine-derived polio virus between 2014–2015. There is a high risk of undetected polio due to civil insecurity making many areas of the country unsafe to monitor.

PROJECT PURPOSE AND CONTEXT

During the 10th and 11th Horn of Africa Technical Advisory Group meetings, members addressed the poor implementation of supplementary immunization activities in the Horn of Africa. One major concern was the credibility of independent monitoring data. While independent campaign monitoring data showed extremely high oral polio virus coverage, sporadic outbreaks continued to occur. This high coverage was even reported in areas that were deemed inaccessible due to flooding, armed conflict, tribal wars and cattle rustling operations, as well as areas that were known to have a shortage of vaccine.

Most of the states provided data that was not independently verified. In some cases, those supervising house-to-house vaccination surveys deliberately altered the results. This overestimation of the coverage of supplementary immunization activities raised red flags. Furthermore, Global Polio Eradication Initiative funding partners raised concerns over late and incomplete reports, questioning the credibility of campaign data.

To correct these issues, the Expanded Program on Immunization Technical Working Group in South Sudan recommended that the CGPP take over nationwide post-campaign monitoring. As of 2013, CGPP has focused on collecting and disseminating credible immunization data to improve subsequent campaign rounds and informed decision making.

STEPS IN IMPLEMENTATION

Post-campaign evaluations are conducted four times a year, mostly during the dry months of February–March and November–December as it is easier to reach remote communities. Data evaluation focuses on children under the age of five. The approach involves a qualitative rapid assessment survey, interviewing caregivers and guardians on a house-by-house basis. The survey uses semi-structured questionnaires developed by WHO as a standard guide for polio campaign monitoring. Two versions are used, one for interviewing people in their homes and another for interviewing them outside the home, such as in the marketplace, at water pumps and churches.

A minimum of two central supervisors are selected per state and receive training in WHO methodology in Juba before being deployed countrywide. Central Supervisors also receive two days' training on polio eradication, data collection methods and the use of mobile phones for data collection. They arrive in

the field one week prior to the end of the household vaccination campaign.

Central Supervisors work with County Education Departments to recruit teachers as data collectors. They then train these teachers on data collection methods and on mapping the accessibility of areas for future data collection. Once these teachers are deployed to administrative districts, *payam*, Central Supervisors oversee their activities, provide logistical support and make incentive payments on completion of data collection. The data is then collated, verified, and transmitted by phone to cloud storage.

During each nationwide campaign, CGPP South Sudan aims to reach all 80 counties and a minimum of four to six *payam* in each county. The *payam* are selected for their history of polio outbreaks, low vaccination coverage, dense population, poor sanitation, inaccessibility during previous campaigns, and reports of non-polio AFP.

Four villages are randomly selected per *payam*. An independent monitor then visits ten households in that village and marks the side of the house and the child's finger with ink once the inhabitants have been vaccinated. These marks act as proof of vaccination, so if the monitor visits three or more consecutive houses where no marks are found, the area is classed as having been missed.

To ensure complete independence of the process, the Central Supervisors select teachers who have not previously participated in planning or implementing household vaccination campaigns. Teachers receive a day's training on how to use the smartphones and chargers. The phones use open data kit forms with built-in GPS. Data collection typically lasts a minimum of three days from the end of the vaccination campaign.

Data is sent through the cloud. The monitoring and evaluation officer in Juba downloads it and employs simple analytical methods to explore the results. Measurable indicators include children's vaccination status, reasons for children not being vaccinated, the number of children who have never received a vaccination, cases where families refuse to immunize their children, and community awareness of immunization campaigns. The data is collated and submitted at county, state and national levels for analysis. Once the technical working group has had a chance to provide input, final results are submitted to the Ministry of Health and WHO to inform future polio campaign rounds.

POSITIVE OUTCOMES AND IMPACTS

This approach to data collection has proved highly beneficial to the national polio eradication strategy:

- The CGPP shares independent, credible polio coverage results with the Global Polio Eradication Initiative partnership, allowing for evidence-based decisions to be made ahead of the next polio campaign.
- Involving third-party monitors vastly improves the quality of data collected during immunization campaigns and states have reported a drastic improvement in survey reach because of the methods used.
- The integration of GPS technology in data collection creates heightened accountability and provides a reliable means of checking which areas have been surveyed.
- The use of cloud transfer means that data is available for analysis almost as soon as it has been collected, allowing for swift updates to decision-making. It previously took WHO and the MOH up to three months to share information with partners.

LESSONS LEARNED

It is a good idea to send monitors out with a supply of paper surveys as a backup in case phones stop working.

PROMISING PRACTICES

This program really brought home the advantages of using mobile technology in data collection. By training independent monitors how to use mobile phone survey tools, the data was uniformly collected and available for analysis within a very short period. GPS tracking helped to ensure that the correct villages and payam were reached. This added an extra layer of credibility to the data.

BURKINA FASO

Documenting the CSO impact on immunization

INTRODUCTION

The Secrétariat Permanent des Organisations Non Gouvernementales (SPONG) is the civil society platform for NGOs involved in the health sector in Burkina Faso. They support civil society involvement in immunization campaigns and health systems

across the country. SPONG decided to publish a report documenting their achievements and outlining best practice in the field of vaccination promotion, drawing on their experiences from 2012–2013.

PROJECT PURPOSE AND CONTEXT

The report examined the first two years of SPONG's project to support the participation of civil society organizations (CSOs) in health system strengthening, and in particular, the ways in which CSOs could help strengthen immunization efforts in Burkina Faso. The report sought to highlight CSO achievements and identify examples of best practice. It also made sector-specific information more widely available and gave a breakdown of important lessons for the future. The goal was to benefit other organizations interested in becoming involved in SPONG and health system strengthening.

STEPS IN IMPLEMENTATION

The report involved meetings and material supplied by a wide range of CSO health sector stakeholders, who were asked to give examples of positive participation and dynamic implementation during their involvement from 2012-2013. This was then compiled into the official report.

The study also devoted sections to lessons learned and challenges encountered. It offered suggestions and recommendations on three key issues At the heart of the Gavi CSO Platforms Project: 1) structuring CSO participation in immunization campaigning, 2) strengthening the technical capacity of CSOs on immunization issues, and 3) increasing the level of interest, commitment and involvement of CSOs in relation to immunization.

POSITIVE OUTCOMES AND IMPACTS

Content from the report showed that SPONG had succeeded in increasing CSO involvement in health sector and immunization initiatives, and in cultivating greater CSO participation in state campaigns. Some of the achievements highlighted in the report included:

- Raising CSO awareness of the importance of vaccinations and increasing their enthusiasm for vaccination campaigning.
- Strengthening the knowledge and technical capabilities of CSOs on the issue of immunization.
- Establishing a national platform to support vaccination efforts.

- Positively involving CSOs with state initiatives to promote vaccinations and creating a collaborative relationship for future activities.

LESSONS LEARNED

It is important to document achievements and best practice for two reasons. Firstly, so that participating CSOs see that their work has been valued and feel proud to have participated. Secondly, to inform potential partners and future initiatives, offering a catalogue of experiential wisdom.

PROMISING PRACTICES

“IF YOU’RE DOING SOMETHING THAT WORKS, YOU SHOULDN’T KEEP THAT KNOWLEDGE IN A DRAWER. IT MUST BE SHARED WITH OTHERS.”

— ATHANASE FIDÈLE KABORÉ, FORMER SPONG PROGRAM AND RESOURCE MOBILIZATION OFFICER

It is important for CSO platforms to document the collective knowledge of their members and make it publicly available. This helps to advance learning at a faster pace and provides a reusable resource for the future.

GLOBAL

The Secretariat Model and global CSO engagement

INTRODUCTION

“ONE OF THE MOST INNOVATIVE THINGS ABOUT THE WORK OF CIVIL SOCIETY IN POLIO ERADICATION HAS BEEN THE DEVELOPMENT OF A SECRETARIAT MODEL.”—ELLYN W. OGDEN, USAID, WORLDWIDE POLIO ERADICATION COORDINATOR

The Secretariat Model guides the work of the CORE Group Polio Project (CGPP). It coordinates the work of over nine international NGOs and 70 sub-grantees (national NGOs) in eight countries. Central to this model is an in-country secretariat. This is a small team of neutral technical advisors, independent of any one implementing partner, that is led by a Secretariat Director. The secretariat facilitates communication, coordination, and transparent decision-making among all partners. Its purpose is to unite community-level expertise with the benefit of international knowledge and experience as part of the Global Polio Eradication Initiative. CGPP countries have successfully implemented the Secretariat Model to coordinate and promote

civil society engagement in polio eradication, coordinating activities between 20,000 community health workers. The Secretariat Model is a unique and crucial contribution to polio eradication.

PROJECT PURPOSE AND CONTEXT

Prior to the use of the CGPP Secretariat Model, some community health efforts were uncoordinated and ineffective. When competitive organizations work in relative isolation to one another, it becomes difficult to share best practice. The Secretariat Model improves collaboration to solve health problems in underserved and marginalized communities. An independently acting in-country secretariat identifies and addresses gaps in capacity, harmonizes actions, tailors campaign messages, and unifies monitoring and evaluation systems. It also helps to establish links to both public and private sector partners. As a result, the entire health system is more equitable and resilient.

STEPS IN IMPLEMENTATION

The Secretariat is a central country office headed by a director who coordinates and supervises the work of partner NGOs in each country, monitoring all technical and financial components. It represents civil society engagement in polio eradication to ministries of health, WHO, UNICEF, CDC, Rotary International, the Bill and Melinda Gates Foundation and other donors, while communicating national and global policies to member NGOs.

The U.S. secretariat serves as a global partnership liaison and provides overall coordination, technical assistance and financial management to partners. Meanwhile, in-country secretariat staff serve as intermediaries between NGOs and national partners, act as a technical resource to partners, and oversee the quality and standardization of project implementation.

The CGPP senior management team consisting of the Global Director and Deputy Director, who identify CORE Group international NGO partners working in the health sector in areas at high risk of polio. The senior team meets with NGO key partners, ministries of health and major international donors, to explain the Secretariat Model and learn about local needs.

CGPP then conducts workshops with a wide range of stakeholders to present the model and elicit transparent discussion. If CGPP obtains government approval because of these discussions, national NGOs who are interested in collaborating on polio eradication submit a joint funding proposal.

Once CGPP is operational in an implementing country, it generally continues to work with the same NGOs throughout its time there. Most CORE Group international partner NGOs have well developed systems for selecting and mentoring local NGOs. In rare instances, where CORE Group international partners are not available, CGPP makes agreements directly with national NGOs.

POSITIVE OUTCOMES AND IMPACTS

There have been many positive outcomes from the Secretariat Model:

- It has been highly impactful and cost effective. 20,000 community health workers support vaccination, mobilization, disease surveillance and other efforts at a cost of \$0.17 per recipient.
- The model reaches deep into communities, building upon the long history of in-country NGO expertise to break down barriers to immunization.
- Working through local NGOs, CGPP reaches children in underserved and hard-to-reach communities.
- The model allows partners to coordinate their work as allies, working in unison rather than competition.
- The secretariat provides a safe space for knowledge exchange and problem solving, helping to promote a common goal and vision.
- The Secretariat Model has attracted national donors and managed activities across a large geographical area with efficiency and transparency.
- The Secretariat has given civil society a voice and representation on national and regional polio eradication planning committees.
- NGO partners have often felt freer to try new approaches and to challenge the status quo of stagnant policies or procedures, knowing they have the support of global partners.
- NGOs have proven that they can meet and exceed service delivery expectations, accessing marginalized communities and contributing high-quality data to inform future programming.
- CGPP's innovative strategies and approaches are mainstreamed towards global polio eradication. These include microplanning, the establishment of child registries, community mobilization efforts, behavioral change and increased communication.

LESSONS LEARNED

Some of the more notable challenges have included the quantity of administration that goes with this level of international coordination. At times, the indirect cost recovery rate of some international NGOs has proved to be higher than expected, and local NGOs sometimes have limited capacity to implement projects in countries with weak health systems.

All eight CGPP countries are still at high risk of re-importation of wild polio virus as well as facing the emergence of vaccine-derived polio due to inconsistent routine immunization coverage, fewer supplementary immunization activities, high population density, poor sanitation, and large mobile populations.

PROMISING PRACTICES

Working in collaboration and not in competition is the basis of the CGPP Secretariat Model, which benefits from the expertise of local NGOs as well as support from country governments. Replication of the model would help to support the reduction of inequities between health services. The Secretariat Model is adaptable for measles elimination, malaria control, improved immunization, maternal mortality reduction and universal health coverage, among other such initiatives. Individual country secretariats are a shared resource for all partners and ensure that NGOs complement rather than duplicate each other's work. The model closely pairs community-level expertise with international knowledge and strategic ambition when it comes to eradicating diseases worldwide.

B. COLLABORATIONS WITH MINISTRIES OF HEALTH

KENYA

Microplanning with the Ministry of Health at the sub-national level

INTRODUCTION

The Kenyan Health NGOs Network (HENNET) was founded in 2005. It exists to overcome a long-standing gap in CSO coordination and networking in the health sector. HENNET is a forum where CSOs can collaborate to implement health interventions, share sector experience and advocate with one, united voice. It brings together a diverse range

of health-oriented organizations who share the common vision of a healthy Kenyan society.

PROJECT PURPOSE AND CONTEXT

HENNET is currently implementing a Gavi-funded project to support civil society participation in the Health System Funding Platform. The project's goal is to contribute to strengthening the capacity of integrated health services, and to resolve health system constraints to increase the delivery of immunization services. By increasing civil society engagement in the health sector, HENNET also hopes to increase the level of equity in accessing services.

STEPS IN IMPLEMENTATION

Prior to implementation, HENNET held a stakeholder meeting with twenty-one civil society organizations to introduce the Gavi CSO Platforms Project to its members.

An eleven-member technical working group was elected at this meeting. The working group represented five thematic project areas: Health System Strengthening, Advocacy, Capacity Building, Child Health and Resource Mobilization. The group was mandated by HENNET to represent other network members during the project's implementation.

The working group members are from Action Africa Help International, BasicNeeds, CARE Kenya, FHI360, Kenya Consortium to Fight AIDS, Tuberculosis and Malaria, Kenya NGO Alliance Against Malaria, Merlin International, Mildmay International, Provide International, Rural AIDS Prevention and Development and World Vision Kenya. Most member organizations are based in Nairobi with field offices in various parts of the country.

HENNET is in the process of running a gap analysis with platform members to build relevant capacity and better engage them on the topic of immunization and vaccination.

INTEGRATION

HENNET works closely with the working group to implement this project. Working group members make up 52 of the total 87 HENNET network members implementing programs related to maternal and child health. The working group's mandate is to provide technical guidance and practical assistance on project implementation.

POSITIVE OUTCOMES AND IMPACTS

Through the Gavi CSO project, working group members have improved their understanding of the immunization and vaccination situation in Kenya by attending Ministry of Health forums. They have also gained knowledge on Gavi's priorities for CSOs.

The network members are working towards partnering with the Ministry of Health to increase public demand for vaccinations and improve access and vaccination services. The network is placing a special emphasis on reaching out to marginalized and underserved communities.

LESSONS LEARNED

Building up a strong network is an ongoing process. Although enthusiastic, many network members still require extra knowledge and skills to improve advocacy efforts and become involved in policy planning. HENNET can help to provide this training, with the support of Gavi.

PROMISING PRACTICES

HENNET is all about networking. Strong and informed CSOs have the capacity to become effective agents of change, influencing grassroots communities, increasing access to immunization services and resolving health system constraints. Their strength comes through shared information and objectives, which an active network helps to provide.

ZAMBIA

CSO-led introduction of new vaccines

INTRODUCTION

The Churches Health Association of Zambia (CHAZ)'s HPV Project was developed to complement the Government of Zambia's efforts to reach out to caregivers of girls aged 9-11 in the districts of Lusaka. The aim of the project was to make sure that all girls of eligible age received the full course of the human papillomavirus (HPV) vaccine.

PROJECT PURPOSE AND CONTEXT

CHAZ stands for the Churches Health Association of Zambia. Founded in 1970, it is the largest non-government health provider in Zambia, with 151-member health institutions. CHAZ is committed to serving poor and underserved communities in

Zambia, helping them to access affordable, quality health care.

Zambia has one of the highest cervical cancer rates in the world, with 90 out of every 100,000 women expected to contract some form of the disease. For this reason, the government decided to introduce new vaccinations against the HPV virus, which is known to increase the risk of cervical cancer.

The rollout of the vaccine began by targeting primary schools across Lusaka in 2013. In October 2015, CHAZ became involved in reaching older girls aged 9–11 to ensure they also received all three rounds of the HPV vaccine.

CHAZ teamed up with cancer NGO Susan G. Komen, the Ministry of Health's Child Health Unit, Lusaka District Health Office and the regional Ministry of Education. Outreach activities relied on community volunteers and health workers to perform plays and educate caregivers on the importance of the HPV vaccine for girls. They also encouraged adult women to go for cervical cancer screenings.

STEPS IN IMPLEMENTATION

The first round of vaccinations for girls aged 9–11 began in October 2015, the second in January 2016 and the final round in June 2016.

CHAZ began by bringing together communication and health professionals to help develop a range of campaign materials including wristbands, posters, flyers and T-shirts. Campaign meetings were used to develop key campaign messages. One of the most popular slogans was 'Be a V.I.P. Girl,' which stands for Vaccinated, Immunized and Protected.

Community volunteers were selected and given training before undertaking a door-to-door sensitization program, visiting caregivers and guardians to explain the importance of HPV vaccination and cervical screening.

Volunteers also spoke at church gatherings, in public spaces such as markets, performed plays and handed out information leaflets. The Ministry of Health even supplied T-shirts and ID cards so that volunteers were easily identified.

The thirty drama groups that participated all received training on HPV and cervical cancer so that they were delivering the same message. These plays proved very popular among local communities and really helped to spread accurate information throughout the districts.

Radio interviews were broadcast with medical experts and cancer survivors. There was a high level of response from listeners asking for more information. Factsheets were also sent to journalists who helped to raise awareness of the subject through newspaper articles.

School parent–teacher associations were engaged. Their support was key in reassuring caregivers that the vaccination was both safe and necessary, and provided an open platform to discuss any concerns. They also allowed caregivers a chance to meet and speak with medical professionals and cancer survivors.

POSITIVE OUTCOMES AND IMPACTS

The third and final vaccination round was completed in June 2016, and the overall campaign had an extremely positive effect:

- 94 percent (14,345) eligible girls in Lusaka districts were vaccinated. The original objective was to reach 90 percent, so the project surpassed its original target.
- 145,098 people were reached by door-to-door volunteers and provided with information about the HPV vaccine and cervical cancer.
- Drama performances played to a total audience of 85,093 people.

LESSONS LEARNED

Some lessons learned during this project included:

- Providing volunteers with campaign T-shirts to make them easily identifiable helped to build confidence among local communities and they were taken more seriously when handing out information.
- Data management and project coordination was not always as strong as it should have been. Whereas the development of the campaign message was focused and collaborative, this level of organization needed to carry over into implementation. A large-scale campaign needs strong logistical support.
- A greater level of sensitization could have been achieved with a larger budget.

PROMISING PRACTICES

The HPV vaccine was being newly introduced to Zambia, and people had little information about the link between HPV and cervical cancer. It was

important to sensitize local communities on the reasons for this vaccination, its life-saving potential and the vaccination schedule. As the vaccination was aimed at young girls, the support of local parent-teacher associations were hugely beneficial in gaining trust and distributing accurate information. Developing a strong campaign message right from the outset, such as ‘VIP Girl,’ is also essential for getting the message out there quickly.

UGANDA

District Immunization Champions and Regional Nodes

INTRODUCTION

As with many economically underdeveloped countries, Uganda’s health care system faces serious challenges. Inadequate funding, a shortage of staff and poor adherence to vaccination schedules have led to a decline in immunization levels. According to the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF), Uganda’s national measles immunization coverage dropped from 71 percent in 2006 to 55 percent in 2010. Due to limited infrastructure, this decline has predominantly been seen in rural areas.

The Uganda Civil Society Immunization Platform is a network of 281 civil society organizations (CSOs) looking to halt the decline in immunization coverage by linking community-level health volunteers with national immunization efforts. They are doing this by promoting District Immunization Champions and Regional Nodes.

PROJECT PURPOSE AND CONTEXT

Small community health centers are the frontline of the battle for rural Uganda’s health, and volunteers are its lifeline. They care for the sick, reach out to the community, and support clinic staff. However, the Government of Uganda is struggling to provide community-level health care. Decades of staffing and budget shortfalls, combined with the challenge of reaching some of the most remote villages in the country, have made national immunization efforts difficult.

Faced with these challenges, local volunteers now play a crucial role in community immunization efforts, raising local awareness and informing the government’s national immunization campaign. Their key aim of this program is to provide immunization planners and decisionmakers at national level with

accurate and up-to-date information from local communities.

To do this, two types of community volunteer have been recruited:

1. District Immunization Champions (DICs), who collect monthly data from local health volunteers and community organizations in their districts.
2. Regional Nodes who collate data from district DICs and filter it up to the CSO platform in the form of monthly reports.

In this way, any gaps in immunization, vaccine supply and outreach can be monitored more accurately at central level. The idea is to bridge the gap between policymakers and communities.

STEPS IN IMPLEMENTATION

The following steps were undertaken to implement this program:

1. The platform identified local CSOs already working in the health sector and trained them in data collection and report writing.
2. 103 DICs were trained and linked up to local CSOs working in the health sector. Each month, DICs visit local health facilities to collect data from these CSOs.
3. DICs report monthly to Regional Nodes, who are responsible for collating all the DIC reports from their district monthly. They then pass this information up to national level
4. These reports go on to inform national immunization policymakers, providing accurate up-to-date information on coverage and vaccine supply across each district.

The platform trains CSO volunteers and selects and trains DICs and Regional Nodes.

INTEGRATION

Fred Chemuko is the Regional Node for Bukedea District. Twelve DICs report to him each month, and he compiles their reports into a single brief which is sent up to the CSO platform at national level.

“I have seen the improvement of the working relationship between the communities and the District Health Officers,” he explains. “We have freed people from their comfort zones to where they are now working together, and that is a big success.”

DICs attend monthly meetings with district-level health officials and share the information they have gathered from their local communities. In this way,

they play a vital role in immunization planning. They also do more than collecting data, often travelling far from home to locate and immunize children, as well as performing awareness-raising activities in underserved communities.

POSITIVE OUTCOMES AND IMPACTS

This program not only reaches local communities but improves health response at national level:

1. Far greater levels of communication between local communities and national policymakers has made it easier to close the gaps in immunization coverage and respond quickly to outbreaks and vaccine supply shortages.
2. The improved working relationship between the CSO platform and local communities leads to greater trust in health services and an increase in people seeking immunization.
3. Involving CSOs and training community volunteers has led to a greater sense of local ownership over health services.
4. Through training DICs, Regional Nodes and local CSO health volunteers, the quality of data collection and reporting has increased, leading to more accurate statistical information.
5. Regional Nodes, such as Fred Chemuko, believe that immunization coverage has increased in their area as a direct result of the improved flow of information.
6. A single DIC can locate and immunize up to 100 children per week over remote areas.

LESSONS LEARNED

The main lesson learned from this program is that many hands make light work. Training and supporting a network of community health volunteers and immunization champions reaches many more people than centralized campaigns alone. Communities actively want to participate in building a functional, effective health system in their region, reaching out to underserved communities and helping to boost immunization coverage.

DICs and Regional Nodes are the way forward for improving national response times to immunization issues and for building a strong sense of community ownership over health services.

PROMISING PRACTICES

Strengthening national-local communication and working relationships in Uganda shows how

important the flow of information is in the battle against vaccine-preventable diseases. Volunteers on the ground are the first line of defense against outbreaks, and the most effective outreach method for contacting remote regions and improving vaccination coverage.

Creating a controlled flow of information from local health centers, through to DICs, then Regional Nodes, and finally national level, means that data is carefully checked and compiled before being presented to decisionmakers. The data that arrives at national level is both current and accurate, leading to better evidence-based decision making on immunization strategy.

KENYA

County Chapters

INTRODUCTION

During needs assessment meetings with sub-county health management teams, it was clear that there was a high dropout rate of children from the immunization schedule. This was due to many factors, including prolonged strikes by health workers, a lack of community understanding of the importance of immunization, and the nomadic lifestyle of certain groups.

The Kenyan Health NGOs Network (HENNET), in collaboration with local health management teams, was able to come up with sub-county specific approaches to address these issues. The health teams helped to identify priority issues and suggest sustainable interventions using minimal resources.

PROJECT PURPOSE AND CONTEXT

HENNET operates in nomadic, pastoralist areas. Two sub-counties, Narok and Kajiado, are largely occupied by nomadic Maasai communities. They are especially mobile during the dry season and this causes problems for health records as the Maasai might visit several different clinics as they move, leading to inaccurate immunization records. These two counties are vast in size, so it is hard to keep track of people. Both family and community decisions are usually taken by men, and traditional Maasai beliefs affect their attitudes toward using health services.

The purpose of this activity was to help strengthen community health systems using local stakeholder engagement. This meant engaging community

health volunteers and religious leaders to sensitize communities on the importance of vaccinations, explain how they can prevent certain diseases, and build community trust in their health facilities.

Local stakeholders and religious leaders provided advocacy platforms to help push the immunization agenda. They acted as key entry points to the community. There are a lot of myths surrounding immunization within religious factions, so having religious leaders on board as immunization champions went a long way to convincing communities that vaccines are safe for their children.

The strategy aimed to help HENNET reach the most marginalized populations. A key focus was

to eliminate the myths around vaccination and encourage caregivers to take their children to get vaccinated without delay.

The overall aim was to see an increase in immunization coverage in those two sub-counties, thereby reducing preventable childhood morbidity and mortality.

STEPS IN IMPLEMENTATION

HENNET began by approaching sub-county health management teams for introductory meetings. This helped to identify sub-counties that needed assistance and were not receiving support from other partners, the county, or the national government. County health management teams further introduced HENNET to sub-county micro-planning and implementation teams. HENNET conducted planning meetings with these teams to identify gaps, interventions and sustainable approaches.

Sensitization meetings were then held with different groups, including community health volunteers, community gatekeepers, stakeholders and religious leaders. Community health volunteers were recruited to help track down people who had missed follow-up vaccinations, to start dialogues on the importance of vaccinating children, and to encourage these patients to return to health outreach clinics and complete the course of vaccination.

HENNET supported activities by religious leaders that were geared towards promoting immunization and improving health-seeking behavior among their congregations. One such activity was Immunization Sunday. This is where religious leaders allowed their places of worship to be used as an immunization facility after Sunday service.

During this program, Kenya experienced five-months of health worker strikes, which saw many health facilities close. This resulted in a significant number of children missing appointments. HENNET, in collaboration with health management teams, was able to recruit community health volunteers to carry out tracing and referral activities during this period. At the same time, community health outreaches were conducted. This meant that as many children as possible were reached in time to receive their follow-up vaccinations.

INTEGRATION

HENNET collaborated with county health management teams to introduce the project and to

IMMUNIZATION WEEKS

African Vaccination Week in Guinea: The importance of gender in immunization programming

Lokoza is more than a hundred kilometers from the capital, Conakry. Many of the people living there have traditional beliefs and resist vaccination. Between October 2017 and May 2018, the CSO platform held community dialogues to counter vaccine myths, provide detailed information on the ten major vaccine-preventable diseases, and offer prenatal consultations including tetanus vaccination.

A little information can go a long way. One woman who attended a dialogue later reported that her husband had been very against having their child vaccinated because he thought that the vaccine would make the child sick. After the child received its first vaccine, her husband had hidden the vaccination book so that she could not find it. After attending an Immunization Week dialogue, however, the mother understood just how important it was for her child to complete the course. When she was alone, she went through the house and found the book. She asked the health worker to copy down the information, and then returned the book to its hiding place. The father never knew, and the mother took her child to complete the course of vaccination in secret.

build a clear picture of each county's immunization status. This helped to identify which counties most needed intervention. Joint micro-plans were then developed, gaps were identified, and approaches were agreed upon. HENNET then helped to select community health volunteers to undertake outreach sessions and establish community dialogue activities.

HENNET, together with sub-county teams, collaborated with these community health volunteers and with local chiefs to organize access to each community. They then set about identifying children who had missed follow-up vaccinations, attempted to find them, and referred them to a clinic to complete the course of vaccination. They also conducted household visits to sensitize people on the importance of completing vaccinations.

Existing community structures enabled HENNET to implement the project smoothly without resistance from community stakeholders. Regular feedback sessions were held with various stakeholders and partners. This helped to build trust between the project teams, health management teams, and local communities.

POSITIVE OUTCOMES AND IMPACTS

The following positive results have been recorded:

- Feedback from the county health teams in both counties indicated HENNET's work helped to improve their routine immunization scores.
- The community health strategists in Kajiado West commended HENNET for supporting community health volunteers in carrying out searches and referrals for patients who had missed vaccinations and stated that no other partner or government agency had ever thought to do this.
- Religious and community leaders felt that involvement in the project was impactful and sustainable.
- The health teams were able to address several listener concerns through media talk shows, and the media was employed as a means of raising awareness across a wider audience.

LESSONS LEARNED

The following challenges were encountered:

- The vastness of the two counties posed a serious challenge and made coordination and follow-up difficult. HENNET learned that it would have been easier to concentrate its efforts on just one county

or sub-county. The impact would have been greater within such a short period of time.

- HENNET platform members are largely CSOs focusing on health but not necessarily immunization. It would be easier if members had a specific focus on immunization and already recognized it as a priority.
- Kenya might have a higher number of fully-immunized children than reported. There is currently no way to collate health information for patients who attend more than one clinic. For example, a child who is part of a nomadic family might receive follow-up vaccinations from a clinic that is different to their birth clinic, but they might still be recorded as missing those vaccines because the first clinic doesn't have that information. It would help if the government could introduce a universal health identification number for children from birth, so that their information could be accessed anywhere in Kenya. That way, no child would go unrecorded even if they seek immunization services from a different clinic.

PROMISING PRACTICES

Highly mobile populations are at greater risk of missing follow-up vaccines or having incomplete vaccination records. Reaching nomadic communities can be a daunting task, especially when they travel across large geographical regions. For this reason, it's important to implement micro-plans, involving regional leaders, religious leaders and media outlets, to try to get the message spread across as wide an area as possible.

PAKISTAN

Shadowing government immunization outreach workers

INTRODUCTION

The village of Khar Bashu is situated 60 kilometers from Skardu, high in the towering mountains of Gilgit Baltistan. A narrow stone path provides the only access, buried beneath snow during the winter months. Traditionally, women in Khar Bashu have resisted getting their children immunized. They were afraid of what went into the vaccines and suspicious of their effects. The village is now home to two local health promoters. A volunteer vaccination champion called Muhammad Reza and a gender-segregated Village Health Committee. Together, they

are responsible for educating the community on the importance of immunization.

PROJECT PURPOSE AND CONTEXT

“WHEN I BEGAN WORKING IN 2009, WOMEN WERE AFRAID OF VACCINES—THEY DID NOT KNOW WHAT WAS IN THEM AND WHY THEY WERE NECESSARY FOR THEMSELVES OR THEIR CHILDREN. THEY WOULD SIMPLY REFUSE TO LISTEN WHEN I TRIED TO CLARIFY THEIR DOUBTS DURING DOOR-TO-DOOR INFORMATION SESSIONS.”— MUHAMMAD REZA, VACCINATION VOLUNTEER

Until Muhammad took up his position as the Vaccinator of Khar Bashu, at least two maternal and infant deaths were reported in the village each year. Including the other three villages on the mountain, that made a total of 10–15 deaths annually.

STEPS IN IMPLEMENTATION

Muhammad was supported in becoming a vaccination volunteer by the Institutional Development Program. He received intensive training, including a week-long visit to District Headquarter Hospital Skardu, where he learned about the composition, preservation and administration of vaccines.

He accompanies the government vaccinator during quarterly visits to the village, to make sure they visit each home and maintain a separate record for women and children. He also distributes Expanded Program on Immunization cards to families between visits.

Muhammad continues to hold door-to-door information sessions on a bimonthly basis to maintain the level of information among households. He specifically focuses on educating women and heads of households. This is a daily task which requires him to travel two hours by foot from his home in Nazimabad down to Khar Bashu.

POSITIVE OUTCOMES AND IMPACTS

One of the most notable outcomes of Muhammad’s efforts is that there doesn’t appear to have been a reported maternal or infant death from vaccine-preventable diseases in the past three years. This has been verified by a fellow health worker, Syed Mustafa. In addition to this, Muhammad believes he has raised the immunization rate from 70 percent to 100 percent, with all mothers and their children receiving timely vaccinations and completing their courses.

LESSONS LEARNED

Muhammad is one man doing a fantastic job, but this often involves very long days travelling great distances. To maintain the impact of his work, he envisions a future network of volunteer vaccinators to help share the load.

PROMISING PRACTICES

A single person, when properly trained, motivated, and linked to a government counterpart, can have a massive impact on community immunization levels.

C. PREVENTING AND RESPONDING TO DISEASE OUTBREAKS

CAMEROON

Community early warning systems

INTRODUCTION

On 14 July 2018, the Public Health Minister, Mr. André Mama Fouda, officially declared a cholera outbreak in four regions of Cameroon: Center, Littoral, Far-North and North. In response, the Platform of Organizations of the Civil Society for the Promotion of Vaccination and Strengthening of the Health System in Cameroon sought to implement a Community Early Warning System.

PROJECT PURPOSE AND CONTEXT

The cholera outbreak led to a number of deaths, including 35 reported by media in the Far-North and North regions. The Community Early Warning System was developed to increase the capacity of community members and clarify their roles when it comes to monitoring, forecasting and managing reported outbreaks. The system focuses on two health districts, Ngong and Pitoa in the northern region of Cameroon.

Ngong is estimated to have 147,385 inhabitants, 44 percent men and 56 percent women. Pitoa has 178 villages spread over four sectors: Fali Kangou, Tinguelin, Bé, and Guébaké. In 2005, the municipality was reported as having 76,715 inhabitants in total.

STEPS IN IMPLEMENTATION

Steps taken in implementation included:

- Stakeholders and facilitators were trained in how to use the Community Early Warning System.
- Geographical locations were chosen for implementation.
- Baseline data was collected from those areas and health risk assessments conducted to establish comprehensive alert levels and determine population vulnerability.
- Community volunteers were recruited to help implement the Community Early Warning System.
- Workshops were held with community representatives, technical services and partners, think tanks, state technical services and local leaders to help validate the alert system and vulnerability data.
- Trained volunteers were deployed within communities at municipal level, under the coordination of administrative authorities in charge of civil protection.

In partnership with the Union of Supporting Organizations for Sustainable Development, volunteers went house-to-house, collecting information and monitoring it against the crisis indicators. That information was then fed into the Community Early Warning System to inform the General Community Monitoring Assembly. Community monitors met once a month or more to exchange findings, and additional health information was fed back to the community in a series of local-level sensitization meetings. This helped to keep communities informed about outbreaks and how to remain vigilant.

POSITIVE OUTCOMES AND IMPACTS

Thanks to the system, the following cases were identified in each area of operation:

Pitoea Health District: Badjouma Center—three cases with two deaths, Badjol, next to Ouro-Sambo—one case.

Ngong Health District: Ngong—seven cases, Tchatchara—two cases, Windé-Ngong—one case, Marouaré-Ngong—one case, Waléol—one case, Sabongari—two cases, Kismatari—one case, Babla—one case.

All reported cases were dealt with by local health centers and helped to prevent the spread of disease.

LESSONS LEARNED

It is important to seek stakeholder input when validating the alert system levels. What seems normal from an outsider perspective may seem abnormal to residents of that area. It is important that alert levels, from no threat to critical, are agreed by all participating regions.

PROMISING PRACTICES

This is an example of how community volunteer mobilization can be employed in a crisis outbreak situation, both to contain disease and treat those affected. Grassroots vigilance is a powerful tool in helping to contain the spread of cholera and other life-threatening illnesses.

BURKINA FASO

Social behavior change in outbreak-prone communities

INTRODUCTION

Social behavior change tools were employed across key areas of the country to raise people's awareness of the importance of vaccination and increase the number of children getting vaccinated. These activities were implemented as part of the platform's 2016–2017 action plan.

PROJECT PURPOSE AND CONTEXT

The project sought to deliver behavior change messages in four districts with low immunization coverage (2017). These included hard-to-reach areas outside Ouagadougou and Bobo-Dioulasso. The large immunization gap made these areas obvious choices for intervention. However, significant outbreaks often occur in areas that report good coverage, raising questions as to whether actual coverage really meets reported coverage.

The goal of this activity was to increase demand for routine immunization. Specifically, this activity aimed to:

- Make people aware of the benefits of vaccination
- Explain which diseases are targeted by the Expanded Program of Immunization (EPI) in Burkina Faso
- Publicize the vaccination calendar in each region
- Encourage people to use immunization services in accordance with health service recommendations

STEPS IN IMPLEMENTATION

The activities consisted of educational talks and radio broadcasts in districts with low immunization coverage. Districts were chosen based on data from the 2015 Statistical Yearbook. Within each district, teams helped to identify health centers with the lowest vaccine coverage. Those health centers helped to identify local villages with low immunization coverage and to conduct sensitization. Each district team was charged with identifying low-coverage areas in their region and set the target of delivering five talks each week, to help spread the message. In addition to these talks, the teams were to take part in regional radio discussions once a month to reach a broader audience. It was the teams' key responsibility to organize these activities, and a methodology for identifying target individuals and collecting data was developed with the help of consultants.

INTEGRATION

Collaboration between public sector and civil society actors was essential for the success of this project. The Expanded Program for Immunization (EPI) manager in each health district provided technical support. Staff from the Health and Social Development Centers were involved in activity monitoring. The intervention relied heavily on the strong involvement of local communities.

POSITIVE OUTCOMES AND IMPACTS

The positive outcomes of this program included:

- People understood the benefits of vaccination
- People understood which diseases the EPI were targeting in Burkina Faso
- People knew the vaccination schedule
- People started to use vaccination services according to health service recommendations
- Platform members from six health regions carried out behavior change communication activities.
- 168 educational talks were held in 68 villages, reaching a total of 8,149 people, including 5,600 women
- Six health regions were visited by supervisors
- 30 radio broadcasts were undertaken

LESSONS LEARNED

The rainy season meant that some communities could not be reached for follow-up sessions. Seasonal weather should be taken into consideration during future activity planning.

Future activities should cover more localities and occur more regularly, with increased field trips. Local health center programs should also be investigated to see how staff are working to increase immunization in their region.

Not only is it important to maintain the increased coverage gained during this intervention, but it is important to mobilize further resources to extend the program to other health districts with poor coverage.

PROMISING PRACTICES

These activities have contributed to improving the platform's governance and functionality. They have also strengthened the capacity of its members when it comes to community mobilization and vaccine provision. The results stand as an example to encourage platforms in other countries to adapt this approach and try to replicate it.

CHAD

Immunization surveillance sites

INTRODUCTION

In 2008, the Ouagadougou Declaration prioritized nine key initiatives for health care in Africa, ranging from improved governance and financial processes through to conducting research and exploring new technology.

As a result, locally-elected Health Committees were established at each community health center. These committees are non-profit associations, overseen by a Management Committee, and officially recognized by district authorities. It is their responsibility to ensure the level of health care provision in each region.

Although a good idea in theory, it was found that these structures did not always fairly represent local community interests, and many have failed to prove functional during evaluation. To restore public trust and encourage Health Committees to interact more with local communities, Observatoires Communautaires Régionaux de Santé (O CRS) were established to encourage greater community dialogue and cohesion.

PROJECT PURPOSE AND CONTEXT

The Plateforme des Organisations de la Société civile pour le soutien à la Vaccination et à l'Immunisation au Tchad (POSVIT) mobilizes local community organizations in the battle against preventable diseases and childhood mortality. The key focus is on making sure that everyone had access to vaccinations.

POSVIT is supported by law 019/PR/99, which reinforces the Alma Ata Declaration's assertion that people have the right, and the duty, to participate in the design and delivery of their health care. The law seeks to empower community participation in planning, financing and managing health services at all levels, as well as collecting data to monitor the effectiveness of health interventions.

To support this health rights framework, POSVIT established regional community committees, called OCRS, who work to promote health care rights among their communities and monitor the reach and efficiency of service provision. OCRS are POSVIT's innovation, in response to the troubled Health Committee structure.

Part of the OCRS's purpose is to help individuals to feel confident in reporting difficulties accessing health care, dysfunctional services and violations against the basic human right to good health. They undertake advocacy and awareness raising to help achieve this.

OCRS have six key areas of intervention, which guide the work that they do. These areas of intervention are as follows:

1. Capacity building of OCRS members
2. Conducting research
3. Increasing public awareness of the right to good health
4. Consulting with health workers
5. Advocating with local authorities
6. Monitoring and evaluation

STEPS IN IMPLEMENTATION

POSVIT facilitated the target communities to establish seven OCRS in October 2017. Three more are in the process of being set up. These OCRS are working with around forty local health centers in communities across the country. The seven places where OCRS have already been established are Mongo for Guéra Region, Massakory for Hadjer-

Lamis Region, Pala for Mayo-Kebbi Region, Moundou for Logone Occidental Region, Doba for Logone Oriental Region, Koumra for Mandoul Region and Sarh for Moyen-Chari Region.

Each OCRS committee is comprised of five members: General Secretary, Deputy General Secretary and Finance Officer, Ethics and Professional Conduct Officer, Communications Officer and Community Relations Officer.

INTEGRATION

OCRS work closely with local health care providers and staff to resolve service access issues and improve the quality of health care that is available. They work to engage local communities, promote dialogue between all health care stakeholders, and encourage respect and equality when it comes to accessing health care. The aim of OCRS is to make Chad a country where health care is universally available for everybody without exception.

POSITIVE OUTCOMES AND IMPACTS

So far, OCRS have proven to have many strengths which help to promote community health care access in Chad:

- Dialogue has been opened between OCRS and local health workers, allowing for greater consultation on improving access to health care and developing efficient systems.
- Collaborating with health workers and service providers has increased understanding of the way in which people use their local health services, their expectations and the barriers they face to receiving appropriate treatment. This has opened the way for in-depth discussions on how to improve quality service provision.
- OCRS have been able to explore and monitor vaccine distribution, including cold chain and storage methods. This type of information makes it easier for OCRS to advocate for more efficient distribution methods.
- Good lines of communication have been established with local health authorities, leading to greater collaboration to overcome problems and build effective structures.
- OCRS have been able to cross-check complaints about unprofessional health workers and policy violations, leading to rectification of those mistakes and an improvement in subsequent services.

- Collaboration between OCRS and the Regional Health Delegation in Logone Occidental made it possible to share data about that region. OCRS helped to combine the Delegation's data with its own community data, providing a fuller picture for analysis.

LESSONS LEARNED

OCRS have been slow to build capacity due to a lack of funding, but this is something that they hope to remedy in the future so that OCRS are better able to reach underserved people in their communities and spread their messages more efficiently.

Other performance gaps:

1. Some health workers have a poor perception of OCRS, possibly because of previous experiences with dysfunctional Health Committees.
2. Budget restraints and the volume of work expected by POSVIT makes it hard to set clear priorities.
3. OCRS members would benefit from more training as many of them have little prior experience.

PROMISING PRACTICES

In the long term, the hope is that OCRS will prove an effective way for local communities to actively participate in informing health services. They provide a channel for dialogue among regional health service providers, effectively encouraging the participation of stakeholders at all levels.

OCRS are not looking to police or criticize local health care efforts but seek to work in a spirit of open collaboration, helping health care staff and facilities to attain best practice and good governance, and to continue improving the quality of care on offer to their communities. OCRS recognize that good health care also requires a supportive working environment for health professionals, and that passion, dignity and professionalism are fundamental to effective health care provision.

SOUTH SUDAN

Community-based polio surveillance

INTRODUCTION

The CORE Group South Sudan Polio Project (CGPP) began in 2010. It quickly coordinated the efforts of small, isolated NGOs into large-scale collaborative interventions. Through linking local civil society expertise with the international effort to eradicate polio, it made it much easier to assist hard-to-reach areas, including conflict-prone regions and those districts situated along country borders. In 2015, CGPP started robust community-based surveillance in the conflict states of Jonglei, Upper Nile, Unity and East Equatoria. The program worked within 36 counties and established a network of around 3,400 community informants targeting more than 1.6 million children under the age of fifteen.

PROJECT PURPOSE AND CONTEXT

After just two years of independence from the Khartoum Government, South Sudan experienced one of its worst civil wars. The states of Jonglei, Upper Nile and Unity were left devastated. Health infrastructure was completely destroyed, including immunization services, due to mass population displacement. An estimated 1.9 million people were internally displaced, and over two million fled to neighboring countries. Many health workers were among the displaced, which led to the breakdown of immunization delivery structures. Many areas became inaccessible due to armed conflict and an increased number of children went unvaccinated. This increased the risk of wild polio virus infection. Establishing surveillance systems has been challenging due to restrictions on movement and few available resources. In 2014–2015 South Sudan experienced an outbreak of vaccine-derived polio virus in Unity State.

Healthy Baby Shows

Teams awarded 2,858 Appreciation Certificates to caregivers whose children were fully and timely immunized in low-coverage areas of India. The awards were made during Healthy Baby Shows, where children's weight and height were measured in accordance with their age. The purpose was to acknowledge good vaccination practices and encourage other caregivers to do the same. On average 30 children participated in each show.

STEPS IN IMPLEMENTATION

At county level, 35 supervisors oversaw the project in eight payams. A payam is a subdivision serving between 10–15,000 people. In addition, CGPP recruited 215 Payam Assistants to supervise the activities of 3,228 community informants. These volunteers were charged with detecting and reporting suspected acute flaccid paralysis cases in their villages. Community informants are people respected within their communities, but who are often illiterate. They include traditional healers, teachers, church leaders, chiefs, traditional midwives and youth leaders. Community informants receive training on how to identify acute flaccid paralysis (AFP) before taking up their positions.

Payam Assistants supervise a minimum of 15 community informants and visit them daily to collect reports of suspected AFP. In some instances, community informants travel to deliver reports to Payam Assistants if they think the situation is urgent. Payam Assistants then go with the informant back to the village to verify the report.

When AFP is identified, Payam Assistants submit a report to their County Supervisor within 48 hours. The County Supervisor visits the scene to investigate further and to complete the report. All AFP cases in a region are recorded on a simple table containing information about the name of the afflicted, their age, location, date of onset, date the case was identified and reported, and the date stool samples were taken, and specimens sent to Juba.

These records assist in tracking AFP cases and match laboratory results to positively confirm cases of wild polio virus. WHO field staff take initial stool samples and transport them to Juba within 72 hours. If WHO staff are unavailable, the Community Supervisor organizes a stool sample collection and transportation to WHO in Juba.

The CGPP Community-based Surveillance System follows standard operating procedures, including a supervision checklist for County Supervisors and a field activity logbook. This documents Payam Assistant activities, including their supervision of community informants.

County Supervisors visit all Payam Assistants at least once a month. Payam Assistants, in turn, visit each of their community informants on a regular basis.

Implementing organizations receive monthly activity updates and use these to compile a report for partners. The Secretariat receives detailed updated

line lists, which include recent cases, old cases, cases from which stool samples have been collected, and recent cases where no stool samples have been collected.

A national database collates and analyzes data from all 34 counties and the information is used to inform policymaking and health interventions.

POSITIVE OUTCOMES AND IMPACTS

Over the last three years, there has been a significant increase in the number of AFP cases reported through the Community-Based Surveillance system. Between January 1, 2017–June 30, 2018, the system accounted for three-quarters of reported AFP cases in CGPP catchment areas. Facility-based surveillance systems reported the remaining cases.

Cases reported through the system adhered to WHO's recommended timeframe, which facility-based reporting did not always do.

According to focus group discussions, community informants say their work motivated them to help their community. The community, in turn, trusted those volunteers to identify cases quickly and report them to their supervisor immediately.

Project reports confirm that AFP cases identified through the surveillance system had a better chance of being promptly investigated compared to those reported through health facilities. One field interview suggested three reasons for this prompt response:

1. Proximity of surveillance volunteers to the community
2. Physical access to every village
3. Staff with skills equal to WHO field staff, specifically trained to investigate AFP cases

LESSONS LEARNED

South Sudan's surveillance system can successfully outperform facility-based surveillance efforts, continuously and effectively monitoring communicable disease outbreaks.

However, it is not always possible to take stool samples straight away due to cold chain issues. There have also been instances of samples disappearing on their way to the laboratory, likely because of regional insecurity.

PROMISING PRACTICES

Effective Community-Based Surveillance systems are extremely important for areas at elevated risk of polio. It is particularly important in countries with weak health systems, such as South Sudan. With minimal additional effort, it can help to expand polio detection and it can also be applied to other communicable diseases. The contribution of surveillance volunteers is critical in improving surveillance in inaccessible and hard-to-reach areas. Volunteers mobilize their communities and raise awareness on disease prevention and treatment.

NIGERIA

Community-based polio surveillance

INTRODUCTION

Nigeria remains one of three polio-endemic countries in the world. To strengthen disease surveillance and achieve polio eradication, CORE Group Polio Project (CGPP) in Nigeria supports the detection of Acute Flaccid Paralysis (AFP), the most common sign of polio infection, through a community-based surveillance system. This approach uses Volunteer Community Mobilizers and Community Informants in CGPP target communities. Community Informants are recruited from traditional healers, herbalists, barbers, birth attendants, bone setters, patent medicine vendors, and others. These two cadres coordinate to detect, and report, suspected cases of AFP.

PROJECT PURPOSE AND CONTEXT

This activity aimed to (1) build a strong polio surveillance system across Nigeria; (2) strengthen community volunteers' knowledge of AFP detection, as most are not medically trained.

Community volunteers are the bedrock of all CGPP activities in Nigeria. A total of 2,348 volunteers (2,132 mobilizers and 216 volunteer ward supervisors) conduct house-to-house mobilization activities to raise awareness of polio vaccination and routine immunization. They engage community gatekeepers such as religious and traditional leaders. Mobilizers encourage pregnant women to attend antenatal care, give birth in health facilities and practice exclusive breastfeeding. They also give health talks on the importance of handwashing and proper nutrition. Community volunteers have been

extremely influential in building trust between health workers and local communities.

To support mobilizers, this activity recruited and supported Community Informants and tasked them with mobilizing communities and raising awareness through the delivery of simple, impactful messages aimed at caregivers.

STEPS IN IMPLEMENTATION

The following steps were undertaken in the implementation of this project:

- CGPP recruited Community Informants.
- Communities nominated Surveillance Focal Persons from amongst the volunteer cadres, tasking them with facilitating and coordinating surveillance activities across the five states.
- CGPP trained volunteers on AFP surveillance and provided refresher training, mentoring, and on-the-job training during monthly review meetings.
- CGPP equipped volunteers with surveillance reporting tools.
- The Secretariat conducted Planned National Surveillance Training for CGPP staff.
- The CGPP gave monetary and non-monetary incentives to volunteers who detected AFP cases.
- Volunteers received transport and food allowances to attend monthly review meetings in Yobe State.
- Volunteers used CGPP-specific Social Mobilization and Social Behavior Change Communication materials for awareness-raising activities.
- Volunteers received a customized resource book which included sections on polio vaccination, routine immunization, nutrition, handwashing, the dangers of self-medication, the benefits of breastfeeding, malaria prevention and diarrhea management. These resource books were used when running awareness-raising and sensitization activities in villages.

POSITIVE OUTCOMES AND IMPACTS

Nigeria requires both a strong formal and informal health surveillance system. Informal, community-based surveillance systems complement formal, facility-based systems to ensure early detection and reporting of AFP cases and a quick response to suspected polio outbreaks.

So far, this dual approach has resulted in:

- An increase in the total number of AFP cases detected by mobilizers and Community Informants from 449 cases in 2016 to 460 cases in 2017 across the five CGPP focal states, demonstrating improved capacity of volunteers to identify AFP.
- After four years of implementation, polio immunization coverage has increased from below 50 percent to 87 percent in CGPP focal areas.
- The average number of children missing follow-up vaccinations has reduced from 4.5 percent to less than one percent in just four years, even with the expansion of the program covering a wider area.
- 99 percent of registered new-borns were immunized within the first two weeks of life and thousands of under-fives were immunized at naming ceremonies.
- One mobilizer in Kano received an award from Rotary International for detecting AFP cases. Another mobilizer received a cash award from the Deputy Governor of Borno State for identifying AFP cases.
- CGPP volunteers have a much greater awareness of AFP identification and have been able to pass this knowledge on to caregivers in their communities.
- Through convergent messaging and the use of known community volunteers, CGPP has built trust among local communities and improved vaccine uptake in its target areas.

LESSONS LEARNED

Lessons learnt from the implementation of this program include:

- There is still hesitancy among caregivers to vaccinate their children despite awareness-raising attempts. This is often down to deep-seated religious misconceptions and the cultural dominance of men, who resist allowing their children to be immunized.
- Community-based surveillance is essential in accessing hard-to-reach areas, particularly in Borno and Yobe States. These states are particularly difficult to sensitize due to the high risk of insurgency and compromised security.
- Difficult terrain and flooding also makes areas in the northeast hard to access.

- Budget constraints in some focal states mean that AFP surveillance relies solely on local resources that do not require funding.

PROMISING PRACTICES

The involvement of community volunteers is central to Nigeria's fight to rid itself of endemic polio. Advocating with important stakeholders, such as traditional and religious leaders, can improve the quality of health care delivery, increase community participation, and create a sense of grassroots ownership over health services. This contributes immensely to polio eradication and complimentary health interventions.



Mother Care Group members take notes as they meet with Davies Mwachamu, Project Officer for the CSO platform, the Malawi Health Equity Network (MHEN), at the Binje Health Post in the village of Kuziona. David Snyder/CRS

PART II

Social Behavior Change

A. PARTNERSHIPS WITH RELIGIOUS LEADERS

KENYA

Immunization Sundays

INTRODUCTION

Between 1-4 June 2017 the Kenyan Health NGO Network (HENNET), funded by Gavi, held an event called Immunization Sunday in churches in Kajiado North, a sub-county of Kajiado County, Kenya. The term 'Immunization Sunday' came about after one religious leader decided to hold an immunization sensitization session after his Sunday service. The idea quickly caught on.

PROJECT PURPOSE AND CONTEXT

Immunization Sunday was the result of HENNET's sensitization campaign with religious leaders and community gatekeepers in the region. One of the action points resulting from these sensitization meetings was for religious leaders to help accelerate the routine immunization agenda in their communities.

Although the first Immunization Sunday was held at a Christian church, the Muslim imam from a local mosque also attended and spoke to the Christian congregants on the importance of immunization. He explained that all religious leaders, and all men and women of the cloth, need to embrace immunization services and accept that "prevention is better than cure."

Religious leaders shared messages on the importance of routine immunization and the need for community ownership of child health. The unity

shown between different religious groups really drove this message home. The service was followed by health service provision near the church, which resulted in 299 children under the age of five being dewormed and treated for common illnesses.

STEPS IN IMPLEMENTATION

Immunization Sunday was held during Sunday service, and run with the support of the Ministry of Health in Kajiado County. Five community health volunteers undertook community sensitization activities ahead of time, so the community expected the event and turnout was good.

INTEGRATION

Key partners in this activity included the Kajiado County Ministry of Health, Action Now Kenya, the Restoration of Life Centre, and Karen Hospital.

Immunization Sunday brought together individuals from different health departments and resulted in an integrated approach to service delivery. This has enabled HENNET to work closely with other health departments, and the teams have agreed that all future outreach should be integrated. This close relationship with religious leaders and community gatekeepers has made it easy for HENNET to work within the communities it serves and to better understand the local dynamics which derail health efforts and lead to poor health-seeking behavior.

POSITIVE OUTCOMES AND IMPACTS

Benefits of the project include:

- 299 children under five received deworming and basic health care services.
- Attitudes and behaviors changed to support immunization.

- The day helped to build relationships between local actors and health CSOs, creating a collaborative approach to awareness-raising.

LESSONS LEARNED

Routine health facility hours may not be convenient for all, so providing people with an opportunity to drop in for health care services after Sunday service can be much more convenient. Making health service times convenient is an important step in increasing health service use. HENNET has included this in the platform’s advocacy agenda.

PROMISING PRACTICES

Immunization Sunday showed that the involvement of grassroots stakeholders, and the influence of local leaders, can accelerate community ownership of child health. Having a common message to promote can help cut through religious divides, as was shown when a Muslim imam attended a Christian church to help spread good health practices.

PAKISTAN

Using religious scholars and texts to counter religion-based vaccine hesitancy

INTRODUCTION

When the Basic Integrated Rural Development Society started its immunization program in remote areas of Khyber Pakhtunkhwa, it faced vigorous opposition from local communities. Many felt that vaccinations were anti-Islamic and were strongly opposed to getting their children immunized.

PROJECT PURPOSE AND CONTEXT

Like many in his village, Mohammad Ishaq considered himself a religious person. For this reason, he refused to get his children vaccinated, explaining clearly to district administration that he felt it was against the teachings of Islam.

As a result, the district administration reached out to the Society, inviting them to conduct a tribal meeting (*jirga*), to help sensitize people on the importance of immunization and to try to resolve religious opposition to the practice. The Society nominated Shahinshah Shaheen, a Basic Integrated Rural Development Society member and respected Islamic scholar, to organize the meeting.

When Shahinshah and his team visited Mohammad, they realized that the gentleman held several misconceptions about immunization. As well as believing it to be against Islamic beliefs, he also thought that it led to infertility.

They realized that Mohammad was not alone in his opinions, and that many in the community held similar beliefs that were preventing children from being vaccinated.

STEPS IN IMPLEMENTATION

The Society organized a set of sensitization sessions, inviting influential local leaders to sit in on them. Shahinshah and his team explained that the vaccination program had the full support of the Pakistani Government and was therefore not anti-Islamic. They also outlined why immunization was important and explained the process of multiple-vaccination doses to protect people against preventable diseases throughout their lifetimes.

They provided translations of the Quran and materials on Hadith and Sunnah, the cultural doctrines of Islamic faith, so that people could look through them and try to reconcile religious messages with messages on health and well-being. The team also presented *fatwa* by respected Muslim scholars, which widely agreed that vaccination was an important part of the parental responsibility to protect children.

One such fatwa read: “Now Muslim scholars have gathered to break the myths and combat preventable diseases through immunization. The National Research and Development Foundation and the United Nations Children’s Fund (UNICEF) have taken 5,000 religious scholars on board for the eradication of polio and other preventable diseases

Rickshaw Rally

To raise community awareness about the importance of routine immunization, CSOs in India organized 57 rickshaw rallies across five districts. Each rally consisted of three rickshaws decorated with messages about polio vaccination and advertising local immunization schedules. Rally routes were organized through the most high-risk communities, reaching more than 10,000 people.

through vaccination. 160 other scholars from Swat have also issued fatwa in favor of administering vaccination.”

To support the sensitization sessions, Shahinshah asked a sympathetic local imam to deliver a Friday sermon on the topic of immunization. This also helped to reassure the local community that vaccinating children was religiously acceptable, especially when he quoted the line, “Who saves the life of one human being, saves the lives of all humanity.”

POSITIVE OUTCOMES AND IMPACTS

This open dialogue helped to win the community, including Mohammad Ishaq, around to the idea that vaccinating children was perfectly compatible with Islamic beliefs. It took several visits, and much debate, but eventually Mohammad reconciled his earlier beliefs with what religious scholars were saying and agreed to vaccinate his children.

LESSONS LEARNED

Many people who are opposed to vaccination, especially in rural areas, have low literacy levels and may not have read the Quran or other religious doctrines first-hand. It is important that people have the chance to fully examine the arguments on immunization and religious tradition in a medium that is easily accessible to them, and to have the time to process and participate in complex ideological debate.

In many of the areas where there was strong opposition to vaccination, the Society discovered that local administrations had attempted to carry out child vaccination without sufficiently engaging with communities on these issues or taking the time to allay concerns.

Changing religious opinions can be a slow process. It requires a lot of time and individual attention to persuade someone that their beliefs are compatible with modern medicine. Involving local influential community leaders and sympathetic religious leaders can help to smooth this process.

PROMISING PRACTICES

Strongly religious communities, especially those with lower literacy rates, can often put up resistance to vaccination on religious grounds. In this situation, taking the ‘I’m right, you’re wrong’ approach won’t help to resolve the issue. One of the best approaches is to enlist the help of sympathetic

scholars and leaders within that religion and try to provide reassurance from within the same religious tenets.

ETHIOPIA

Churches engage as members of CSO platforms

INTRODUCTION

The Ethiopian Evangelical Church Mekane Yesus is one of 230 members of the Ethiopian Civil Society Health Forum. Pastors of the church regularly deliver vaccination messages to their congregations at Sunday prayer.

PROJECT PURPOSE AND CONTEXT

Presila Opodhi Akway, 28, is a mother of two from Abobo District in Gamebela Regional State. Her eldest child is four and did not complete his full vaccination schedule because he developed fever and cried a lot after receiving his first vaccination, so Presila didn’t want to take him back to complete the course.

Presila’s experience is a common one. Temporary side effects from vaccinations can put caregivers off fully immunizing their children against life-threatening illnesses.

Two years later, the pastor at Presila’s church began preaching about the importance of immunization and telling his congregation that all children should complete the full course of vaccinations. Presila listened to this message and decided to get her next child fully vaccinated.

STEPS IN IMPLEMENTATION

Local religious leaders are equipped with information on the importance of vaccinating children and pass on this information to their congregations during Sunday worship.

In addition to the information given at Sunday services, local community health workers provide supplementary information on the importance of attending prenatal clinics.

POSITIVE OUTCOMES AND IMPACTS

Positive outcomes include:

- Presila attended a pre-natal clinic to receive the tetanus vaccine before giving birth to her next child.

- Presila and mothers like her have started to complete vaccination courses for their children after receiving information from church pastors, who are seen as strongly trustworthy.
- Caregivers are returning to finish vaccinating older children who have missed doses.
- Local communities have a much better understanding of the importance of fully vaccinating children.

LESSONS LEARNED

Messages about vaccination carry more weight, and are more likely to be listened to, when they come from a person in the community who is considered a trustworthy authority figure. Religious leaders are often believed more readily than visiting health workers.

PROMISING PRACTICES

Religion is often a strongly unifying force in many communities. People listen to respected religious leaders and, as services are held regularly, these leaders prove important partners in distributing accurate information about the importance of vaccinating children. They make helpful allies in the fight against vaccine-preventable diseases.

SIERRA LEONE

Religious leaders lead the development of behavior change messages

INTRODUCTION

Many caregivers in Sierra Leone refused to vaccinate their children during the Ebola outbreak of 2014-15. People feared to enter the clinics and schools where Ebola patients were being cared for. They also feared to attend immunization outreach events outside the clinics and schools, due to a common myth that health professionals were spreading Ebola. In the four years following the epidemic, religious leaders worked in partnership with civil society to increase trust and immunization coverage through awareness-raising activities.

PROJECT PURPOSE AND CONTEXT

Religious leaders command high respect within communities. Almost every village in Sierra Leone has a church or a mosque. This is why it was

so important to engage religious leaders. They worked to raise awareness on the importance of immunization across 14 districts, explaining how it helps to prevent illness and death. Imams and pastors sensitized communities through a Social Behavior Change and Communication strategy, developed by the Division of Health and Education.

Religious leaders worked with community stakeholders to engage communities and increase immunization coverage for National Immunization Day. National Immunization Day was established by the Ministry of Health and Sanitation to highlight the importance of continuing vaccinations, such as polio. The Deputy Program Manager for the Expanded Program on Immunization, Dr. Mariama Murray, explained that National Immunization Day has “tried to eradicate the polio virus.” She added, “This routine yielded dividend. The last case of polio was recorded in 2010.” The purpose of these community engagement events is to encourage religious leaders to continue to mobilize people to take their children to be vaccinated on time, protecting them against life-threatening and debilitating diseases.

STEPS IN IMPLEMENTATION

Religious leaders created alliances with traditional healers and local leaders in order to confront community resistance. This approach is called the One Voice strategy. Each group brings unique skills to community engagement events in order to deliver a unified message: *Gud it en welbɔdi pas gentry*, meaning ‘health is wealth’ in Krio. A perfect example was the 2016 National Health and Nutrition Fair, where religious leaders attracted audiences by reciting passages from the Quran and the Bible, while local leaders entertained through song and dance, and traditional healers shared stories.

They also used interpersonal communication, visual aids and evidence-based messaging to raise awareness among their congregations. The Ministry of Health and Sanitation distributed information on immunization outreach activities for religious leaders to include in their sermons. Imams and pastors deliberated on the duty of a community to protect and care for its children, informing them that vaccines have the same importance as food, clothing and shelter.

Passages from the Quran and the Bible were read to illustrate examples of conviction and harmony when dealing with others.

“SIERRA LEONE HAS A CLEAR UNDERSTANDING OF WHAT RELIGION REALLY IS – THAT RELIGION IS NOT THERE TO CREATE PROBLEMS BETWEEN PEOPLE, BUT INSTEAD TO BRING PEOPLE TOGETHER.”—

RAMADAN JALLOH, CHIEF IMAM AT JAM’IYATUL HAQ MOSQUE IN WESTERN AREA URBAN

INTEGRATION

“IMMUNIZATION IS EVERYONE’S BUSINESS. IT IS NOT ONLY A WOMAN’S RESPONSIBILITY, BUT FATHERS HAVE ALSO A VITAL PART TO PLAY.”—CHEICK IBRAHIM CESAY, LEADER OF THE ISLAMIC ACTION GROUP

CRS strengthened the platform’s capacity to perform effectively, helping to develop skills in leadership, advocacy, and resource mobilization. It provided feedback on the platform’s performance during routine compliance monitoring visits, which were undertaken in the hope of increasing transparency and accountability regarding donor funds.

Focus 1000 hosts SUNI-CSP, Sierra Leone’s national CSO platform for immunization and nutrition. This platform facilitated communications between civil society organizations and the government. It also provided information and feedback on the progress of immunization outreach activities and community engagement interventions.

The Ministry of Health and Sanitation responded with efforts to improve health systems. They increased outreach services so that a larger portion of the population had access to vaccination.

The Division of Health and Education worked with SUNI-CSP to create jingles, slogans and posters that informed the public of the importance of immunization. They frequently met with community leaders to determine how these messages were impacting beneficiaries.

The Expanded Program on Immunization (EPI) promoted synergy between public health programs working to control disease. It extended target groups to include older children, adolescents and adults.

Other platform members supported religious leaders in implementing mass-sensitization and mobilization events. They participated in community dialogue with religious leaders’ congregations, in marketplaces, and on radio shows.

District Coordinating Bodies organized platform activities within districts. They mobilized community

efforts to strengthen immunization and health systems and provided updates to the national SUNI-CSP steering committee.

POSITIVE OUTCOMES AND IMPACTS

“THANK YOU FOR EDUCATING US ON THE NEW POLIO VACCINE. BY THE GRACE OF GOD, THIS NEW METHOD IS THE FINAL METHOD TO DRIVE POLIO AWAY FROM OUR CHILDREN.”—ESHEKA KALOKOH, REGIONAL CHAIRMAN FOR TRADITIONAL HEALERS

Religious leaders joined together in formal and informal networks that went beyond their own faiths. These interfaith mechanisms leveraged the social, spiritual and moral assets of each religious community to rally around common problems and accomplish positive change.

Positive outcomes included:

- People were better able to make evidence-based decisions instead of decisions based on fear and inaccurate information. This influenced other people in the community to change their behavior.
- Religious leaders focused their efforts specifically on the promotion and protection of children’s rights.
- An increased number of children were vaccinated and cared for by both female and male caregivers and guardians.
- Restored trust and stronger partnerships between caregivers and health professionals.

LESSONS LEARNED

Employing different delivery methods for messaging, such as video, radio, posters, storytelling and drama reaches a much wider audience and is important for getting those messages across to illiterate members of the community.

Community mobilizers found it difficult to reach families who worked in the fields and markets during the day. In response, the platform worked with women in the marketplace, and with religious leaders, to disseminate messages about immunization campaigns in public places.

The greatest challenge faced by the program was a change in MOH policy, which shifted from a mass-immunization approach to a caregiver-led approach. The SUNI CSP platform incorporated this change into their community monitoring structures and

continue to encourage caregivers to immunize children.

The Ministry of Health and Sanitation's limited involvement with community leaders resulted in weak partnerships and poor coordination. Religious leaders advocated for change in the way that events were planned and managed. They sought to work with local authorities, district medical health teams and other community leaders, to establish independent community monitoring structures. This helped to deliver better information about vaccination and health services to the community, and ultimately helped to change community behavior towards immunization.

PROMISING PRACTICES

Religious leaders helped communities to understand that independent community monitoring structures were not there to police, but rather to assist in identifying issues that needed to be addressed and offer solutions.

Many people were reluctant to vaccinate their children due to misconceptions about health workers and their agenda. Religious leaders used passages from the Quran and the Bible to change attitudes and build trust and respect between the community and health workers.

NIGERIA

Imams address vaccine hesitancy during Iftar

INTRODUCTION

The CORE Group Polio Project (CGPP) is a major partner in Nigeria's Polio Eradication Initiative. The Iftar Strategy is an innovative intervention that happens during Ramadan, at the evening break of fast. It seeks to address vaccine rejection in CGPP focal settlements in four northern states. CGPP identified that heads of households, predominantly fathers, often made the decision on whether to vaccinate children or not. They tended to be strongly influenced by religious leaders. For this reason, CGPP worked closely with local imams, providing them with information on the importance of immunization so that they could pass these messages on to local communities.

PROJECT PURPOSE AND CONTEXT

Noncompliance is a term used to describe caregivers who refuse to present eligible children for vaccination. CGPP has documented noncompliant families in states that are at high risk of polio due to chronic vaccine refusal. This behavior presents a major challenge to achieving necessary levels of immunization coverage. The problem is usually perpetuated by male heads of household who forbid their wives from vaccinating their children. It is therefore important to target fathers and persuade them to immunize all children under five.

STEPS IN IMPLEMENTATION

During Ramadan, men gather at their local mosque at dusk to break their fast together after communal prayer. This is called Iftar and presents an opportunity to reach many heads of household at the same time.

The steps are as follows:

1. One week before Ramadan, CGPP visits local leaders and influential people, talking to them about the importance of vaccination and providing information and materials.
2. These leaders help to organize sensitization sessions and dialogue with the local community.
3. CGPP Volunteer Community Mobilizers create a list of families who are noncompliant with the vaccination schedule.
4. Community and religious leaders help to advocate with these families on the benefits of immunization.
5. Imams identify mosques where many noncompliant fathers are likely to gather at Iftar and provide estimated numbers.
6. The imam helps to address noncompliant fathers with positive messages about vaccination and identifies compliant fathers among the congregation who are willing to help support this message.
7. Noncompliant families then bring their children to be vaccinated the next day at Iftar.
8. This vaccination program continues for four days in a given area. On the fifth day, mobilizers go door-to-door to try to find any families who have not already been reached.

POSITIVE OUTCOMES AND IMPACTS

In 2017, the Iftar Strategy resulted in more than 90 percent of children from noncompliant households receiving vaccinations. This rose to 93 percent in 2018.

LESSONS LEARNED

Lessons learned include:

1. Religious leaders prove strong allies in spreading the message on immunization, and it's important to include them in strategic planning. They have an important role to play in improving health care outcomes by increasing community acceptance and building trust.
2. Targeting heads of households with strategic messages using local resources and forward planning can improve vaccination coverage.
3. Fewer children were vaccinated in Kaduna and Katsina states because families didn't trust CGPP, believing that they were using food to persuade them. This again highlights the need for trust and the support of local influential people.

PROMISING PRACTICES

Knowing the local practices and customs of a population can help a vaccination campaign choose the most appropriate time and place to talk to people, especially those who are reluctant to participate. With the help of local leaders, and the time of year, noncompliant heads of households were reached far more quickly than a door-to-door campaign.

B. MALE ENGAGEMENT

TOGO

Champion Papas

INTRODUCTION

Appui au Développement et à la Santé Communautaire is a Togolese NGO working to help support and develop community health. In 2013, it developed a community mobilization strategy which they call Papas Champions (Champion Dads), which was implemented in Sokodé, Central Region.

PROJECT PURPOSE AND CONTEXT

A coordinated strategy was needed as there is a high level of reluctance towards vaccination in Togo. This is largely due to traditional and religious beliefs. To help overcome this reluctance, the NGO introduced a program to recruit male community volunteers who could help to change attitudes. They specifically sought to recruit fathers willing to collaborate with their female partners to remember vaccination appointments and accompany children

to the clinic when it was time for the children to be vaccinated.

The strategy was designed to help protect pregnant women and children aged 0–11 months from diseases with epidemic potential. These include: measles, poliomyelitis, hepatitis B, yellow fever, tuberculosis, diphtheria, tetanus, whooping cough, and haemophilus influenzae type b.

STEPS IN IMPLEMENTATION

At the end of the selection process, ten Champion Dads were chosen to mobilize the wider community. The men volunteered to go on home visits, deliver educational talks and meet with families one-on-one to explain the benefits of immunization. They helped families to remember and keep vaccination appointments and encouraged caregivers, through personal stories, to complete the dosage. The work of these committed fathers has helped families in Sokodé to protect their children from preventable diseases and increased the number of visits made to facilities such as Bon Secours Medical-Social Center. They have also helped to get the message about the importance of immunization out to the wider community.

There are ten criteria a volunteer must meet to be considered as a Champion Dad:

1. They must be married.
2. They must have at least one child who has completed their entire course of vaccinations.
3. They must be familiar with the process of vaccination and local vaccination services.
4. They must be a member of at least one local community organization.
5. They must be accepted by the local community and recognized as a responsible and respectable person.
6. They must be open to receiving training and available to attend.
7. They must speak the local language and be able to communicate well.
8. They must be stable in their home and social life.
9. They must remain in the local community after training.
10. They must be literate and know how to read and write to a good standard.

Beyond these basic criteria, Champion Dads must also meet certain ethical standards. They need to:

1. Display a good level of morality
2. Be dynamic
3. Be in good health
4. Maintain discretion and honesty
5. Have the ability to express themselves clearly

On top of their community roles, they are also occasionally invited to take part in radio discussions which reach a wider audience, and to supervise teams of community volunteers in running awareness-raising events.

INDIA

Barbers motivate fathers to participate in immunization programs

INTRODUCTION

India's CORE Social Mobilization Network provides concentrated social mobilization support in high-risk areas of Uttar Pradesh and Haryana. It works in twelve districts of Uttar Pradesh and two districts in Mewat, Haryana through a network of volunteer mobilizers who conduct activities relating to polio and routine immunization. The CORE consortium members are the Adventist Development and Relief Agency, Project Concern International, and CRS. The Secretariat works in close collaboration with the Ministry of Health, WHO, UNICEF, Rotary International and USAID.

Barber's Initiative

Barbers are an integral part of Indian society. They can be found in even the smallest villages. Their shops provide services, but also act as important meeting places for conversations about family life, village politics, cricket, and many other issues. CGPP built the capacity of barbers to provide accurate information about immunization and to initiate discussions on the topic. This helped sensitize fathers, brothers and uncles on the importance of immunizing children and increased male participation in child health care.

PROJECT PURPOSE AND CONTEXT

CGPP observed that timely OPV3 immunization of children was very low in areas where all communication interventions targeted only mothers. It is common in traditional Indian families for fathers to be the main decisionmakers in the household, therefore it was necessary to target certain interventions at them.

CORE decided that one way to do this would be to target barbers, as most Indian men visit their barber on a regular basis. Barbers are an integral part of Indian society and can be found in even the smallest villages and outlying hamlets. They not only provide a service, but their shops often act as important meeting places where men can talk peer-to-peer. Barbers are also considered key figures during social rituals, such as birth ceremonies and weddings. As barbers reach many male clients every day, they can be a leading influence in behavioral change. The project sought to educate them on the importance of timely polio immunization and routine vaccinations as well as general sanitation such as handwashing and hygienic use of toilets, so that they could pass this information on to men in their communities.

STEPS IN IMPLEMENTATION

The following steps were taken in implementing the project:

1. Building the barbers' knowledge on the importance of immunization and hygiene, so that they could confidently speak with customers.
2. Encouraging them to start discussions at their shops, speaking with fathers, uncles and grandfathers about the information they had learnt.
3. Asking them to hand out learning materials and information brochures to clients, as well as stickers, immunization kits and aprons, so that the message wasn't forgotten.

POSITIVE OUTCOMES AND IMPACTS

Many barbers are involved in spreading the message of timely immunization and general hygiene. The project was widely held to have been a success in reaching men within the community.

LESSONS LEARNED

Lessons learned during this project include:

- Regular, hands-on support is essential at field level
- Refresher training should be planned at least twice a year

- Picture-based reporting tools are important for non-literate volunteers

PROMISING PRACTICES

Many immunization information programs focus specifically on women. To maintain a high level of immunization coverage, it is important that both men and women have access to accurate information and the chance to address concerns and questions through an open exchange with peers.

PAKISTAN

Fathers promote immunization

INTRODUCTION

Like most regions of Pakistan, Sibi District in Balochistan works on a tribal system. This caused several challenges for Bright Star Development Society Balochistan when they attempted to introduce their immunization project to local people.

PROJECT PURPOSE AND CONTEXT

One of their greatest challenges came in the form of Ahmad Khan, a respected father in the village of Talli, who was extremely opposed to vaccinating children.

Ahmad regularly refused invitations to attend immunization awareness-raising sessions but would regularly make his feelings known in public. He would accuse health workers of trying to brainwash people about vaccination and could not understand how a few ‘drops of water’ could benefit a child’s health. “I see no harm in not immunizing children,” he would tell people.

Most frustratingly, he would tell other members of the community not to participate in immunization activities, which meant that he was in danger of jeopardizing the village’s immunization coverage.

STEPS IN IMPLEMENTATION

Ahmad would not come to events, which made it difficult to reach out to him. The opportunity to do so came more by chance than design. One day, some members of the team saw him standing outside a general store, buying groceries. One of the team decided to buy something from the same shop and struck up a conversation. Ahmad was friendly towards the team member and they walked home together.

When the team member asked about the health of Ahmad’s children, he became defensive. The team member assured Ahmad that he only wanted to chat, not to lecture, and that he had great respect for Ahmad’s views. He told him, “Learning is a mutual process, we should learn from each other.”

The team member went out of his way to encourage Ahmad to speak, and to actively listen to what he was saying. Ahmad’s concerns came from the fact he had heard of cases where vaccination had harmed a child, and as he didn’t feel it was necessary to vaccinate children anyway, why put them at risk?

The next day, the team provided Ahmad with materials outlining the advantages of immunization. As Ahmad was illiterate, they read to him and provided pictorial information that he could easily understand. Members of the team passed by to talk to Ahmad regularly over the next few days, to discuss his thoughts and concerns.

POSITIVE OUTCOMES AND IMPACTS

One of the most positive outcomes from this one-on-one approach was that Ahmad opened up on the subject with his wife. His wife turned out to be in support of immunizing their children, as she had heard about the benefits from friends who had attended the sessions. This surprised Ahmad and helped to sway his opinion.

Ahmad agreed to attend the next awareness session and from there became an active pro-immunization campaigner. He proved to be a natural leader and people listened when he spoke. He was particularly good at reaching out to others like himself, who had initially been against immunizing children, because he understood their concerns.

LESSONS LEARNED

People’s opinions are often change through dialogue rather than being lectured at. Most people are willing to listen if you approach them in the right way.

PROMISING PRACTICES

Ahmad’s case showed that even the most anti-immunization members of a community can still be reached, but it often takes time, patience and a lot of active listening. Always be on the lookout for opportunities to build trust and dialogue.

MADAGASCAR

Male immunization champions

INTRODUCTION

It is not common for men in Ankadimbarika, Marofoty Commune, to respond to social mobilization activities. Child health is considered women's business and they tend to let mothers get on with it. The Malagasy civil society platform for immunization (COMARESS) tried to implement a plan to encourage more men to take part.

PROJECT PURPOSE AND CONTEXT

Men who take an active interest in their children's health are often made fun of. People call them 'women who have been missed,' which directly questions their masculinity.

In contrast, mothers usually attend immunization sensitization sessions in number. They listen attentively as health workers explain the importance of vaccinating against preventable diseases, and actively engage in social dialogue.

Whereas it was good that women in the community turned up to participate, COMARESS felt that men really should play a more active role in their children's welfare. They attempted to reduce stigma on the matter.

STEPS IN IMPLEMENTATION

COMARESS managed to find two men who were willing to step forward as Male Immunization Champions. Both champions were already engaged in COMARESS efforts, one helping to run community dialogue sessions and the other a trained vaccinator who was already vaccinating other people's children.

The men made it a point to turn up to awareness raising days and to engage with fathers in the community to discuss the importance of immunization, and a father's role in caring for the health of his child. One successful argument was that if fathers saw to their children getting vaccinated now, they would have to worry less about health care in the future.

POSITIVE OUTCOMES AND IMPACTS

As a direct result of the two champions' efforts, fathers started to bring their children to be vaccinated during the polio campaign. These men were commended for their bravery in standing up against traditional opinion.

LESSONS LEARNED

For fathers to continue to behave in a positive way when it comes to child health, it must feel as though it is their decision to be involved, rather than being pressured into it. They need a lot of reassurance that their actions won't negatively impact on traditional customs and values.

PROMISING PRACTICES

Men are just as aware of peer pressure as women, and often need support breaking with traditional customs, even if doing so would benefit the health of their children. Men need constant positive reinforcement so that they feel the benefits of changing their behavior outweigh any disapproval they might face from their community.

C. HARD TO REACH POPULATIONS

GUINEA

Fundamentalist religious women counter religion-based vaccine hesitancy

INTRODUCTION

The Sounabougou sector of Siguiri has been following Islamic fundamentalism (*wahhabism*) for nearly two decades. All women are expected to wear veils and are forbidden any physical or verbal contact with men who are not their husband or immediate family. Wahhabi women often have many children, but the myth has been industriously circulated that vaccinations are a weapon used to

Khushi Express

To sustain polio eradication efforts, an information van called *Khushi Express* was driven through high-risk villages in low-coverage areas of Uttar Pradesh and Haryana in India. This van was equipped with a loudspeaker and carried a troupe of magicians and street performers who conducted quizzes on immunization with the public. They reached more than 95,000 community members and sensitized them on immunization and handwashing.

make children infertile. Men are often stubbornly opposed to vaccinating children, and women have no authority to overrule them.

Due to low immunization coverage among this group, the Prefectural Committee for Immunization Support has made outreach to the Wahhabis a top priority. The Committee has had previous success campaigning on polio T6 and T7 vaccinations in 2016.

PROJECT PURPOSE AND CONTEXT

The Committee took the approach of creating Community Change Champions. This meant enabling progressive female members of the Wahhabi community and educating them on the benefits of immunization, so that they could help to change the behavior of other community members.

Although many women were receptive to vaccinating their children after speaking with a Community Change Champion, some were still fearful that their husbands would know and punish them. One of the main concerns was the practice of putting an ink mark on the finger of a child who has received the polio vaccine. The mark makes it easy to identify children who have been recently vaccinated in transient communities. Women also feared their children becoming sick as a side effect of the vaccine and their husbands being angry at this, so the Committee had to consider how to address these issues during implementation.

STEPS IN IMPLEMENTATION

This intervention had four core activities:

1. Sympathetic imams were approached and educated on immunization. They were asked to allow female champions and vaccination agents to attend religious services. They agreed to spread the message that Islam does not condemn vaccination.
2. Community Change Champions were selected from among the female Wahhabi community. They were trained on the importance of vaccination and in social mobilization techniques. These Community Change Champions then talked with other women in the community to spread their knowledge and encourage vaccinating children.
3. To overcome the fear of male reprisal, women were allowed to mark their children's fingers after the vaccination. In this way, they could make a small mark that their male family members would miss, instead of having to let the health worker make a big obvious mark. Champions also gave women a phone number to call if there was a problem at home.

4. A few days after children had been vaccinated, Champions visited women at home to check that the children were well, and to reassure any caregivers who were concerned.

INTEGRATION

This intervention relied heavily on the support of the neighborhood chief, who was indispensable in helping to identify families who were reluctant to immunize their children. He also intervened if the subject of immunization raised tension within a Wahhabi household.

Social mobilization activities were reported to local health authorities on a continual basis, and local radio stations helped to get the message out to a wider audience. This was complimented by messages of support for immunization by sympathetic imams.

POSITIVE OUTCOMES AND IMPACTS

This intervention was deemed highly beneficial to the Wahhabi community. More Wahhabi women are aware of the benefits of vaccination and how the process works, and nearly one hundred children have been vaccinated against polio in Sounabougou.

The project has also been beneficial to the Committee. The results of the project were presented in an information exchange seminar on good practices, so the lessons learnt on social mobilization were shared between member health organizations. Because of the successful implementation of the intervention, the Committee has risen in trust and credibility in the eyes of local authorities, the Prefectural Health Directorate, the Expanded Program on Immunization, WHO and UNICEF.

The successful intervention model in Sounabougou was duplicated in Conakry, at Ratoma Commune, with similar levels of success, helping to significantly boost immunization coverage.

LESSONS LEARNED

It has been proposed that the Ministry of Health formalize its partnership with the Committee and its civil society members, and that Gavi could contribute by strengthening the capacity of those members through further training and equipment.

PROMISING PRACTICES

A strong commitment to grassroots networking helped to reach women who are heavily marginalized when it comes to health care. Working with female

Community Change Champions to spread the message of vaccination to other women in their communities meant that the information they passed on was seen as coming from a reliable and friendly source. Making sure they had the support of local chiefs, health workers, and religious leaders gave them confidence in going forward.

KENYA & SOMALIA

Outreach to nomadic populations, internally-displaced people, and refugees

INTRODUCTION

The CORE Group Polio Project (CGPP) is supporting the global polio eradication initiative in Kenya and Somalia by working closely with their respective Ministries of Health and other partners. The project supports outreach services for hard-to-reach mobile populations and underserved communities, such as nomadic pastoralists and internally displaced people who inhabit areas along the Kenyan and Somali border. CGPP provides technical and logistical support to the public health facilities, thereby increasing access and utilization of immunization services.

PROJECT PURPOSE AND CONTEXT

CGPP works in the most difficult areas along sparsely populated borders inhabited by marginalized, insecure and high-risk mobile populations. The health care infrastructure is weak. Many health facilities are closed due to security concerns whilst those that are open remain understaffed.

Nomadic pastoralists are a large part of the CGPP-focused population. Pastoralists continuously travel with their livestock across semi-arid terrain in search of water and fresh pasture for their animals. Their migratory lifestyle is a significant challenge to the standard model of health care delivery, a challenge which is exacerbated by the region's poor physical infrastructure. Due to the protracted conflict in Somalia, there are many internally displaced people and refugees that lack essential health services.

The critical challenge to disease prevention, specifically polio eradication, is to reach these vulnerable, low-immunity populations.

STEPS IN IMPLEMENTATION

Steps implemented in reaching hard-to-reach and mobile populations included:

- Working to support border health facilities through detailed microplanning for immunization service delivery.
- Recruitment and training of community health volunteers for nomadic communities and internally-displaced people. These volunteers helped to link vulnerable people with health facilities, as well as sensitizing them on the importance of immunization and disease surveillance.
- Designating nomadic health volunteers within mobile communities who were able to move with their people and work with health centers located nearest to new surroundings.
- Mapping catchment areas, villages, settlements, nomadic pastoralist migratory routes and watering points.
- Facilitating staff and community health volunteers in outreaching to nomadic and displacement camps in line with planned vaccination schedules. Community health volunteers maintain a community register for tracing vaccine defaulters.
- Facilitating mother-to-mother support groups for preventative community outreach. Working through these groups to deliver behavioral change messages and sensitize local communities on the importance of immunization and disease surveillance.
- Using motorbikes to track nomadic communities across difficult terrain.

POSITIVE OUTCOMES AND IMPACTS

Creating outreach networks between local health volunteers, volunteers within nomadic communities and regional health facilities is a cost-efficient and sustainable intervention. This makes it suitable for the Reach Every Child strategy and ideal for tracing those who have missed follow-up vaccinations. It is especially useful for reaching nomadic pastoralists, underserved communities and internally-displaced people.

LESSONS LEARNED

Community volunteers are excellent resources in supporting people to link with health facilities, particularly in cases where these health facilities

do not have the capacity or resources to conduct community outreach of their own.

PROMISING PRACTICES

When working to reach nomadic, pastoralist communities, it is important that stationary health services work in collaboration with health volunteers within those mobile populations. This allows them to keep track of previous immunization coverage and unimmunized members as they travel from one place to another. Nomadic, community-based volunteers can help to monitor immunization coverage provided communication links with regional health facilities are strong.

MALI

Women's groups reach nomadic communities during market days

INTRODUCTION

Between June and September 2018, a coalition of aid organizations conducted an active search for unimmunized and defaulter children in Sèguè, in the Koulikoro Region of Mali.

PROJECT PURPOSE AND CONTEXT

The community of Sèguè has around 6,360 inhabitants, a mixture of Bambara and Sarakolé permanent residents and Fulani nomads. Most of the inhabitants are farmers, and the village—and its health center—is located along the Bamako-Dakar trade route, placing it close to the major commercial city of Didiéni. Its weekly market draws traders from Bamako, Kayes and Mauritania.

These markets attract many nomadic herders, coming to trade and sell cattle. On average, the local vaccinators see around thirty children and ten pregnant women each market day. The women seek vaccination and pre or post-natal advice. They receive tetanus injections, while their children receive a BCG shot.

The local community health association (ASCOM) teamed up with Projet d'Appui au Développement Communautaire, a woman-led CSO in Sèguè, to try to increase the number of people visiting the local health center.

STEPS IN IMPLEMENTATION

The ASCOM prioritized a proactive approach to reaching out to nomadic and transient communities.

They recruited women from many different backgrounds, from mothers and grandmothers to community leaders in the search for children who had slipped through the health care system. A wide diversity of women from different socio-economic backgrounds were included in the effort. These women were then able to influence the behavior of their peers and improve immunization behavior.

Many of the women's husbands supported their actions and offered the use of their bikes and motorcycles to help them to cover a wider area.

The women worked on a voluntary basis but received small incentive fees paid by ASCOM.

Unlike previous awareness-raising campaigns conducted through static health centers, these women reached out into their communities, taking information to household level and back to nomadic communities on the move.

Ahead of market day, information was given to people renting accommodation to nomadic traders. When those communities arrived, they were presented with awareness-raising material and directed to the local health center where they could receive treatment.

On market day, the health center gave priority to non-residents so that people who were only staying for a short time did not have to wait long to receive vaccinations.

POSITIVE OUTCOMES AND IMPACTS

One of the most important outcomes was that children from outside villages and nomadic communities were registered with the local health center, so that their vaccination history could now be monitored, and a treatment schedule drawn up.

The result of involving so many women from such different backgrounds meant that many pregnant women and children who had previously gone unimmunized or not been fully-immunized, completed their vaccination schedules.

The region now has a much higher level of awareness of the importance of vaccinating children, and they know where to go to do that.

The program also included teachers from Sèguè school who participated in sensitization activities, so an ongoing relationship has been formed with the school and community health agents hold regular sessions there.

LESSONS LEARNED

Greater awareness led to greater demand for vaccination services, but the village only had one vaccinator. Most people came at the end of the market day, around 3 p.m., when their trading had finished. It would be good to have more trained vaccinators on hand to deal with peak-demand times.

PROMISING PRACTICES

Organizing immunization events around a busy weekly market or cattle fair is useful for reaching large numbers of nomadic people. It is easier and more cost-effective to give out information when people come together in one place than try to drive out and try to contact each nomadic community as they move across remote areas.

MADAGASCAR

CSO participation in the Reach Every Child campaign

INTRODUCTION

The village of Ankadibarika lies in the rural municipality of Marofoty I, Madagascar, more than 10 kilometers from the nearest basic health center. It is home to 1,731 inhabitants, of which 58 (three percent) are children under one year of age. The remoteness and isolation of the village causes a big problem when it comes to immunization coverage. It is also cut off by the Fiherenana River during the rainy season, and locals cross the river by canoe during the rest of the year.

PROJECT PURPOSE AND CONTEXT

The Coalition malagasy pour le renforcement du système de santé et de vaccination (COMARESS) uses Gavi funding to assist the Madagascar government to access hard-to-reach areas through the Reach Every Child program.

In Ankadibarika, a village with very low immunization coverage, COMARESS members raised awareness of immunization and nutrition through home visits and introduced a community register to help health centers monitor and identify children lost to follow-up.

STEPS IN IMPLEMENTATION

COMARESS facilitated a community dialogue to discuss how best to make vaccination more

accessible to the villagers. Local leaders and caregivers participated. Participants decided that a vaccination specialist should visit the village of Ankadibarika, rather than asking caregivers to cross the Fiherenana River. Caregivers at the meeting agreed to organize a canoe to bring the vaccination specialist across the river.

It was also decided that the COMARESS motorcycle would be made available to transport a supply of vaccine at the same time, and that the municipality would cover the cost of fuel for this vehicle.

POSITIVE OUTCOMES AND IMPACTS

Because of this intervention:

1. A total of 55 out of 58 children were immunized, including:
 - 10 children lost to follow-up
 - Three never-vaccinated children
2. The area health center committed to ensuring vaccine availability in the village.
3. Caregivers committed to vaccinating their children.
4. The introduction of a community register has created a lasting way to monitor and record children who have missed follow-up vaccinations.

LESSONS LEARNED

Community dialogues are an essential first step in Reach Every Child programming. They must include women. They must allow community members time and space to understand and investigate their immunization coverage and equity issues, determine the underlying causes and drivers of those issues, and propose solutions.

House visits were most effective when they gave integrated messages on nutrition and immunization.

Keeping an immunization register at the community level is a good way for communities and the local health center to monitor immunization status.

PROMISING PRACTICES

In situations where communities are geographically very difficult to reach, it is important to organize immunization activities in those places, rather than asking caregivers to travel long distances across difficult terrain. This improves the chances of caregivers bringing their children to be vaccinated.

INDIA

The Social Mobilization Network

INTRODUCTION

India's CORE Group Polio Project (CGPP) Social Mobilization Network provides concentrated support for social mobilization in high polio risk areas of Uttar Pradesh and Haryana. It works in 12 districts of Uttar Pradesh and two districts of Mewat, Haryana through a network of mobilizers who conduct social mobilization activities for polio and routine immunization. The CGPP consortium members are the Adventist Development and Relief Agency, Project Concern International, and Catholic Relief Services. The secretariat works in close collaboration with WHO, UNICEF, Rotary International USAID and the Ministry of Health.

PROJECT PURPOSE AND CONTEXT

During the introduction of house-to-house vaccinations in 1999, the program met huge resistance to polio immunization. CGPP responded by identifying volunteer Community Mobilization Coordinators who could tackle resistance in selected high-risk areas of Uttar Pradesh. These volunteers gradually became the heart and soul of CGPP India's polio eradication program. Despite the network's focus on tackling community resistance, Coordinators continued to face difficulty convincing caregivers to get their children vaccinated. Neither interpersonal approaches nor group meetings seemed to work. Part of the reason seemed to be that these approaches were not addressing other needs within the community, such as hygiene and diarrhea management. In response, CGPP revised its communication plan to include messages on breastfeeding, routine immunization, diarrhea management and using soap when washing hands.

Quiz Competition

NGO partners in Meerut, India, conducted a district-level competition called *Kaun Banega Quiz Champ*, along the lines of *Who Wants to be a Millionaire*. Auxiliary midwives and female health workers were invited to participate. The questions focused on routine immunization and polio eradication, to see who had the most knowledge.

STEPS IN IMPLEMENTATION

At village level, each Coordinator is responsible for 300–500 households, mobilizing community members through both one-on-one approaches and group meetings to effect behavioral change. All Coordinators are trained in good communication techniques, provided with tools and materials, and receive mentoring support from their supervisors. The awareness-raising campaigns included the importance of breastfeeding, routine immunization, handwashing with soap, hygienic use of toilets and methods for preventing and managing diarrhea. Including this information made the talks relevant to local communities and elicited a more attentive response to health education.

POSITIVE OUTCOMES AND IMPACTS

The benefits of training Coordinators include:

- Most importantly, the uptake of polio vaccination since the campaign has risen from 76 percent in 2010 to 90 percent in 2017, and for routine immunization from 81 percent to 89 percent in the same timeframe.
- Pro-active community dialogue has been achieved on health matters directly relating to local populations and addressing their specific health concerns.
- A single Coordinator can reach between 300–500 households.
- Local leaders and influential people have been enlisted to help persuade resistant families of the importance of immunizing children.

LESSONS LEARNED

One of the most important lessons learned was that the delivery of health messages should directly address health concerns at the heart of communities. Information about vaccinations was much more likely to be listened to if it was delivered alongside information on diarrhea management and handwashing, which the community felt were high priorities. Short and simple messages were the most effective, being easier to explain and more likely to be remembered.

PROMISING PRACTICES

Community volunteers play a vital role in sensitizing the wider population, especially underserved and hard-to-reach communities. It's important to do some research beforehand to identify the

priority health concerns in each region. If you deliver information about sensitization whilst also addressing other health concerns, the message is more likely to be heard.

PAKISTAN

Increasing immunization coverage in urban slums

INTRODUCTION

Urban slums bring their own challenges to Pakistan. They are often difficult for district management authorities to work within, including the Expanded Program for Immunization (EPI) department. Urban slums are often characterized by weak security, highly mobile populations, poor access to services, and low levels of literacy. Health care is often given little priority, and it can be especially difficult reaching women as their activities are usually restricted. As a result, many urban slums in Pakistan have very low immunization coverage.

PROJECT PURPOSE AND CONTEXT

This initiative was implemented in urban slums in Rawalpindi (Punjab province) and Quetta (capital of Balochistan province). The living conditions in slums are poor, they include extreme population density, lack of sanitation, and inadequate access to safe water. Housing and sewage systems are substandard, and the environment of urban slums is highly favorable for the spread of communicable diseases, particularly among children.

The Pakistan CSO Coalition for Health and Immunization has been working to mobilize civil society efforts to improve immunization coverage in these urban slums.

Rawalpindi is one of the twin cities of the federal capital of Islamabad, with an immunization coverage rate of 83 percent. In contrast, Rawalpindi's urban slum did not have a vaccination program or local health worker.

Quetta's immunization coverage is 54 percent. Quetta's urban slum, Orak Hanna, is situated sixteen kilometers to the northeast of the city.

In 2017–2018, CSOs launched a low-cost equity model to demand access to, and promote, immunization in these two urban slums. The initiative aimed to showcase best practices, presenting a successful model of how CSOs can make a meaningful contribution to EPI efforts.

Specific objectives were:

- Increase EPI coverage among children under eleven months.
- Increase EPI coverage in the selected slums to 80 percent.
- Vaccinate 85 percent of children who had missed a follow-up vaccination or not completed their course.
- Vaccinate 80 percent of children who had never received a single vaccination.
- Administer the BCG vaccine to 90 percent of children.

STEPS IN IMPLEMENTATION

The initiative was implemented with the close coordination and support of EPI teams. The aim was to reach around 20,000 people in each slum, immunizing all children younger than 23 months.

A door-to-door micro-census was conducted to ascertain how many eligible children there were, and when they were most likely to be available. Teams were then deployed to provide counseling and information on the immunization procedure and its importance. They also checked for any children who had been born since the micro-census and might also require vaccinating.

As well as door-to-door campaigns, communal sensitization sessions were organized at locations throughout the slums. Mosques were also enlisted to help make announcements on the importance of immunization and asked to display posters on the walls.

Following vaccination, families were provided with information leaflets and called afterwards to remind them of follow-up appointments.

INTEGRATION

Many partners were involved in implementation. The federal EPI cell helped to oversee a competitive bidding process to enlist partner CSOs. Successful CSOs were issued with partnership agreements for the duration of the program. Provincial EPI cells were also consulted while choosing the geographical areas of intervention. For example, the provincial EPI cells of Balochistan and Punjab issued formal letters nominating specific urban slums for this initiative. Later, district health departments were included as joint partners in the planning and execution of activities.

Community engagement was ensured through the selection of community volunteers and the formation of local health committees. These health committees provided the backbone for all field activities, communal sensitization sessions, door-to-door visits and vaccination camps.

District health departments were key to the success of this operation. They coordinated the administration of vaccines to meet increased demand.

POSITIVE OUTCOMES AND IMPACTS

The initiative was highly successful:

- 20,000 people in 1,093 households were reached in Rawalpindi, including 1,063 children under 23 months.
- Around 20,000 people were also reached in Quetta, across 2,324 households, including 1,113 children under 23 months.
- Because of the program, the district health department assigned Rawalpindi an official vaccinator to maintain vaccination coverage and reach new families.
- CSOs established a model of best practice which was recognized and endorsed by district health departments.
- It created an excellent CSO-government partnership model for increasing immunization coverage, particularly among children who had either never been vaccinated or missed follow-up doses.
- Many traditional myths about vaccination were dispelled and community attitudes have changed to embrace immunization efforts.
- A strong link between communities and district health departments has been established.

LESSONS LEARNED

Some lessons that have been learned include:

- Working in highly mobile communities can make it difficult to track children and keep them on schedule.
- The government vaccinator was not always available to attend vaccination camps. Combined with vaccination shortages, this made it very difficult to cover the entire target area.

- It was particularly difficult to reach mothers as women's activities are often highly controlled in conservative slum communities. Often, women are not allowed to leave the house without a male chaperone and literacy levels are very low.
- Separate lists were developed for children who were completely unimmunized and those who had missed follow-up vaccinations. This made it easier to administer efforts. Targeting these two groups made a huge difference to overall immunization coverage.

PROMISING PRACTICES

Urban slums represent a threat to the overall vaccination coverage of a regional population. They are often overlooked when it comes to quality health care initiatives, and levels of suspicion and illiteracy are endemic. Conservative populations face the added issue of limited female participation in educational activities and health services. It is vital for the health of a nation that outreach activities don't ignore slum environments, and that people living in slums receive full vaccination services in line with the rest of the population.

D. PEER OUTREACH

INDIA

School children educate their peers

INTRODUCTION

In 2001, wild polio virus was geographically clustered in a group of four districts in Western Uttar Pradesh, India. These clusters were in Moradabad, Rampur, Bareilly and Badaun. Nearly 40 percent of the total population of these areas is underserved. The CORE Group and UNICEF initiated intensive social mobilization work through social mobilization networks to reach these families and immunize their children.

PROJECT PURPOSE AND CONTEXT

In 1999 the CORE Group Polio Project (CGPP) undertook its first major activity in the area, finding people who could help overcome community resistance to polio vaccination. CGPP recognized that school children could act as a key resource in informing caregivers about polio campaigns and inspiring behavior change in their communities.

Previous polio communication strategies targeted adults, but this innovative approach shifted engagement to children. Aware that this shift would be challenging, the CGPP believed that the participation of children would increase awareness about polio immunization throughout families and thereby reach the entire community.

STEPS IN IMPLEMENTATION

The local Community Mobilization Coordinator conducted polio classes called Fun Classes prior to each polio vaccination round and organized children's brigades (*bulawa tolis*) to invite caregivers and guardians to attend fixed immunization booths.

The Coordinator addressed the importance of immunization, hand-washing, sanitary use of toilets and virus prevention once a month at these Fun Classes, using innovative tools such as games, creative communication materials and the school curriculum.

POSITIVE OUTCOMES AND IMPACTS

A high number of children were immunized at booths and an increase in handwashing before school lunches was observed. On polio vaccination day, children's brigades fetched children to the booths for immunization. Involving children in supporting the polio eradication program increased awareness and promoted the spirit of volunteering. This concept is now being implemented in other non-intervention areas. Taking children to polio booths has become a normal activity. More than a thousand schools are involved, and booth coverage has reached around 82.4 percent in intervention areas compared to 47.1 percent in non-intervention areas in CGPP districts.

LESSONS LEARNED

Lessons learned from this initiative include:

- Make communication simple and interesting.
- Address all doubts and concerns raised by teachers and students as soon as possible, using simple language.
- Involve school teachers from the beginning to ensure greater knowledge transfer.
- Incentives and recognition are necessary to help boost and enhance the morale of children who participate in the program.

PROMISING PRACTICES

School children have a profound influence in promoting healthy behavior, especially immunization and hand washing. It is important to include them in any program looking to encourage widespread behavior change within a community.

MALAWI

Mother Care Groups

INTRODUCTION

The need to thwart vaccine-preventable diseases is vital as an investment in the future, and mothers are playing a key role.

Malawi Health Equity Network (MHEN) a member of the Gavi-funded civil society platform, has helped to found Mother Care Groups in hard-to-reach places such as the mountainous village of Kasonga in Zomba District. The work of the Civil Society Platform has been strongly welcomed by the Ministry of Health's Expanded Program for Immunization (EPI).

There are currently eight Mother Care Groups, and MHEN is helping to establish new groups in Mizemba and Kalumeya in Neno District, and in Traditional Authority Chikowi in Zomba District.

PROJECT PURPOSE AND CONTEXT

Binje is a remote health clinic located almost 70 kilometers from the nearest hospital. Unfortunately, the remote beauty of this place is also its greatest challenge when it comes to providing health care to the local population. Neno District Council finds it difficult to fund its rural outreach initiatives, with immunization services being among the hardest hit. The problem is further compounded during the rainy season.

In response, MHEN helped to establish Binje Mother Care Group and trained women in health advocacy, so that they could better raise the local community's awareness of their right to health services. Chairperson Aines Chisenga, explained that the most important thing after establishing the mothers' group was to instill a sense of local ownership:

"We had meetings with chiefs from all villages in the area, where we agreed to sensitize communities and raise awareness. We work with them to share messages about vaccines. Due to our sensitization

and awareness work, a lot of women started patronizing the clinic for immunization services...”

One of the advocacy activities already undertaken by Mother Care Group members has been to write to the regional District Health Office to highlight the need for sheltered immunization facilities, as immunization clinics often take place beneath trees, which afford little privacy and no protection during the rainy season.

MHEN worked with women in Kasonga to form a Mother Care Group in October 2015. It became a crucial link between health clinics and community groups. The Mother Care Group now has 34 members, 30 volunteers, one traditional leader and three Health Surveillance Assistants from the local clinic. Together, they provide immunization and information to more than 12,000 people.

STEPS IN IMPLEMENTATION

MHEN works with remote villages to identify and select mothers who are interested in founding Mother Care Groups and receiving training on immunization and advocacy techniques.

These groups then help to spread the message on the importance of vaccinating children through community dialogue, songs, plays and sensitization sessions.

“MOST PEOPLE ARE ABLE TO LEARN ABOUT IMMUNIZATION THROUGH OUR SONGS.”—MOTHER CARE GROUP MEMBER, MERINA CHIWAULA

Mother Care Groups also undertake advocacy between their local health facilities and government officials, helping to identify and record problems, write letters and organize campaigns. Campaigns include issues such as lack of transport for community health workers, scarcity of vaccines and lack of adequate cold storage facilities.

In addition to this, Mother Care Groups assist health care facilities by tracking child vaccination status, sending out reminders to caregivers to attend follow-up vaccinations and identifying unimmunized children.

POSITIVE OUTCOMES AND IMPACTS

Mother Care Groups have been instrumental in bringing about change in many ways. Some of their key achievements include:

1. Increasing vaccination coverage through awareness raising campaigns and tracking follow-up vaccination

schedules. Mizemba Mother Care Group in Mwanza District recorded 65 immunized children when it began in November 2016. One month later, they had increased that to 153. The determination of Mother Care Groups to battle on against vaccine-preventable diseases, despite the challenges of infrastructure, is extremely inspiring.

2. Thanks to the efforts of Kasonga Mother Care Group, immunization coverage in the area has increased from 12 percent to 100 percent in just one year. Not one child has been reported as missing a vaccination in the past six months. More than 1,100 children under the age of five have been immunized since their project began.
3. Part of their success has been working with Health Surveillance Assistants to implement better tracking of children’s vaccination schedules. Surveillance Assistants keep each child’s vaccination record on a card which moves along a card system, alerting them when a child is due for their next dose. Surveillance Assistants then notify a Mother Care Group volunteer who reaches out to that family and books them into an outreach clinic.
4. Mother Care Groups have been extremely active in their advocacy roles. Binje Mother Care Group wrote a letter to their District Health Officer when they noticed that clinic sessions were being cancelled due to lack of transport, inadequate funding, and staff shortages. Their letter managed to get clinics resumed. The Kasonga Mother Care Group empowered their local community to take social action. They successfully lobbied the Ministry of Health to supply refrigerators for the cold storage of vaccines and are now petitioning the District Health Office to supply motorbikes for extension workers.
5. The groups also make sure to seek support from local leaders. The support from local leaders in some areas has been so great that it has led to a change in district by-laws. In some places, a family can now be fined 500 kwachas (USD 0.71) for failing to fully immunize their child.
6. The introduction of Mother Care Groups has been so successful that the civil society platform is looking to apply this model to other districts with low immunization coverage.

LESSONS LEARNED

Health workers face a lot of challenges accessing certain areas. Lack of transport makes it difficult to conduct immunization surveillance as Health Surveillance Assistants do not have motorbikes. Carrying equipment on foot can get tiring over difficult terrain. A lack of cold chain storage facilities also makes it difficult to preserve vaccine in hard-to-reach areas.

Members of Mother Care Groups agree that there is a need for MPs, councilors and village development committees to join hands and collaborate when it comes to improving health infrastructure.

PROMISING PRACTICES

Mother Care Groups play a seminal role in strengthening community-based health systems. Improved coordination between clinics and community groups has had a big impact on immunization coverage, and members of Mother Care Groups have proved instrumental in spearheading advocacy campaigns to improve infrastructure and vaccination coverage.

MALI

Women micro-entrepreneurs promote immunization

INTRODUCTION

The Associations de Santé Communautaire (ASCOM) are community health associations that run health centers in Mali. The ASCOM for Commune III of Bamako District, the area known as the heart of the region's vegetable markets, spearheaded an initiative to reach out to stallholders, most of whom are women, and involve them in immunization efforts.

PROJECT PURPOSE AND CONTEXT

Women working in the markets tend to spend most of their time behind the stall, often working close to twelve-hour shifts, from 7:30 a.m. to 7:00 p.m. They are the first to come and the last to leave.

This population predominantly lives on the outskirts of the municipality. Many of them are pregnant, and those with children often bring them to work. Because they work long hours, they are often overlooked when it comes to the country's vaccination efforts. For this reason, ASCOM wanted to reach out to female vegetable sellers and ensure that both they and their children received full courses of vaccination.

STEPS IN IMPLEMENTATION

ASCOM arranged a series of sensitization sessions run by women and invited female vegetables sellers to attend. These sessions explained the importance of immunization, where to receive vaccinations, and discussed other primary health topics. The sessions were held in the marketplace so that women did not have to leave their stalls to receive information.

POSITIVE OUTCOMES AND IMPACTS

Women who attended the sensitization sessions went on to help promote the importance of immunization among other vegetable sellers and their local communities. Many have gone on to become champions of vaccination and reproductive health. This has been particularly effective in spreading the message to highly mobile and migratory workers.

LESSONS LEARNED

Going to women in their place of work, rather than waiting for them to seek out a health center, was a much more effective method of spreading the immunization message. It allowed for educational material to be handed out and afforded women an opportunity to ask questions of qualified health workers. Peer-to-peer messaging was a particularly effective way to create lasting behavior change.

PROMISING PRACTICES

Women working in marketplaces as traders and merchants often work very long hours which prevent them from seeking medical advice and immunization services. This makes them particularly vulnerable to vaccine-preventable diseases. To increase coverage among this population, it is important to be proactive and take information directly to them.

PAKISTAN

Local human resources disseminate awareness-raising messages

INTRODUCTION

Since 2002, Friends Foundation has been working to support immunization programs through social behavior change in Pakistan. They also help to deliver vaccination services. From 2005 onwards, a government vaccinator began visiting Friends Foundation health centers on fixed days to vaccinate newborns and eligible children. These centers also provide maternal and child health, immunization, and nutrition services, hepatitis screening, and outpatient facilities.

PROJECT PURPOSE AND CONTEXT

When Friends Foundation started working in its field offices, the number of unimmunized children and those missing follow-up vaccinations was very high. This was due to a few reasons, including a lack

of parental awareness about immunization and a highly displaced, and therefore mobile, population. At the time, there was only one available vaccinator covering two union councils. Out of a total of 4,500 eligible children under 23 months, 434 were untraceable and 32 had defaulted on vaccinations.

Friends Foundation decided to intervene. They fixed a day for routine immunizations in all four of their health centers. They then set about raising awareness among patients. Uptake increased in all areas in which Friends Foundation operated, so they decided to scale-up and take the message out to the wider community by using educational materials with pictorial messages at sensitization sessions.

The main message was, “Immunization not only saves lives, but the cost of treating sickness. Therefore, it protects the future by protecting the present.”

STEPS IN IMPLEMENTATION

After the success of their community sensitization sessions, the Friends Foundation team wanted to do more, so they started with a brainstorming session to come up with ideas.

As a first step, Friends Foundation trained its own staff across each health center. The training focused on delivering immunization services and was led by a vaccination specialist. Friends Foundation also made sure that learning materials were available in each of their centers so that patients could easily access information about immunization.

Once their staff had been trained, they began administering vaccinations to all children visiting the health centers. When children came in with their caregivers, or for other treatment, the staff would check the child’s vaccination status and make sure they were fully immunized.

TT shots were also administered to pregnant women. Many had not received the vaccination during previous pregnancies because they had not been aware of it.

“I HAD NOT RECEIVED TT SHOTS DURING MY LAST PREGNANCY AS I HAD NO KNOWLEDGE ABOUT ITS IMPORTANCE. WHEN I CAME HERE TO TAKE MEDICINE FOR MY SORE THROAT, I TOLD THE LADY ABOUT MY PREGNANCY. SHE INFORMED ME ABOUT THE IMPORTANCE OF TT SHOTS FOR PREGNANT LADIES AND ASKED ME TO GET INOCULATED ACCORDINGLY. I DID SO FOR THE VERY FIRST TIME. NOW I HAVE COME FOR THE SECOND TT SHOT.”— PATIENT AT HEALTH CENTER

POSITIVE OUTCOMES AND IMPACTS

Because Friends Foundation staff were trained in administering vaccinations, the health clinics no longer had to wait for a visiting vaccinator to come, so they were able to offer vaccinations seven days a week. When a patient came in with children, they could immediately establish a child’s vaccination status and make sure they were fully vaccinated. The same was true for pregnant women and TT shots. This made it much more likely that people would receive follow-up vaccinations at a time that was convenient to them, raising local vaccination coverage.

LESSONS LEARNED

The main lesson of this project is that it’s much better to train health center staff on how to administer vaccines than to rely on visiting vaccinators from outside the area. This makes health centers much more efficient at delivering vaccines and patients are more likely to receive follow-up doses on time.

PROMISING PRACTICES

Health center staff are the strongest resource in the fight against vaccine-preventable diseases. Including them in brainstorming problems is a great way to find effective solutions. Making sure that they are trained in delivering vaccinations themselves makes a health center far less reliant on outside help and better able to maintain local immunization coverage.

LIBERIA, MADAGASCAR, UGANDA

Community dialogues

INTRODUCTION

Extensive community dialogue has been undertaken in Uganda, Madagascar and Liberia to attempt to increase the number of caregivers taking their children to be immunized. Each country has faced different challenges to increasing immunization coverage, yet community dialogue has proved effective in each instance.

PROJECT PURPOSE AND CONTEXT

Every country faces challenges to increasing immunization coverage.

A disorganized, top-down approach to registering immunized children in Uganda led to health worker

confusion over how many children had been immunized and how to locate those that had missed follow-up appointments. Children were assigned to their local health center for immunization, but if they received vaccination at an alternative health center, those doses often weren't recorded properly and couldn't be traced back to that child's medical history by their assigned health center.

Villages in Madagascar are often located in difficult terrain, making them very hard to reach. Seasonal weather and lack of roads have led to entire communities being underserved by vaccination efforts.

The Ebola epidemic of 2014-16 caused many families in Liberia to mistrust health workers. Some even believed that vaccinations were the cause of the outbreak. For this reason, caregivers started to refuse vaccines. Between 2004-13, Liberia managed to increase its immunization rate for basic childhood vaccines from 31 percent to 89 percent despite emerging from fourteen years of civil war. Now Ebola-related fears threatened to undo this good work.

Each country implemented efforts to engage local communities in dialogue about the benefits of immunization. They went about this in different ways, but each one saw significant social behavior change from their efforts.

STEPS IN IMPLEMENTATION

Each of the three countries went about implementing community dialogue in the following ways:

Uganda: In 2007, members of Namalemba, an at-risk village with low immunization coverage, held a series of community dialogues to understand why their area lagged behind other communities. Synergy Uganda, a CSO member of the Ugandan Civil Society Immunization Platform, facilitated dialogue together with the regional District Health Team and community leaders.

Community members, religious leaders and health service providers formed three discussion groups. Each group met separately to learn about the new immunization law, discuss immunization service delivery bottlenecks, and find sustainable solutions. They shared their views on how immunization defaulters could be identified and immunized.

A general meeting was then convened for all groups to present their feedback and discuss workable solutions that could improve the quality of

immunization services. An action plan was developed from this meeting and a Quality Improvement Committee was formed of six representatives from across all groups. One of the health facilities agreed to help follow up on the action plan.

Madagascar: The village of Ankadibarika is one of Madagascar's hardest to reach communities. It is situated more than 10 km from the nearest basic health center, across a river which is often impassible during the rainy season and requires a canoe at other times. Among its 1,731 inhabitants were 58 children under the age of one, who had either never been vaccinated or not been fully vaccinated.

The local CSO platform organized a community dialogue at the village, inviting local leaders and mothers to participate. One of the main reasons for holding this dialogue was to raise awareness of the importance of vaccinating children, allowing caregivers to raise and discuss any concerns they might have. Because of this, the community agreed to organize a canoe so that a vaccination health worker could cross the river and immunize their children. The CSO platform also agreed to provide transport for vaccine to accompany the health worker.

Liberia: Despite more than two decades of successfully boosting immunization coverage, Liberia's progress was in danger of taking a step backwards when the Ebola crisis unfolded. Many communities listened to superstition and rumors surrounding vaccination, such that immunization coverage for under-fives dropped from 89 percent in 2013 to 55 percent in 2015.

To combat this, Hope Village in Nimba County decided to hold a set of community dialogues. Due to its location, it attracts a lot of cross-border trade,

Game Changer

CSOs in India use indigenous tools to make communication effective and interesting. Games can be developed using anything found in the surrounding environment, such as mud and sticks, or adapting other games, such as snakes and ladders. Games are a great way to raise awareness of the importance of immunization and to encourage people to complete their full course of treatment.

with many locals involved in farming. Local leaders helped to organize discussion around vaccination concerns and to invite mothers to bring their children to vaccination days. These educational events were scheduled on busy market days to reach as many caregivers as possible.

POSITIVE OUTCOMES AND IMPACTS

“AS A RESULT OF THE COMMUNITY DIALOGUES, COMMUNITY MEMBERS HAVE BEEN EMPOWERED TO IDENTIFY AND REPORT IMMUNIZATION DEFAULTERS TO HEALTH WORKERS AND LOCAL LEADERS. IN ADDITION, HEALTH WORKERS HAVE REDUCED THE WAITING TIME FOR MOTHERS WHEN THEY BRING THEIR CHILDREN FOR IMMUNIZATION. THIS HAS IMPACTED POSITIVELY ON THE IMMUNIZATION INDICATORS OF NAMALEMBA VILLAGE.”—MR. WATETA GEORGE, EXECUTIVE DIRECTOR OF SYNERGY UGANDA

Each style of community dialogue proved successful. Whether it was speaking to a specific village in Madagascar or to a larger crowd on market days in Liberia. In all cases, immunization hesitancy decreased. In Uganda’s case, an ongoing strategy was developed, in Madagascar, arrangements were made to help transport health workers and vaccine to remote areas, while in Liberia, caregivers were much more willing to have their children vaccinated once their initial fears had been addressed.

LESSONS LEARNED

It is important to engage the support of local and religious leaders when undertaking community dialogue. Audiences may come in the form of small villages or large towns, even entire districts, but people are generally willing to listen if they trust the source of the information. When there is mistrust for external or visiting health workers, they will turn to people they know for assurance that the information is trustworthy.

PROMISING PRACTICES

Every community is different and so are the challenges they face when it comes to increasing immunization coverage. That makes it very important to talk to people in those communities, to better understand their concerns and to involve them in ways of overcoming low coverage rates. When people feel heard, and when they are actively involved in developing a strategy to help their community, they become more invested in carrying out that strategy.





A baby receives a dose of oral polio vaccine at a baby health monitoring session near Ndombi Village, Zambia, as part of the CRS FANSER project. At the session mothers also receive instruction on good nutrition and hygiene. Jim Stipe/CRS

PART III

Stronger Community-level Systems and Services

A. LOCAL SOLUTIONS TO HEALTHCARE ACCESS

PAKISTAN

Community ownership of health centers

INTRODUCTION

The Pakistani NGO, Basic Development Need, launched an immunization initiative in Nowshera District in 1995. This initiative aimed to involve local communities in planning and developing their health services. The NGO has since opened several maternal and child health centers in hard-to-reach villages such as Khan Kohi and Bara Banda. These villages are located across difficult terrain along steep roads, a long way from the nearest cities, yet these two villages alone cater to the needs of 250,000 people. The centers are extremely busy, and it is estimated that a woman gives birth in one of their centers every eight hours.

PROJECT PURPOSE AND CONTEXT

The model is based on community participation and ownership. It has established a network of village development committees in each village where it operates. These diverse volunteer committees comprise teachers, students and female health workers. They work with household-level clusters to identify need, and to plan and carry out local initiatives.

The model has a twofold objective: 1) increase demand for maternal and child health services, and 2) strengthen the availability of high-quality, accessible services.

This locally-owned system ensures community participation and allows Basic Development Need to

tailor its initiatives to the unique needs of each target village.

Instilling a strong sense of community ownership is the foremost reason why Basic Development Need has been able to operate so successfully in remote, high-risk locations. Each one is run from a donated community space or private home.

STEPS IN IMPLEMENTATION

The initial phase of the program involved forming village development committees and building their capacity. People from all walks of life were included in cluster groups and mobilized to play an active part in building local ownership of health services

Donated land and property were sought within each location to build sustainable community health facilities.

Center staff provide round-the-clock care to the people they serve. Although the first centers were initially started to provide maternal and child health services, they now also provide vaccinations and host pharmacies thanks to their strong relationship with local health authorities. Vaccinators at the centers liaise with the district Department of Health on a regular basis and carry out its immunization schedule to ensure that no child is missed.

POSITIVE OUTCOMES AND IMPACTS

Each center is registered at district level but operates independently. The model serves as an excellent example of a successful public-private partnership in several ways. Firstly, it was the district government in Nowshera who employed a vaccinator and Assistant Nutrition Officer at the Bara Banda maternal and child health center. That center is also a fixed point for the government's routine immunization coverage activities, immunizing hundreds of children each month.

Furthermore, the Nutrition Officer also keeps track of malnourished children. With the support of donors, they are supplied with high-density diet plans. Monthly meetings are held between district governments and maternal and child health centers to review progress and plan future campaigns.

LESSONS LEARNED

Basic Development Need recognized the importance of coordinating with, and complementing, district authority health activities. This enabled Basic Development Need to acquire technical materials for training staff, such as the health worker and vaccinator manuals. Most importantly, this relationship with local government ensured a continuous supply of vaccine to high-risk and hard-to-reach areas. These two elements further complemented each other by creating a link between community volunteers, vaccinators and female health workers, which helped to map unvaccinated children and those who had missed follow-up appointments.

PROMISING PRACTICES

Even the most resource-constrained communities have resources they can willingly dedicate to achieving the common goal of better health care for all. Start small, relying on communities themselves to set the project priorities, recruit human resources, and find space. Once communities are invested and leading, there is a good chance that external resources will be forthcoming.

ZAMBIA

Increasing access to immunization in hard-to-reach areas

INTRODUCTION

The Zambia Civil Society Immunization Platform contributes to government efforts to vaccinate every child in rural Mufulira District. To help with these efforts, Mukuba Community School has been turned into a center for vaccinating children and distributing awareness-raising material.

PROJECT PURPOSE AND CONTEXT

Mukuba is located 44 kilometers from Mufulira town and is considered a hard-to-reach area. Despite this, there is a strong understanding among many caregivers that vaccination is an important step to ensuring their children grow up healthy. This is largely thanks to awareness-raising activities

conducted throughout the region in partnership with the Alejo Community Support Project, a member of the Zambia Civil Society Immunization Platform.

To help meet increased demand, the community has decided to open the local school once a month to invite caregivers to get their children vaccinated and to deal with general health concerns.

STEPS IN IMPLEMENTATION

Community volunteers have divided local communities into zones, to help monitor and plan awareness-raising activities. These community volunteers have been highly successful in increasing demand for child immunization services.

On the 26th of every month, Mukuba Community School is turned into a health post. Visiting health workers from Mufulira use its classrooms to vaccinate, weigh and perform check-ups on hundreds of children.

Nurses and community health workers also give talks on child health care, which many caregivers say has been beneficial and allowed them to address common concerns. These talks include information on vaccination, but also on nutrition.

POSITIVE OUTCOMES AND IMPACTS

“HAVING MY CHILDREN VACCINATED AND PROTECTED FROM DISEASES SUCH AS POLIO, WHOOPING COUGH AND MEASLES... MEANS MY CHILD WILL GROW UP HEALTHY. THAT’S ALL A PARENT CAN WISH FOR, THEIR CHILD TO GROW UP HEALTHY.”—ELIZABETH SIMFUKWE, PARENT

As a result of community volunteer efforts, the local community has become much more aware of the importance of vaccination, and this has become apparent through the large increase in caregivers seeking immunization services.

Many of the caregivers attending awareness-raising have been mothers, but the message is being taken home and reluctant fathers have been persuaded by their partners to allow their children to be vaccinated.

“[MY HUSBAND] WAS A BIT HESITANT AT FIRST, BUT ONCE I EXPLAINED THE IMPORTANCE OF WHY OUR CHILDREN NEEDED TO BE VACCINATED, HE IS THE ONE THAT NOW ENCOURAGES ME TO BRING THEM EVEN WHEN I AM FEELING TIRED AND LAZY BECAUSE OF THE DISTANCE.”—JUDITH MUMBA, PARENT

LESSONS LEARNED

The success of the awareness-raising campaigns means that demand is starting to overwhelm the monthly vaccination sessions. Caregivers start to arrive around 9 a.m. and many do not leave until 4 p.m. Meanwhile, the school is still some distance for many caregivers to reach, often carrying young children with them. It might be helpful to expand these immunization sessions to be held more regularly and across new locations, or to provide transport between villages for those who must travel the farthest.

PROMISING PRACTICES

Using local facilities such as the school has provided an easily-accessible meeting point for caregivers seeking to follow-up on sensitization activities by getting their children immunized. Even for those who still must travel long distances, it is closer than the nearest town, making it more likely that they will attend.

PAKISTAN

Self-help health centers

INTRODUCTION

Shehri Ijtamai Taraqiati Council (SHATAC) was established in 1959 and registered as a non-profit organization in 1970. It was certified by Pakistan Center for Philanthropy in 2010 and employs 97 people. SHATAC is based in the Mandi Bahauddin district of Punjab, catering to a population of 1.4 million and operating in the areas of health, education and poverty alleviation. The SHATAC maternity home was established in 1998 and was expanded in 2012 to include a health center and mother and child primary health unit.

PROJECT PURPOSE AND CONTEXT

SHATAC started out with very humble beginnings. Lala Bashir Ahmad, one of the founding fathers of SHATAC, had always wanted to help the poorest and most underprivileged people in society. He started an initiative, asking each of his neighbors to put aside one fistful of flour each day to help those most in need. "If all of us could store one fistful of flour in a separate earthen-pot every day, we would have enough in a week to distribute to some of the neediest people in the community," he explained.

Soon, the same group of friends decided to set up an organization to take their small initiative to the next level. Flour was replaced by donations and they began to reach out to the community in a much

more expansive way than they had previously. They started by assisting deserving students with school fees and providing monthly stipends for orphans and widows.

The first health-related initiative was a clinical lab established in 1992. This was later expanded to include ambulance services. Their maternity home was set up six years later, followed by a welfare pharmacy catering to a much larger population than initially expected. Their maternity home alone now has an annual budget of PKR 55 million (\$410,000).

SHATAC operates with the simple, yet powerful, objective of endeavoring to better the social and economic conditions of the poor, handicapped, widowed and orphaned by providing 'suitable aid to develop self-reliance so that they may be able to maintain themselves'.

STEPS IN IMPLEMENTATION

As well as its maternity home, SHATAC has also established a health center at Mandi Bahauddin. The health center serves poor people with general outpatient care and maternity services. SHATAC works without donor funding, charging only minimal fees for its services. Fees for normal delivery are typically PKR 5,000 (\$37) or PKR 16,000 (\$129) for a cesarean section. In a similar vein, the pharmacy dispenses prescription drugs at very low cost to struggling patients. Outpatient consultation fees are typically PKR 50 (\$0.37). Despite such modest pricing, SHATAC provides most of its health services free of charge. Of the 35,644 maternity patients between 2010-2011, 93 percent were treated without payment.

POSITIVE OUTCOMES AND IMPACTS

Positive outcomes from SHATAC's work include:

- SHATAC operates entirely without donor funding, working on a nominal fee basis.
- The Health Center has established links with the Department of Health at district level to help ensure routine immunization, reaching the most marginalized communities in Mandi Bahauddin.
- In 2014 alone, SHATAC treated more than 70,000 individuals, delivering vaccinations to more than 2,000 people, of which 365 were mothers.
- The health center has earned a credible reputation through its devotion to bettering the lives of the poor. It provides round-the-clock health services, including immunization, and is often preferred by patients over the district hospital.

- SHATAC implements human resource practices that directly improve its staff's commitment and performance. It encourages its staff to have their say on policy-making and supports its staff to perform their duties by providing a hostel for female health workers and lunch at subsidized rates.
- The facility has attracted top professionals willing to donate their time, such as Dr. Kanwal Saeed who has worked for over six years in the outpatient department, free of charge. She looks after more than 100 patients a day and says she feels honored to be a part of such a noble cause.

SHATAC's success in operating the maternity home has encouraged them to start building MBPHU, envisioned as a 100-bed hospital. The project is in progress and SHATAC has opened an initial facility comprised of twenty beds, with diagnostic and nephrology units. The average number of patients per month stands at 250, but this is expected to grow as the range of services expands.

LESSONS LEARNED

A health center can run with little or no donor support if a fair pricing structure is introduced, so that the poorest patients can still afford care.

PROMISING PRACTICES

More than anything, SHATAC's success shows that great things can come of small ideas. From a fistful of flour to a busy maternity hospital, this community-built initiative stands as a great example of what can be achieved. Part of SHATAC's success is their commitment to involving their staff and health workers in decision-making, empowering them to plan future activities and supporting them with good living conditions.

B. COMMUNITY-LED HEALTH SYSTEM STRENGTHENING

UGANDA

Community-owned child registers

INTRODUCTION

Despite the introduction of child health cards and the training of healthcare staff, district-level child immunization monitoring continues to be inconsistent in Uganda. This makes it hard to

obtain accurate figures for immunization coverage. The Uganda Civil Society Immunization Platform proposes that this inconsistency stems from the country's traditional, manual-entry longitudinal child register which is facility-based and fails to track children who (1) were vaccinated elsewhere; (2) are unvaccinated. The CSO platform sought to find a better way of recording vaccinated children and improve the ability to track unvaccinated ones.

PROJECT PURPOSE AND CONTEXT

The Uganda Expanded Program for Immunization (EPI) Catchment Population Policy assigns children to specific health centers to receive immunization. This practice frequently misses migrant workers, nomadic peoples, internally-displaced people, cross-border births and those who have been immunized at health facilities other than the one designated to them.

It is estimated that 30-50 percent of target children attend two or more facilities for immunization, yet the standard child register only registers children at their assigned health center. Children from other catchment areas are either tallied in a tally book, recorded at the back of the register, recorded in the outreach register, or recorded in a separate book for visitors, but without a registration number.

These multiple registers cause confusion among health workers and add to the stress of their job. It also leads to a lot of lost data and wasted time trying to track down children who may have already been vaccinated elsewhere.

The overall purpose of this project is to develop an efficient tracking system for finding unimmunized children and those who have missed follow-up doses. It also seeks to improve the consistency of immunization data between health facilities.

STEPS IN IMPLEMENTATION

The following steps were taken in the implementation of this project:

1. Permission for the project was sought from the relevant authorities, such as the Uganda National Council of Science and Technology, the Ministry of Health and the Research Ethics Committee. Two districts were approached for the trial, one intervention district and one control district.
2. A baseline study was conducted to measure existing child immunization attendance and completion in both districts.
3. A second baseline study measured the existing discrepancy between routine immunization child

health card data, child registers, and HMIS 105 forms in the two study districts, to see how well recorded data matched known cases.

4. Community health volunteers were then trained and equipped with community-owned child tracking registers to track vaccine defaulters.
5. Health service providers were also trained and equipped with the new child registers that were aligned with existing child health cards and HMIS 105 forms.
6. The control district continued to use the standard longitudinal child register and tracking mechanisms.

This experiment is ongoing, with results expected by 2020.

INTEGRATION

The Uganda CSO platform has strategically collaborated with key players in the design of this project. During the preliminary design stages, the Ministry of Health, PATH Uganda, CRS, and the Uganda National Expanded Program on Immunization were involved in developing study tools.

Administrative approval was sought from the Research Ethics Committee, Uganda National Council of Science and Technology and the Ministry of Health's Director General of Health Services. Selected districts, health centers and communities were also involved in project design. These collaborations have enhanced the study's credibility and created a sense of community ownership.

POSITIVE OUTCOMES AND IMPACTS

Expected positive outcomes from this project include:

1. Children that have been immunized at facilities other than the one designated to them will be tracked between health centers and their immunization histories made easily accessible to vaccination workers.
2. Health staff will waste less time attempting to track down children to ascertain their immunization status, because they will already know whether a child has been fully immunized, regardless of where they received their vaccine doses.
3. All children within a given community will receive follow-up notifications, regardless of whether they are specifically registered with the nearest health center.
4. Local communities become more empowered to identify and treat children within their locale and to

treat all members of their community regardless of how long those members stay. This will make it easier to welcome children from nomadic and displaced families who are passing through.

5. Health workers are more likely to enter data into the new child register as it doesn't require going back through previous registers to try to identify the child receiving a vaccine.
6. Whereas the traditional, longitudinal child register only recorded a child's age, weight and height on their first vaccination, the integrated child register does so every time a child comes for immunization. This makes it much easier to see the last date of a given dose and to monitor the child's overall health and growth.

“THE NEW REGISTER HAS EASED OUR WORK, FOR WE DO NOT NEED TO LOOK INTO SO MANY REGISTERS AS IT WAS BEFORE.”—HEALTH WORKER AT KIRYANDONGO HOSPITAL

LESSONS LEARNED

Lessons learned so far include:

1. The provision of a child register is not enough by itself. Sometimes facilities lack items such as child health cards, so additional supplies should be budgeted for.
2. The initial cost of introducing the new system might be higher than using traditional methods, but over time it should save money by reducing the number of additional registers, visitor's books and tally sheets currently used. One stakeholder summed it up like this: “Accurate data comes at a cost. If I incur extra cost to get accurate data, it is better than having fake data at a low cost.”—Uganda National Expanded Program on Immunization Official, Ministry of Health
3. Switching from the longitudinal child register to the new register is relatively easy. Health workers find it straightforward. However, switching from a facility-led child tracking system to a community-led one is more challenging, especially in less well-educated communities. Time and patience are required.

PROMISING PRACTICES

A community-owned immunization tracking system is more efficient, more empowering, and more sustainable than a top-down approach. Combined with a cross-sectional child register as opposed to a longitudinal one, this means that more children can be accurately tracked through their immunization programs, regardless of whether they move from one place to another. It also helps to reduce the burden of paperwork for health care staff and frees up their time for patient care.

CHAD

Training community health volunteers

INTRODUCTION

Only 22 percent of children under one are fully immunized in Chad, according to the most recent Demographic and Health Survey. Reasons vary across the twenty-three regions, but largely include a lack of understanding of vaccination among caregivers, socio-cultural burdens, and poor reception when approaching health facilities.

PROJECT PURPOSE AND CONTEXT

Providing accurate information to caregivers plays a huge role in combatting misconceptions and suspicion. Sensitizing caregivers on the benefits of immunization and dispelling rumors, prejudice and other socio-cultural constraints is crucial for increase demand for immunization services and improving coverage. This is the mission of the Platform of Organizations of the Civil Society for the Plateforme des Organisations de la Société civile pour le soutien à la Vaccination et à l'Immunisation au Tchad (POSVIT), founded in 2013.

POSVIT sought to establish a link between local communities and their health services through four of its seven regional committees in Guera, Logone Occidental, Moyen-Chari and N'Djamena. It has done this by recruiting community volunteers and supervisors. There were 112 of these in 2015, of which 63 were female members of CSOs belonging to the platform.

STEPS IN IMPLEMENTATION

Who to recruit as volunteers was guided by the applicants' commitment to the program. To help them accomplish their mission effectively, community volunteers and supervisors benefited from capacity building. The training they received included communication skills focused on home visits and how to initiate informative dialogue. Training also covered knowledge on the benefits of immunization, targeted diseases under the Expanded Program on Immunization, the vaccination schedule for mothers and children, how to actively search for children who had missed follow-up appointments, and community diseases surveillance methods.

INTEGRATION

As POSVIT's aim is to support government efforts, and more specifically the Ministry of Public Health, it focused on building strong communication between those agents and Regional Health Delegations (RSDs) to enact widescale social behavior change. RSD managers were invited to deliver presentations during volunteer and supervisor training sessions, and to chair activity feedback sessions.

Beyond health authorities, regional committees collaborated with administrative and communal authorities to increase the success of outreach sessions and track children lost to the system. Mayors in charge of municipalities were invited to chair launch ceremonies and helped to mobilize district leaders, traditional chiefs and other opinion leaders. This helped to ensure that planned interventions were successful.

POSITIVE OUTCOMES AND IMPACTS

During the 2015 vaccination campaign against measles and polio, 112 community volunteers visited 18,500 households to sensitize caregivers on the importance of immunizing their children. Around 80 percent of households visited said that this was the first time they had received information on vaccination, suggesting that previous partner interventions had not reached them. As a result, the number of mothers requesting immunization services increased considerably and the number of children missing follow-up appointments sharply decreased.

POSVIT intends to build on this momentum by training volunteers and supervisors in all regions that they work in. To do so will require more partners and further resources.

LESSONS LEARNED

Local radio stations proved instrumental in helping to spread the message on vaccination to a wider audience.

PROMISING PRACTICES

Local community volunteers played a crucial role in reaching a wider audience and changing public opinion. Household visits allowed caregivers time to discuss concerns and dispel myths with a well-trained individual, equipped with accurate information and materials.

PAKISTAN

Village Health Committees

INTRODUCTION

In 2009, the Civil Society Human and Institutional Development Program (CHIP) launched a program supported by Gavi to improve immunization outreach for its mother and child health services in the Jhelum district of Punjab, the Skardu district of Gilgit-Baltistan, and the Swabi district of Khyber Pakhtunkhwa.

PROJECT PURPOSE AND CONTEXT

CHIP is a Pakistani non-profit company created in 2004. It has five offices and sixty staff members conducting outreach programs in all five provinces of the country.

CHIP's health interventions in the districts of Jhelum, Skardu and Swabi focused on demand creation for immunization services and maternal child health care at community level. On the supply side, it sought to improve the quality and outreach of primary health care facilities.

STEPS IN IMPLEMENTATION

CHIP set about identifying all children under 23 months as well as pregnant women who needed to begin or complete immunization courses. As a result, two sets of children and pregnant women were identified: 1) children and women who were regularly getting their doses according to the recommended immunization schedule and 2) children and women who were either completely unimmunized or did not continue their full course. This categorization system helped to identify those who had missed doses and pregnant women living in highly inaccessible villages.

CHIP enlisted volunteers to create Village Health Committees, a highly effective community mobilization and awareness-raising strategy. These committees are diverse, including people from all walks of life. The committee in Bhimber, a remote village 40 kilometers from Jhelum, includes religious leaders, shopkeepers, housewives and trained birth attendants, among others. This diversity ensures that different perspectives are considered, and program initiatives are catered to different members of society.

Committees hold monthly meetings to plan awareness-raising initiatives amongst local

communities. They are also responsible for preparing a work plan each quarter.

Committees help CHIP to achieve its goals, taking responsibility for advocating on the importance of immunization and maternal and child health by tapping into local community networks. Committees identified local male and female activists to train as community health workers. These activists then went out into the community to conduct one-on-one sessions with the mothers and guardians of any child under 23 months. Mobilization sessions were also conducted with pregnant women and caregivers of unimmunized children or those who had missed follow-up appointments.

Capacity building of Committees focused on strengthening their institutional capacity so that they could take responsibility for owning their immunization program, independent of regional health departments. Committees were trained on the importance of immunization, as well as community mobilization skills and basic maternal and child health care knowledge.

District health forums were organized to bridge the communication gap between communities and health departments. Committees advocated on issues related to immunization and child health care in their respective villages, while health department representatives addressed gaps in service provision. This helped to create a capable volunteer force working in close partnership with local health authorities.

Puppet shows, interactive street theatre, healthy baby competitions, posters, articles and quizzes were also employed throughout schools and colleges, as well as with caregivers and local leaders, to help to promote the message on immunization. A series of sensitization sessions were conducted with both male and female religious leaders on the importance of immunization, and these religious leaders later became advocates, helping to spread the message as part of their sermons and in their day-to-day teachings.

CHIP understood the importance of local networks from day one. It envisioned Village Health Committees as an integral part of the sustainability of the intervention. Long-term partnerships with Committees significantly helped to pave the way for CHIP to phase out its own involvement without affecting the continuation of the overall program.

POSITIVE OUTCOMES AND IMPACTS

“CIVIL SOCIETY ORGANIZATIONS MAKE ALL THE DIFFERENCE, THEY ARE LIKE OUR HELPING HANDS. THE VILLAGE HEALTH COMMITTEES ESTABLISHED WERE VERY HELPFUL THROUGHOUT THE CAMPAIGNS. WE SHARED RESPONSIBILITIES WITH THEM FOR BETTER, MORE EQUITABLE OUTREACH OF IMMUNIZATION SERVICES. THE COMMITTEE MEMBERS PLAYED AN INTEGRAL ROLE PARTICULARLY IN THE VACCINATION OF MISSING AND DEFAULT CHILDREN IN THE PROJECT AREAS.”—MR. IRFAN SULTAN MALIK, NUTRITION OFFICER, DISTRICT DEPARTMENT OF HEALTH

In 2010, only 66 percent of children in the focus villages in Jhelum and Skardu had received vaccination doses. This figure was brought up to 83 percent by the end of 2013, and currently stands at 100 percent. Similarly, TT coverage in the target villages has increased from 31 percent to 85 percent.

LESSONS LEARNED

Analysis highlighted that most unimmunized children were girls belonging to very poor families, and that many mothers resisted immunization efforts having lost young children in the past and believing that immunization posed an unnecessary risk to health.

PROMISING PRACTICES

This intervention has been instrumental in ensuring vaccination for all children in a given village, regardless of differences in gender, economic condition or geographical accessibility. One of the most impressive outcomes of this intervention is the way in which Village Health Committees can continue to ensure the program’s activities even once CHIP starts to focus its efforts elsewhere, creating a truly sustainable message on immunization.

MADAGASCAR

Nutrition volunteers promote immunization

INTRODUCTION

Andemaka Township in the southeast of Vatovavy-Fitovinany lies 23 kilometers from Vohipeno. It is home to 855 inhabitants, of which 37 are children under one year of age. As an outlying village, it faces several challenges to immunization coverage, particularly vaccine hesitancy on the part of caregivers.

PROJECT PURPOSE AND CONTEXT

Andemaka is a culturally conservative village. Most caregivers had previously received no formal information about immunization, and therefore didn’t see the need to have their children vaccinated. As a result, immunization coverage was very low in children under twelve months.

To try to combat this, a Community Nutrition Officer was enlisted to make house visits. As well as giving caregivers advice on their child’s diet, he also provided information on the importance of vaccination.

STEPS IN IMPLEMENTATION

The Community Nutrition Officer went door-to-door, sometimes accompanied by technical experts from the Malagasy civil society platform for immunization (COMARESS), to speak with mothers of young children and expectant mothers. He spoke to them about child nutrition, but also about the importance of vaccination.

The government made a commitment to ensure the availability of vaccines, so mothers were then referred to health centers to receive courses of treatment.

Once mothers were sensitized and made aware of their child’s vaccination schedule, they became much more invested in carrying it out. The Community Nutrition Officer also received training on how to track children who had missed follow-up vaccinations so that he could contact them and encourage them to attend.

The local radio station, Rakama, also devoted a spot to broadcasting vaccination messages, especially during campaigns. This helped to sensitize the wider community and reach any households the Community Nutrition Officer might have missed.

INTEGRATION

In the future, the Community Nutrition Officer would like to collaborate more closely with local health coordinators to develop greater synergy between their health activities and immunization activities.

POSITIVE OUTCOMES AND IMPACTS

There has been marked improvement in parental behavior regarding child health care. More caregivers are taking their infants to be vaccinated and more pregnant women have been requesting tetanus shots.

LESSONS LEARNED

Radio has played a big part in spreading vaccination messages among the local community and made it easier for the Community Nutrition Officer to reinforce those messages at household level.

Stronger communication between the Community Nutrition Officer at grassroots level and the local health committee could help to improve the reach and effectiveness of vaccination efforts.

PROMISING PRACTICES

Household visits by a trusted child health care professional make it more likely that caregivers will listen to advice on vaccination. If that message is delivered alongside other information, such as nutritional advice, that caregivers already see value in, then additional information is also likely to be accepted.





Voluntary Community Mobilizers conduct a polio vaccination campaign as part of the CRS-lead CORE Group Partners Project in the community of Ungwan Shanu. David Snyder/CRS

PART IV:

Advocacy

MALAWI

Evidence-informed advocacy

INTRODUCTION

Known by many as the Warm Heart of Africa, Malawi is a country with much to offer. Unfortunately, it is also a country where few people have access to quality health care. In recent years, this unequal access has been further exacerbated by a shrinking national health care budget. Civil society watchdogs report that the immunization program is among those hardest-hit.

PROJECT PURPOSE AND CONTEXT

Malawi's health care funding shrunk from 14.1 percent of the national budget in 2010 to just 8.8 percent in 2014, which has impacted strongly on the country's national immunization program. Malawi Health Equity Network (MHEN) is a health advocacy platform with more than forty members. MHEN members have seen firsthand how the funding drop has affected children in underserved communities.

“WE ANALYZED THE BUDGET AND FOUND THAT THE 2014–2015 ALLOCATION WAS NOT ADEQUATE TO SUPPORT HEALTH CARE AND [IMMUNIZATION] ACTIVITIES, SO WE PROVIDED THE PARLIAMENTARY COMMITTEE ON HEALTH [WITH] INFORMATION [THAT ALLOWED THEM] TO ABLY CONTRIBUTE TO THE DEBATE.”—DAVIES MWACHUMU, PROJECT OFFICER, MHEN

Equipped with MHEN study findings, parliamentarians lobbied the government for increased health care funding. They showed evidence that much of the funding intended for the health sector was being diverted to national agriculture projects, a disturbing trend in a country

where an estimated 68 out of every 1,000 children dies before their fifth birthday.

STEPS IN IMPLEMENTATION

In 2013, MHEN launched an immunization arm of their civil society network to further engage civil society organizations in the country's immunization efforts. Fifteen organizations make up the platform's core team and represent the platform at national level in both government and non-government sectors.

They receive their information from three regional committees, and work together with government health officers to extend the reach of Malawi's immunization program. They are also in constant contact with Malawi's Mother Care Groups, local volunteer-run groups of mothers who work to sensitize their communities on immunization and track children who have missed follow-up appointments. MHEN helped to establish these Mother Care Groups in 2013, and today they prove to be a strong line of communication between health CSOs and grassroots communities.

Efforts on this campaign really began when MHEN examined government spending figures.

“WHEN WE SAW THAT [SO MUCH MONEY HAD BEEN DIVERTED FROM IMMUNIZATION TO AGRICULTURE], WE STARTED ADVOCATING. WE PRESENTED OUR FINDINGS AND ASKED THAT THEY REALLOCATE THE MONEY FROM THE FERTILIZER AND INPUT SUBSIDY TO THE HEALTH SECTOR BUDGET.”—DAVIES MWACHUMU, PROJECT OFFICER, MHEN

They conducted a situational analysis on immunization and discovered a lot of gaps in service provision and demand creation. They developed a case against funding cuts on the grounds that it

was negatively impacting national immunization coverage.

They took this information to the government and organized community workshops where government officials were invited to see the situation for themselves.

POSITIVE OUTCOMES AND IMPACTS

The impact of MHEN's advocacy efforts soon became apparent in parliament. When the final budget for 2014-15 was passed, it included a one percent increase for health care, approximately a \$17 million boost, including \$2.1 million earmarked specifically for immunization.

“THIS WILL REALLY HAVE AN IMPACT ON THE LIVES OF PEOPLE HERE. IT WASN'T JUST FOR IMMUNIZATION, BUT FOR THINGS LIKE HIV/AIDS AND UNDER-FIVE CHILD CARE. IT FELT GOOD BECAUSE AT THE END OF THE DAY SOMETHING GOOD CAME FROM OUR WORK.”—DAVIES MWACHUMU, PROJECT OFFICER, MHEN

Buoyed by the dramatic success of their advocacy, MHEN now seeks to expand their Mother Care Groups into every district of the country. They are working with community clinics to advocate for 15 percent of the national budget to be spent on health care.

LESSONS LEARNED

MHEN's local connection, especially the regional Mother Care Groups that they helped to found, proved invaluable in supplying grassroots information to help the advocacy case against budget cuts.

PROMISING PRACTICES

MHEN's success shows the importance of building strong, evidence-based advocacy campaigns and sharing information between grassroots communities and government departments. To bring about big changes, facts and figures need to be clearly explained and their relation to human cost highlighted in a way that strongly persuades decisionmakers to act.

NIGERIA

National immunization champions

INTRODUCTION

The Civil Society Platform on Health and Immunization was inaugurated in thirteen states in

Nigeria thanks to funding from Gavi. One of the most active and functional state platforms is the Akwa Ibom Chapter of the Civil Society Platform on Health and Immunization (the Chapter), in Akwa Ibom State.

PROJECT PURPOSE AND CONTEXT

In 2015, the Chapter recruited State Health Educator and Social Mobilization Officer Evelyn Eyo as an advocacy champion. Her mandate was to assist the platform in reaching government decisionmakers and to establish advocacy events with government officials. As Advocacy Champion, she would also work with government agencies on follow-up activities relating to meeting outputs and assist platform members in participating in health sector meetings at all levels.

STEPS IN IMPLEMENTATION

After her appointment as Advocacy Champion, Evelyn set about arranging meetings and preparing advocacy campaigns with government ministries and development partners. This led to CSO platform members being invited to conduct sensitization campaigns in several regions, leading to better awareness of health issues and uptake of certain vaccinations.

POSITIVE OUTCOMES AND IMPACTS

As Advocacy Champion, Evelyn has yielded significant results that have strengthened the participation of CSOs in health and immunization activities. She has also helped to promote partnerships between civil society and government agencies.

As a result, a meeting was held between civil society and the State Immunization Officer, Ime Udoh, on 27th July 2016. The meeting took place at the Ministry of Health, and resulted in the following outputs:

- The Chapter suggested strategies that the government could adopt to increase community immunization uptake.
- A conference call occurred between government officials, the CSO platform and its development partners to discuss best practice in switching to the bivalent oral polio vaccine.
- Four platform member organizations were engaged in implementing immunization governance within the European Union SIGN Nigeria Project.

Another result of the engagement was that in August 2016 the government asked platform CSOs to

sensitize mothers in Urua Akpan through health talks highlighting the benefits of immunization and the dangers of not completing vaccination courses.

In October 2016, CSOs sensitized 84 communities in 15 Local Government Areas on the importance of vaccinating against Lassa fever and measles after the CSOs held sensitization sessions and distributed informational materials. There was a notable uptake of the measles, mumps and rubella vaccine at primary health facilities following these sensitization activities.

LESSONS LEARNED

Inviting a high-level official to champion health advocacy has opened doors for civil society organizations in Nigeria. It is a good idea to seek out a go-between to make introductions to government ministries and highlight all the ways in which CSOs can help to achieve policy goals.

Not all chapters are as active as the Akwa Ibom Chapter, and perhaps they could benefit from the Chapter's example and by sharing best practices.

PROMISING PRACTICES

The Akwa Ibom Chapter of the Civil Society Platform on Health and Immunization, with the help of Advocacy Champion Evelyn, has helped to smooth the way for good relations between health-related CSOs and the government of Nigeria. It has shown the government that they can rely on CSOs to answer the call when immunization sensitization is needed and allowed CSOs to participate more fully in national policymaking.

MADAGASCAR

Rights-based advocacy for health system strengthening

INTRODUCTION

The community of Ankarinarivo Manirisoa in Upper Matsiatra had lost confidence in its Basic Health Center. According to the community members, the health workers were repeatedly absent, and the service quality was poor. Data management was so weak that the center had no complete records of births or vaccinations. The CSO platform, COMARESS, was asked to intervene.

PROJECT PURPOSE AND CONTEXT

The Communal Committee for Social Development, in partnership with COMARESS, decided to hold a community dialogue to ask service users and the

local community what could be done to improve the situation. Their rationale was that communities are a pillar of the health system, and they have both the right and the responsibility to monitor and inform the services available to them.

Local administrative officials, such as the district president and the local mayor were also invited to attend.

STEPS IN IMPLEMENTATION

A plenary meeting was held with Communal Committee for Social Development members and local leaders in Fianarantsoa II. From this, a set of nine articles was drafted, explaining how the health center should be run, and what local people could expect from it. These articles are based on the people's right to health, which is enshrined in national legislation.

Article 1: Every primary health care center must offer antenatal care services and assisted delivery services.

Article 2: Every child from 0–9 months must be vaccinated and must finish their vaccines on time.

Article 3: The Ankarinarivo Manirisoa health center must offer all essential maternal and child health services.

Article 4: Birth and death registrations at the commune cannot be approved without presenting the health records of the mother or child.

Article 5: Post-natal follow-ups at the health center are obligatory in case of delivery by a traditional birth attendant. Only a fully-qualified birth attendant can register births with the commune.

Article 6: Self-medication is prohibited. All patients must attend the health center for treatment.

Article 7: A community sanction (*dina*) will be applied to any person in violation of these provisions.

Article 8: The Chief of the region and his community agents are responsible for disseminating and implementing this information within the community.

Article 9: This decree is in force throughout the municipal territory once approved by the Mayor.

COMARESS and local health workers helped to share these articles with the local community, so that everyone understood the role of their local health center and their responsibilities as patients.

POSITIVE OUTCOMES AND IMPACTS

COMARESS participation in helping to draft these articles has strengthened its relationship with the local health center, and the performance of the health center has shown an improvement.

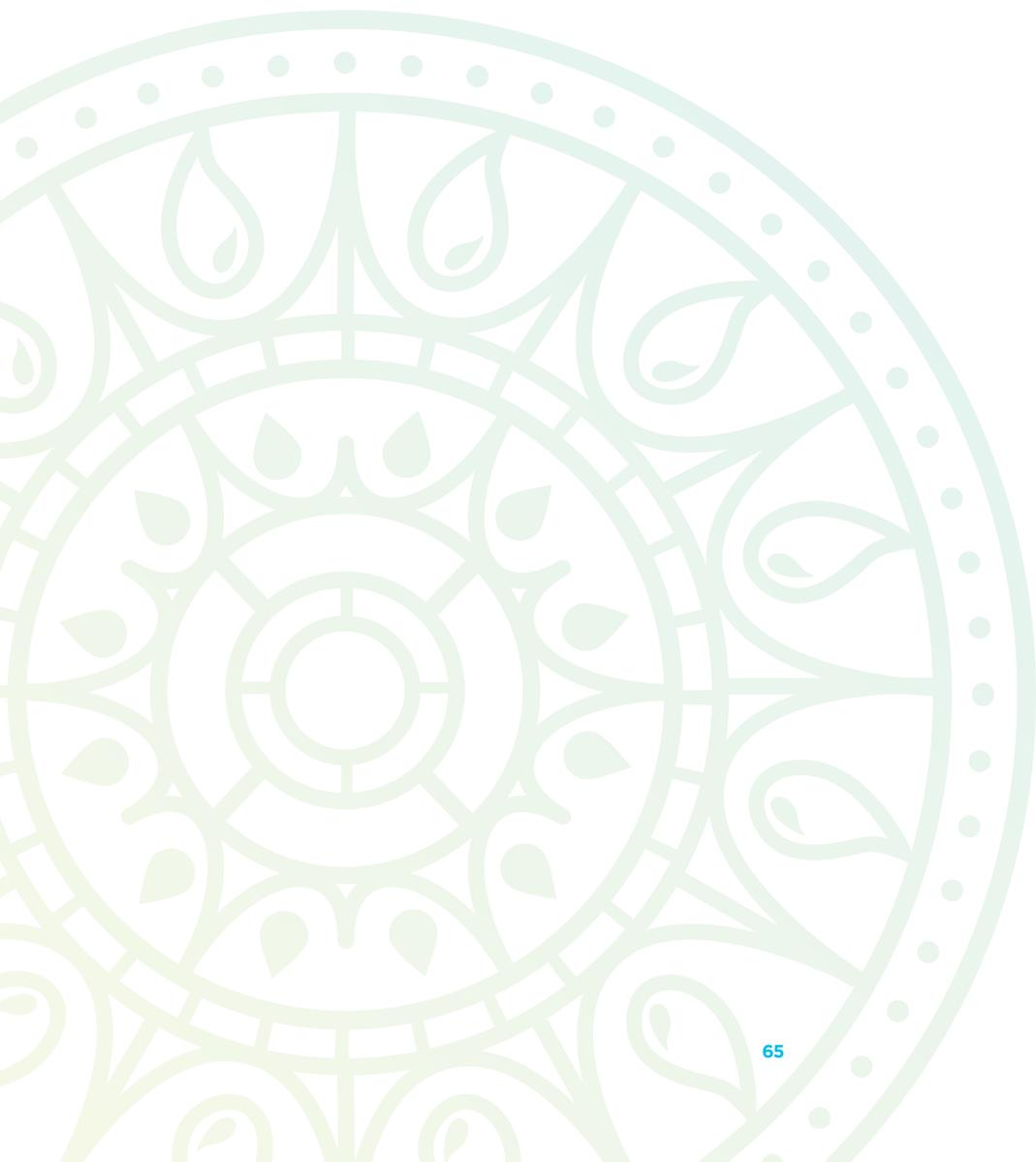
COMARESS continues to be involved in planning immunization activities within the local community and in assisting the health center to increase the quality of its service provision. This will ensure the ongoing immunization of all children and expectant mothers who live in this remote area.

LESSONS LEARNED

Community members are essential actors in health system strengthening. By giving them the information and tools they need to engage with the health system, and by establishing an enabling environment, such as through the encouragement of local leaders, they can improve their local health center and hold service providers accountable for protecting and fulfilling their right to health.

PROMISING PRACTICES

Clearly outlining patients' expectations of their health center, and best practice policy, can help to build trust between local communities and their health centers. It also provides a point of reference if things aren't going to plan.





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