Request for Concept Note and Proposal background information

Overview

Title: Enhancing service quality and caregivers' experience in Karachi Super High-Risk Union Councils (SHRUCs)

Duration: 24 months

Budget: 2.0 million (USD)

Geographic Location: 8 SHRUCs in Karachi, Pakistan, with a focus on mobile and migrant populations

1. Introduction

Karachi, as Pakistan's largest and most densely populated city, remains a critical focal point for improving immunization coverage, particularly among zero-dose (ZD) and under-immunized children. In 2019, Super High-Risk Union Councils (SHRUCs) were designated based on polio epidemiology, socio-economic conditions, and living environments. All eight SHRUCs in Sindh are located in Karachi, accounting for 26% of the city's total ZD children, despite comprising just 13% of the population.

Polio eradication efforts remain intensive, yet Karachi continues to experience persistent virus detection in environmental samples and rising vaccine refusals. In 2025, Sindh reported 42,999 polio vaccine refusals—41,875 (97%) of which were in Karachi. Moreover, 17% of refusal families in Karachi's SHRUCs overlap with recorded zero-dose families, signaling broader immunization challenges. In six of the eight SHRUCs, the majority of ZD children are from Pashto-speaking communities. Although Pashtuns represent 25% of Karachi's population, they constitute 70–80% of the unvaccinated in SHRUC areas, underscoring deep inequities in vaccine access and acceptance.

Investments in health system infrastructure—including human resources, vaccine supply and cold chain, and monitoring systems—have greatly expanded routine immunization (RI) services in Karachi's SHRUCs. A 2020 geospatial analysis confirmed 99.6% of ZD children in SHRUCs are physically within 1 km of both fixed and outreach sites. Session availability in Karachi's SHRUCs was high, with vaccinators regularly conducting outreach and fixed-site sessions. Caregivers do not cite direct cost of seeking care as a major barrier, indicating that physical access alone does not explain persistently low coverage.

Trust in government health services remains low, especially among caregivers in Karachi's SHRUCs, where past interactions with both public and private systems are often perceived as poor in quality. Caregivers report limited access to information, inadequate counselling, and a general sense that the health system does not respond to their needs. These perceptions are particularly acute in underserved communities, where frustration grows when vaccination is prioritized while more pressing needs—like food, sanitation, infrastructure and income—remain unaddressed.

Trust in vaccinators themselves is also strained. Many caregivers report feeling coerced to vaccinate, especially during campaigns. Qualitative data from three SHRUCs revealed that 67% of zero-dose (ZD) caregivers felt they were visited too frequently by Community-Based Vaccinators (CBVs), and 65% reported feeling pressured during these encounters. These negative interactions—combined with dissatisfaction over vaccinators' attitudes and communication styles—erode confidence and fuel resistance to both routine immunization and polio campaigns.

At the point of service, quality of care is often sub-optimal, across both public and private providers. Sessions are frequently scheduled at inconvenient times, especially for female caregivers juggling domestic responsibilities and, in many cases, restricted by gender norms that limit independent care-seeking. Even when services are accessible, caregivers report poor treatment, rushed visits, and missed opportunities for vaccination (MOV). Post-care, 63% of caregivers reported experiencing negative side effects, especially fever, which contributes to broader concerns about vaccine safety. Managing these mild but distressing side effects imposes both direct and opportunity costs—such as income loss—on already resource-strapped families. While pilots to distribute paracetamol or provide post-vaccination reassurance have shown promise, these measures remain limited in scale.

Collectively, these systemic, interpersonal, and logistical challenges shape caregivers' perceptions of immunization and reduce their intent to vaccinate. Among ZD caregivers in Karachi's SHRUCs, half believe vaccines are unimportant, while 51% consider them unsafe. These beliefs are further reinforced by social and gender norms: 39% of caregivers report that close friends and family oppose vaccination, and over half (56%) of mothers say they need permission from male relatives to immunize their children.

These gaps in service quality and negative service experiences are key barriers to vaccine uptake. Addressing these issues may help close the coverage gaps that investment in health system infrastructure and service capacity— alone—have not resolved. Developing approaches to address these gaps is a critical step towards increasing vaccination uptake in Karachi—and may offer important lessons for Sindh and other contexts in Pakistan.

Defining Service Quality and Service Experience

In this RFP, we draw a distinction between *service quality* and *service experience*, while recognizing their deep interconnection and shared impact on caregiver trust and vaccine uptake.

- **Service quality** refers to the structural and procedural elements of care—*what* is being delivered and *how effectively* it is delivered. This includes technical competence, the availability and timing of services, counseling protocols, management of side effects, integration of gender-responsive approaches, and overall adherence to care standards. For example, missed opportunities for vaccination, inadequate post-vaccination care, or poor vaccine administration practices (e.g., causing unnecessary pain or abscess) are indicators of service quality gaps.

- **Service experience**, by contrast, reflects the caregiver's *perception and emotional response* to care—how services are delivered, how people are treated, and whether the interaction fosters trust, dignity, and cultural alignment. This includes factors such as feeling respected, listened to, and not coerced; comfort with the health worker's attitude, profile, background and language; and access to information in a supportive environment. For instance, repeated uninvited visits by CBVs, lack of counseling after vaccination, or disrespectful treatment shape negative service experiences—even when services are technically available.

In contexts where communities already experience marginalization, gaps in service quality and negative service experiences often compound one another—reinforcing distrust in the health system and reducing intent to vaccinate. This initiative seeks to address both dimensions holistically, with the understanding that meaningful improvements in either can help rebuild trust and drive uptake.

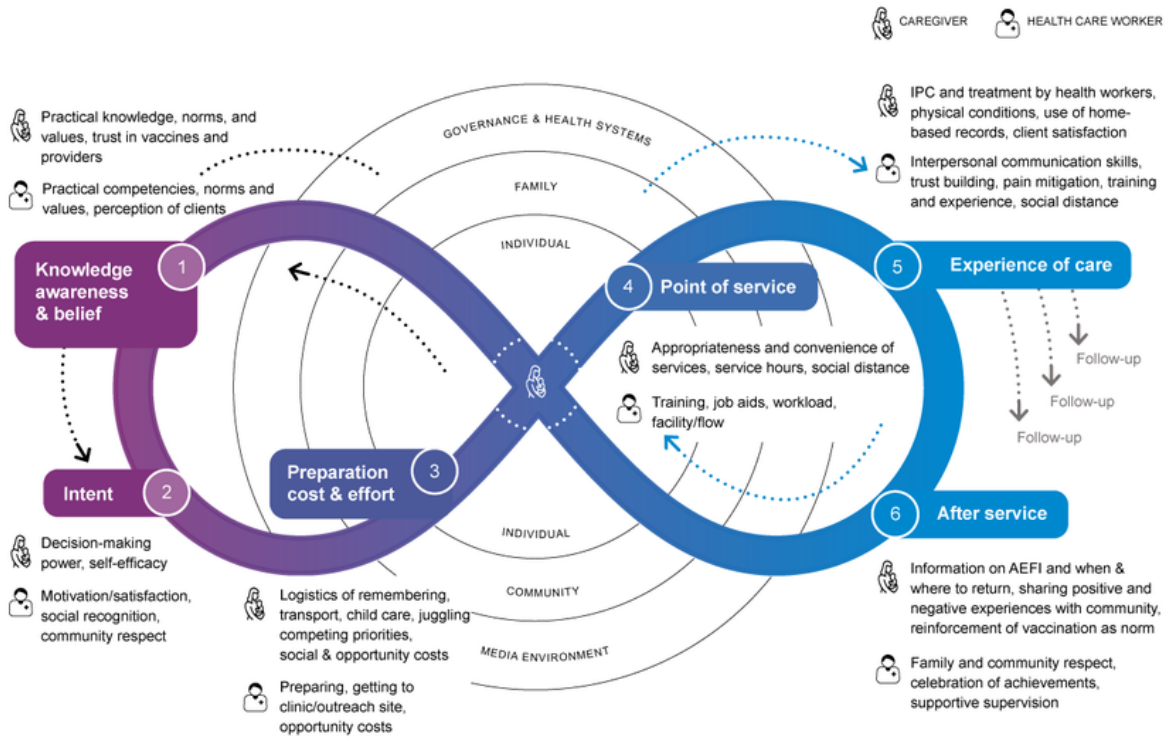
Background and Rationale

Despite the increased investment and attention to service delivery in Karachi, improving uptake among ZD and under-immunized children remains a challenge. The impressive supply-side investments in recent years both have paid great dividends and have potentially reached a saturation point. Meanwhile persistent gaps and challenges in trust, awareness, social norms, agency, service quality and post-care service/side effects continue to hinder resilient demand and coverage.

For the purposes of this RFP, we distinguish between **service quality**—what services are delivered and how effectively—and **service experience**—how those services are

perceived and emotionally processed by caregivers. While interrelated, these two dimensions shape trust and vaccine uptake in different ways. This framing underpins the design and analysis approach for proposed interventions.

Figure 1: As outlined in the Journey to Immunization, the experience of the caregiver during and immediately after vaccination directly influences future intent to vaccinate. This project focuses specifically on addressing the barriers that happen during (4) point of service, (5) experience of care, and (6) after service and their interaction and subsequent impact on (2) intent.



Key barriers include[1],[2]:

- **Inconvenient session timings**: Vaccination sessions often conflict with household and caregiving responsibilities, particularly for female caregivers who bear the burden of childcare and domestic duties. In contexts where women require permission or accompaniment from male household members to access care, services must also align with male caregivers' availability—further narrowing the window of access.
- **Long wait times**: Extended waiting periods at service points create logistical burdens and reduce the likelihood of caregivers returning for follow-up visits. For working caregivers, this translates into lost income and time, compounding the perceived cost of seeking care.

[1] Zero Dose Learning Agenda Readout, Sindh, December 2024
[2] VillageReach, 9 Month Immunization Study Gender Analysis – Pakistan Results, June 2024

- **Missed Opportunities for Vaccination (MOV)**: In both public and private settings, routine interactions with the health system are not always leveraged to offer or administer vaccines. This results in caregivers making multiple, unnecessary visits or missing doses altogether, undermining continuity of care.
- **Improper vaccine handling and administration:** Caregivers have voiced concerns about the technical quality of vaccine administration, including instances of abscess formation. These issues signal gaps in health worker training and adherence to clinical protocols.
- **Concern about post-vaccination side effects and their management:** Caregivers frequently cite concerns about vaccine side effects, especially common side effects (e.g., 63% of caregivers reported negative experience with vaccines, including fever), with limited access to effective counseling and symptom management. Fever and pain at the injection site following immunization, use of alternative medicines, and a history of AEFI are associated with increased vaccine refusal. When compounded by inadequate counseling or follow-up support, vaccine side effects signal poor service experience.
- **Negative past experiences**: Many caregivers report inadequate follow-up and support after immunization. In particular, common side effects like fever are poorly managed, leaving caregivers to navigate symptoms without guidance or reassurance. This has contributed to growing concerns around vaccine safety and hesitancy in ZD communities.
- **Poor treatment by health workers**: Reports of caregivers feeling pressured to vaccinate—particularly during mobilization campaigns—highlight challenges with interpersonal communication and informed consent. Such coercive experiences can erode trust and deter future engagement with health services.
- **Migrant and Mobile Populations:** Community insights suggest that mobile and migrant populations—particularly Pashtun communities in Karachi's SHRUCs—experience systemic neglect and social marginalization, which contributes to deep-rooted distrust in health services (note Pashtun communities represent 70-80% of the unvaccinated SHRUC communities but only 25% of Karachi's population).
- **Gender-related barriers:** In cases where vaccination services are available and convenient, invisible barriers still exist such as social norms, agency and mobility, and safety concerns hinder access, especially for female caregivers. Limited engagement with fathers and elders who are primary decision-makers for immunization and health;
- **Trust in the health system:** High Risk UCs and Zero Dose households in Sindh also have low trust and fewer touch points with the public health system. The interactions they do have are often suboptimal.
- **Negative vaccinator-caregiver interactions:** Health workers can demonstrate poor interpersonal communication (IPC) skills. In particular, recent reports

highlight dissatisfaction and harassment during polio campaigns, impacting trust in immunization and health services more broadly. Findings from September 2024's campaign show that 17% of zero-dose (ZD) families in Karachi SHRUCs overlap with polio refusal families, demonstrating a shared challenge in reaching both groups.

Many barriers—such as concerns around side effects or feelings of coercion—can relate to both service quality and service experience, underscoring the need for integrated solutions that address both the technical delivery and emotional perception of care. The table below outlines how each of these factors is related to service quality, service experience, or both.

Table 1: Intersection between service quality and service experience barriers

Barrier	**Service Quality**	**Service Experience**
Inconvenient session timings	Session times conflict with domestic/work responsibilities, reducing accessibility.	Can lead to frustration or perceived disregard for caregiver routines and priorities.
Long wait times	Operational inefficiency increases the time burden on caregivers.	May cause stress, discomfort, and feeling undervalued / disrespected.
Missed Opportunities for Vaccination	Vaccines not offered at routine health visits, undermining procedural quality.	Can cause confusion or fatigue from repeat visits and a lack of clarity of what is required or comes next..
Improper vaccine handling	Poor administration practices (e.g., abscess formation) indicate gaps in technical competence.	Poor administration practices can cause emotional distress, physical pain and undermine trust in the vaccinator and vaccine.
Concern about post-vaccination side effects	Side effects due to poor administration or lack of pre-emptive guidance.	Emotional distress and perceived lack of empathy or information.
Negative past experiences	Lack of follow-up and technical support for side effects shows procedural failure.	Caregivers feel unsupported or abandoned, increasing fear and hesitancy.

Poor treatment by health workers	Coercive or rushed behavior may reflect structural campaign pressures and a lack of training.	Disrespectful or dismissive behavior undermines trust and dignity.
Migrant and mobile populations	Touchpoints may not reflect cultural priorities or appropriateness, including in HCW profile, location, and timing.	Perceived exclusion or marginalization by the system; limited culturally sensitive engagement.
Gender-related barriers	Structural limitations in female staffing or facility setup hinder access.	Norms around autonomy, safety, and male gatekeeping reduce comfort and agency.
Trust in the health system	Fewer touchpoints, inconsistent quality of services erode perceived system reliability.	Negative expectations, emotional detachment, or suspicion toward health actors.
Negative vaccinator-caregiver interactions	—	Poor IPC; reports of harassment or coercion during visits.

This investment aims to support the design and testing of interventions that address barriers like these, improving both service quality, service experience and overall trust in immunization services to reduce zero-dose, polio refusals and under-immunized populations in Sindh. Proposals should include the conceptual framework (e.g., the UNICEF Journey to Immunization, or the Behavioral and Social Drivers Model) and theory of change underpinning their intervention approach.

Critically, the investment will result in a strategic framework that builds on current Mobile and Migrant Population strategies—strengthening and expanding them to more effectively address the unique barriers faced by these high-risk groups. While previous approaches have recognized the disproportionate burden of zero-dose children among mobile and migrant communities, in particular Pashto-speaking communities, more is needed to understand and design for their unique vaccination barriers, preferences and strategies to build trust in health services. This new framework will prioritize demand-side insights and take a systems-level approach, integrating behavioral and anthropological insights with operational realities. It will identify practical, scalable ways to improve trust, increase continuity of care despite mobility, and ensure that

communication, service design, and outreach strategies are tailored to the language, norms, and lived experiences of mobile groups—including Pashtun populations in Karachi's SHRUCs.

The focus of this project is both on practical intervention development and implementation and on generating learnings and findings to inform system level change and policy decisions. While some validation of existing data with key communities may be part of a human-centered intervention design process, we expect proposals to primarily emphasize innovative intervention design and rapid testing and rather than extensive new data collection.

While the barriers outlined above are well-documented through existing research and caregiver feedback, many persist because the health system lacks the mechanisms or incentives to *see*, prioritize, and respond to them. Gaps in data, limited feedback loops, and rigid operating procedures often mean that service quality and experience issues—particularly those related to trust, side effects, gender and cultural dynamics, or community perceptions—remain invisible within formal program structures. As a result, these issues are not systematically addressed, even when they are known to frontline workers or community actors.

Proposals should consider not only *how* to address specific barriers (e.g., inconvenient session timings, poor HCW interactions), **but also *why* those gaps persist—and how systems can be better equipped to recognize and respond to them.** This may include designing interventions that build visibility, responsiveness, and accountability within the service delivery system itself, enabling more sustained improvements over time. These insights will be critical for shaping more responsive, scalable approaches to improving trust and vaccine uptake.

2. Scope of Work

This initiative is a "proof of principle" investment to design, test and quantify the impact of improvements in service quality and caregivers' experience on vaccine uptake in high-risk areas of Karachi, Sindh. By testing and validating targeted interventions, the project will generate evidence-based recommendations for scalable, cost-effective approaches to strengthen immunization coverage.

In the long term, these findings will help identify high-impact, catalytic investment areas where enhancing service quality, in particular for women caregivers and high-risk mobile and migrant populations, leads to measurable improvements in vaccine acceptance and trust. This may include identifying, testing, and validating innovative approaches that are cost-effective, rapid and impactful. While targeted intervention design remains a key focus, this initiative should also surface opportunities for

strengthening system processes and policy structures that support continuous quality improvement. In particular, proposals should consider how to institutionalize feedback loops between caregivers, frontline workers, and decision-makers, to enhance the system's capacity to detect and address service delivery challenges over time.

This initiative will be grounded in data from existing surveys and assessments on service quality, experience, HCW performance, and caregiver trust. It will focus on the unique challenges facing ZD, under-immunized, refusal and underserved families in the 8 SHRUCs in Sindh, with proposed interventions spanning both fixed and outreach immunization services.

Interventions should be based on existing evidence of opportunity areas and could include, but not be limited to the following approaches. (Please note that these approaches are only indicative of the type of interventions that could be considered, and innovative ideas outside of this list are welcome and encouraged).

Sample Intervention Areas to Investigate

1. Vaccine Counseling and Management: Develop and test interventions to improve caregiver confidence in vaccination services
    - Developing clear, standardized counseling protocols for HCWs
    - Understanding concerns related to the quality of vaccine administration (e.g. administration leading to abscess formation)
    - Understanding the provision of Panadol and other simple interventions to manage mild side effects influences uptake during campaigns
    - Testing post-vaccination follow-up messaging to reassure caregivers
2. Improving Service Quality and Accessibility:
    - Reducing wait times and service barriers identified through evidence, where applicable
    - Exploring more convenient service hours based on community feedback
    - Improve HCW skills in interpersonal communication, referrals, and client-centered service delivery
3. Improving Service Experience:
    - Developing and integrating training modules on interpersonal communication, motivational interview and focusing on HCW attitudes toward Pashtun/mobile communities
    - Embedding accountability and monitoring mechanisms for discrimination cases
    - Adapting these lessons to polio campaigns, addressing emerging reports of dissatisfaction and harassment.
    - Targeting healthcare workers and facilities to improve missed opportunities for vaccination (MOV), including through integrated service

provision that reduces fragmentation and supports a “one-stop” experience for caregivers in both public and private facilities

4. Improving Meaningful Community Engagement and Human-Centred Approaches
    - Developing mechanisms to regularly engage with community representatives to identify and address service quality, service experience gaps in a more continuous and strategic way
5. Targeted Strategies for Mobile & Migrant Populations
    - Mapping high-risk mobile groups and identifying tailored outreach strategies
    - Creating a strategic framework that builds on current Mobile and Migrant Population strategies—strengthening and expanding them to more effectively address the unique demand barriers faced by ZD caregivers among mobile and migrant populations
    - Ensuring that HCWs are equipped to build trust and engage transient communities
6. Gender-Intentional Approaches
    - Designing service delivery approaches that enable female caregivers to more safely access vaccination services
    - Aligning vaccination schedules with women’s domestic routines, reducing the opportunity costs of participation
    - Ensuring the presence of appropriate female vaccinators and frontline workers at outreach and fixed sites to increase comfort and cultural acceptability
    - Improving the safety, cleanliness, and dignity of service environments, including reducing waiting times and offering private spaces where needed
    - Expanding home-based or door-to-door services in communities where women’s independent mobility is limited
    - Engaging with both female and male caregivers to develop relevant approaches addressing gender-specific barriers

7. Enabling Policy Reform and System-Level Change:

    - Identifying regulatory or policy-level barriers that limit improvements in service quality, caregiver experience, or trust in immunization services.
    - Engaging with provincial and district health authorities to co-design policy recommendations that institutionalize successful intervention models.
    - Supporting the development of protocols, guidelines, or accountability mechanisms that enable sustained improvements in service delivery and caregiver engagement—particularly for mobile and marginalized populations.

- Recommending systemic policy shifts that promote adoption of gender-intentional and community-responsive practices within the immunization ecosystem.

In order to maximize impact and sustainability, interventions should be designed, tested, and evaluated in partnership with caregivers, community leaders, workers, EPI managers, and other relevant stakeholders using human-centred approaches, including co-design and iterative prototyping and feedback.

To ensure long-term impact, applicants should incorporate a cost-benefit analysis to evaluate efficiency, feasibility, and scalability of service quality improvements, while also proposing innovative approaches that challenge conventional thinking. We seek solutions that not only demonstrate value for investment but also introduce novel perspectives and methodologies that can transform service delivery.

Both public and private facilities should be included for consideration when thinking through intervention design.