

THEMATIC ANALYSIS OF THE CULTURE OF UNICEF IN RESPONSE TO POLIO
ERADICATION EFFORTS

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Abstract

UNICEF is the largest contributor of vaccines to the developing world. Under the framework of Global Polio Eradication Initiative, UNICEF has deployed a strategic approach called the Communication for Development (C4D) approach that utilizes community engagement to effectively disseminate the oral polio vaccine (OPV). UNICEF stresses how the C4D approach results in the structuring and implementation of programs that reflect the community's thoughts and actions. Documents focused on the existing C4D approach in Pakistan were analyzed to see how themes of community knowledge are relayed according to document type and level. Based on the various levels of documentation (ranging from a qualitative study of community thoughts to briefs presented to UNICEF experts), it appears that while community ideas surrounding OPV and Polio are at first recorded in their full nuance, this complex information is lost at the highest level of documentation. This points to a cultural of optimism that may be obstructive to critical and strategic thinking.

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Abbreviations

AFP - acute flaccid paralysis

COMNet - Communication Network

EPI- expanded program of immunization

FATA- Federally Administered Tribal Areas

GAVI- global alliance for vaccines and immunizations

GPEI- global Polio eradication initiative

IMB- independent monitoring board

OPV - oral Polio vaccine

UCs - Union councils

WASH - Water Sanitation and hygiene

Introduction

In 1980, soon after the success of the smallpox eradication campaign, the scientific medical community was poised to find the next disease to eliminate. Meetings were held at the National Institute of Health (NIH) to choose a new global health initiative. Measles and Polio were identified as the most promising candidates.¹ There was initial dissent on whether to eradicate or 'control' Polio, as it was not a major public health concern in the developing world.¹ Eventually, in 1985, Polio eradication advocates were able to garner support.² The selling point was utilizing Polio eradication as a strategy for strengthening regional health systems.²

In 1988, approximately 125 countries were still documented to be transmitting indigenous Wild Polio Viruses (WPVs), which contributed to paralysis of more than 350,000 children a year worldwide.³ The Global Polio Eradication Initiative (GPEI) was launched in 1988 with the intent to eradicate Polio by 2000.⁴ Under this initiative, UNICEF, the World Health Organization, Rotary International and the U.S. CDC formed a partnership to spearhead efforts to support country-level governments in their eradication efforts. GPEI thus formed as a collaboration of governments, international organizations, the private sector, and civil society. Of the various partners involved in the initiative, UNICEF had already played an essential role as the largest provider of vaccines for developing countries.⁵ Billions of doses of oral Polio vaccine (OPV) had been disseminated globally.⁵ The timely dissemination of the vaccination is one of the most essential links in eradication

efforts. Mass OPV campaigns have since been credited for the disruption of Polio outbreaks within numerous countries.

As a result of GPEI's work, there was a 99% reduction in Polio cases over the next 10 years.⁶ Three WHO Regions (the Americas, Western Pacific and European Regions) were certified as Polio free by 2002.¹ By 2005, transmission of indigenous Wild Polio Virus had ceased in all but 4 endemic countries: India, Nigeria, Pakistan, and Afghanistan.¹ These countries became intractable in terms of eliminating the virus, and the campaign for worldwide eradication of Polio by 2000 failed.

Pakistan continues to present many obstacles to eradication efforts, and 80% of all recent cases can trace their genetic roots back to Pakistan.⁹ The eradication of Polio in Pakistan has been exceedingly difficult despite GPEI's adoption of expanded program on immunization (EPI) in 1994.⁷ Since 2012, Pakistan has been the only Polio-endemic country that has seen a consistent rise in cases.¹⁰ Multiple adverse factors intersect that make Pakistan world's largest reservoir for Polio. Geography and climate are two of the major barriers to eradication. Fecal-oral transmission of Polio Virus is rampant in Pakistan's hot climate. High population density, poor quality water and limited sanitation infrastructure contribute to the virus's outbreaks.⁸ Pakistan's political structure presents additional challenges. The country is in a constant state of conflict as it faces internal political struggles along with pressure from international agents. Such conflict reduces the importance of Polio as resources and attention are shifted elsewhere.⁸ Even from a purely health standpoint, Polio is by no means a top priority. It is ranked only 34th as cause of health years lost in the country. To add to the complexity of the problem, the

eradication of Polio using OPV is also less effective in this region primarily because of issues surrounding inadequate storage. With these factors considered, even in the case of most optimal immunization strategies success may take time, and early campaign attempts should be expected to be suboptimal. This difference between long-term eradication horizon and short-term expectations is one of the central themes of this paper.

The GPEI is determined to eradicate Polio because of regional and global implications, as well as its need to successfully reach the zero case target mark that has been consistently pushed back. New and innovative programs under the auspices of GPEI are constantly being crafted. A recent program by the name of Communication for Development was initiated to push through perceived barriers to eradication.¹¹ GPEI has broadly defined these barriers under the themes of inaccessibility, violence, misconception and misinformation, in addition to intricate tribal and cultural norms and systems. However, as this proposal will attempt to demonstrate, certain barriers have been systematically externalized, with health organizations paying surprisingly little attention to internal misconceptions, knowledge-gaps, and histories of failure. In particular, this proposal seeks to elucidate and contextualize this lack of internal focus through an examination of the culture of UNICEF. A greater understanding of the underlying culture of this organization may identify areas or values within the sponsoring organizations that are in themselves barriers to eradication efforts. The first section will present a detailed overview of Polio eradication efforts in Pakistan and frame the central argument. It will be followed by a description of methods used. The analysis portion

will concentrate on extracting UNICEF's revealed approaches, priorities, and understanding of barriers, and putting these in conversation with more ground-level approaches. Central themes will be taken up again in the discussion portion. Along with the critique of UNICEF's approach, attempt will be made to make the case for a redoubled effort to focus on internal issues.

Background

As part of GPEI, WHO, UNICEF and other partners have contributed human and financial capital to high-risk countries. The GPEI-funded staffers assist in the international coordination of eradication strategies and follow best practices. GPEI is recognized as a leader in innovation and research. GPEI has crafted strategies based on particular social contexts and cultures as a result of sincere recognition of the various barriers existing in Polio-endemic countries. Strategies include providing zinc supplements to children to reduce the incidence of diarrheal disease and transmission. One of the most effective strategies has been the house-house vaccine delivery service established in the early 2000s.

However, despite the publicity and seeming success of the GPEI, eradication targets in these countries have been pushed back or have yet to be realized. While the GPEI intended on eradicating Polio by 2000, most Polio endemic countries had only begun to implement their programs in the mid 1990s. The Democratic Republic of the Congo and Sierra Leone had only implemented their Polio eradication program in the beginning of 2000.¹ Some of these obstacles to implementation arise from the lack of medical infrastructure. Surveillance for Polio eradication is complicated by the fact that paralytic Poliomyelitis cannot be readily diagnosed on clinical grounds.⁸ Additionally, the majority infected virus shedding individuals do not show symptoms and contribute to 'silent' virus transmission. Monitoring of Polio cases occurs by tracking all cases of acute onset flaccid paralysis (AFP) in persons less than 15 years of age with a follow up of a virological examination of stool specimen. Even with this framework of global surveillance standards, wild

Polio Virus chains are missed in part because of subnational gaps in AFP surveillance quality. Surveillance gaps can greatly hinder program planning in endemic areas.⁸ However, what's of interest is that standard analyses of these failures externalize most of the blame to affected countries. Indeed, lack of resources and commitment by political and health authorities at the country level has resulted in delayed implementation. For example, Pakistan, with a population of 160 million, only spends 2% of the GDP on health. For every 10,000 people there are only 8 physicians, many of whom are clustered in urban areas. Yet, despite the knowledge of the poor health infrastructure of Pakistan, the early Polio eradication campaigns by GPEI consisted of only two mass immunization day campaigns and two door-to-door visits during a year span in the 1990's. The belief was that these efforts would be sufficient to place Pakistan in a full eradication time frame within a 2 year period, which never transpired. Thus, not all issues occur at the country level. GPEI is committed to strong immunization systems for delivery of routine childhood vaccines, yet in many areas vaccination rates remain inadequate.¹

How is it that the barriers to eradication are seemingly recognized by the GPEI and member organizations, yet the progress and programs implemented in Pakistan often fall short? One of the major contributors to the literature on GPEI's efforts in Pakistan [from an international health organization standpoint], Svea Closser, has identified a series of problems within these organizations and created a framework that reflects how the culture of an international organization, and not necessarily the culture of the community, contribute to barriers to health goals. Her work with staff and employees of the WHO revealed that the Polio eradication

initiative officials were well versed in the complexities and nuances of local community attitudes toward Polio immunization. Staff members understood the dynamics of the vaccination campaign in district health systems across Pakistan. Yet, despite the awareness of the complexities, the knowledge of these individuals never went past discussions and internal briefs. The nuanced knowledge of local context was lost when aggregating information. At the same time, only those strategies and tools deemed successful were highlighted and stressed to the public. This created a false sense of accomplishment while overlooking some fundamental barriers to eradication. For instance, Closser points out that Polio eradication officials minimized the difficulty of containing cross-border transmission, and instead exaggerated its effectiveness at an Afghanistan-Pakistan meeting. This cross-border transmission strategy was again emphasized at a 2007 WHO conference in Geneva, where it was reframed as an innovative tactic that had the potential to end transmission, failing to mention that the cross-border transmission strategy had been in existence since 1998. Again in a 2010 Montreal meeting, the very same cross-border strategy was coined as something that would “rewrite the Polio eradication playbook”. This trend has been apparent even in cases where barriers have to deal with the nature of the virus. For one, the problem includes choosing the appropriate immunization strain. WPV consists of three types, type 1, type 2, and type 3. Type 2 has been eradicated. But the OPV that was disseminated in 2005 was targeted only for type 1. This resulted in a reduction of type 1 circulating virus but a resurgence of type 3 viruses. The reduction in type 1 was emphasized in the headlines while the resurgence of type 3 was not discussed.¹²

Eradication programs are part of a larger landscape of Global Health Initiatives. GHIs focus on specific disease and selected interventions through joint decision-making among multiple partners from the public and the private sector. These initiatives have taken a dominant position within the global health policy network. GHIs execute large-scale, well-funded strategies, often receive the most resources for health by donors like the Bill & Melinda Gates Foundation. GHIs increase the resources available to global health but also reinforce a business approach to governance and circumscribed, technical solutions to health. As a result, programs within Global Alliance for Vaccines and Immunizations (GAVI) have received pressure to incorporate health system strengthening.

Overall though, Closser found that in Pakistan, at the regional level, successful districts were those that were well run, well resourced, and had skilled staff.⁸ Issues arose as a result of poor skills and a lack of authority in resource allocation and human resource management, limited advocacy and communication resources, a lack of skills and training among staff at all levels in the PEI/EPI in almost all aspects of the program, deficiency of public health professionals, poor health services structure, administrative issues, unreliable reporting and poor monitoring and supervisions systems, limited use of local data for interventions, and unclear roles and responsibilities after decentralization.

In contrast to these findings, Taylor using epidemiological evidence, desk-based review of literature, and field experience proposed that the eradication of Polio hinges on maximizing household OPV acceptance and delivery in endemic countries.¹³ “While vaccinator performance generally, and physical access related to

security, creates blockades in the vaccination supply-side, unwillingness to be vaccinated by small groups of households and communities constitutes the principle demand-side barrier.”¹³ He reflects that culture has been seen as the determining resistance to vaccination.¹³ Within geographic areas it appears that attitudes toward the Polio program “vary and instead public orientation appears to be shaped by a combination of religious-cultural and more localized socio-economic factors explicitly the aggressive nature of mass vaccination and the under development of other goods and resources.”¹³

A web of issues entangle and reduce the effectiveness of the GPEI, but since history so often repeats itself GPEI has yet again set a date for Polio eradication. In 2013 GPEI launched the eradication and “Endgame strategic plan” to achieve a Polio free world by 2018.² This plan intends to improve upon existing structures and eradicate Polio on multiple levels including halting transmission, expanding focus to improve childhood immunization, and protecting public health gains made to date. In order to succeed, UNICEF is collaborating with its partners and national Ministries of Health to raise community awareness. This multi stakeholder approach is designed to increase community and household awareness, mobilize the use of available immunization services, and respond quickly and effectively to communities’ immunization concerns and needs.

To ensure maximum community and caregiver participation, UNICEF is following the Communication for Development (C4D) strategy. C4D is novel and distinct in that it synthesizes and embraces a systematic, evidence-based strategic planning and implementation process to create positive and measurable change in

individual and community behaviors. C4D is premised on social and behavior change theories while also utilizing data and still maintaining participatory techniques. Various communication strategies are formulated to reflect observed social and cultural behaviors in the national and local context. Where C4D differs from other conventional communication methods is how the program provides a forum for community members to actively participate as well as express their individual voices. This type of engagement of the community consists of recognizing and inevitably bolstering the issues and ideas of caregivers, families, religious leaders and larger social networks. The C4D approach wishes to impact development beyond the singular Polio eradication initiative as it entwines other health threats into the structure. C4D stresses that the participation and ownership by the community with regards to the Polio initiative is key to ensuring complete vaccination for “every last child”. Yet, despite these explicit commitments, a thorough examination of UNICEF’s communication and information aggregation strategy can reveal significant obstacles in the way of these commitments. Thus, while Polio eradication in various regions, particularly in Pakistan, admittedly faces multiple barriers, the question is to what extent has UNICEF learned from prior structural, cultural, managerial and systemic problems.

One way to approach these questions is by examining whether the lessons of the past will be reflected in written communication produced by UNICEF for different stakeholders including internal communications, external partners, and staff and field worker trainees. The most important litmus test is whether these materials reflect a consistency of community messages and culture.

Methods

This thesis uses an exploratory approach to examine underlying themes in documents supporting UNICEF's Communication for Development strategy for the eradication of Polio in Pakistan. The thematic analysis utilized in this thesis is based on Grounded Theory. This framework is premised on reviewing the data until concepts or elements become apparent and are coded thematically. For this project, documents created by members of UNICEF and/or by groups related to the UNICEF Polio initiative were reviewed and thematically analyzed. The material examined consisted of 12 separate documents that were obtained from a UNICEF medical anthropologist working on various projects including the Pakistan Polio project. A connection with the medical anthropologist was established a year prior to this project. Once the documents were received they were carefully read and catalogued. Document type (powerpoint, pdf, excel, docx) and a brief descriptor on the document's focus, creator, and purpose were recorded.

A preliminary reading was done to become oriented with the documents. Afterwards reoccurring themes that were present in more than one document were noted. This initial thematic analysis sought to isolate reoccurring ideas in each of the documents that UNICEF and the other allied creators wished to highlight. The first thematic overview looked at the data at face value and took note of the obvious themes that were immediately recognizable by the audience. The themes identified included: importance of input from various stakeholders of the Pakistani community; the Polio epidemic at large and regionally; the organization and

structure of C4D; perceived strengths and weakness of the C4D approach; role of religion; misperception of vaccination; and, inaccessibility.

Once the explicit themes that could be easily extracted from the documents were isolated, an additional cross document comparison of the themes was conducted. This approach was utilized because while all the documents were linked to the Community 4 Development approach, each document approached the topic from a different vantage point. Documents were ordered and categorized on a spectrum according to technical voice (technical vocabulary and higher level of expertise required), perceived audience, perceived proximity to community voice, and usage of aesthetics and images. For instance the document “C4D Strategy 2014-2015.pptx” was somewhat technical, targeted to a larger UNICEF audience, highly aesthetic, and considerably technical compared to the other 11 documents. This system provided an orientation in which to analyze the way in which the themes were conveyed. This technique highlighted gaps in knowledge at each level of informational conveyance through an understanding of how themes were conveyed in each document.

In addition to a cross comparison of themes between the documents, these methods included situating the themes that UNICEF highlighted within a larger context of literature surrounding Polio efforts by UNICEF in Pakistan. This provided a third layer or informational realm of understanding of the UNICEF documents, adding to the cross comparison document analysis and what is explicitly stated in the documents. Situating the documents in the external realm identified new

themes, such as, minimization of security risk, dismissal of cultural gender norms, and reduction of cause for population movement.

Results

Analysis 1- Individual document review

The following documents were analyzed: a series of presentations on UNICEF Polio eradication strategies; summary of findings from a qualitative survey conducted in Pakistan; a programmatic narrative of C4D; a series of briefs; eradication strategy plans; two excel sheets of COMNet relating contact information with corresponding districts; a framework for UNICEF low season strategy; a presentation that visually lays out the global C4D strategy; a presentation of current program status and barrier to address in the global Polio realm; a presentation by McCann (an advertising firm) of a public health campaign overview strategy with applicability towards Polio including mass media images; a presentation that identifies all potential stakeholders and defines stakeholder roles and perceptions in a series of tables; and, a presentation incorporating strategies for media types for the polio campaign. These documents are meant for dissemination to a variety of audience types including; donors, small UNICEF staff meeting, multiple GPEI partner meetings. Most documents are mainly focused for Pakistan and the region, but four are globally oriented.

The following lists a sample of documents from the larger data set with their corresponding 'take away' themes. Each document was analyzed at first on its own accord. The themes were captured by the frequency of mention in the in the document as well as identification of context clues in which these ideas were stressed in the documents. UNICEF and collaborators through underlining, bolding,

repetition, unique font style and coloration, stressed the key themes in the documents. Themes were also stressed through accompanying visual imagery and graphic data displays.

C4D Support Priorities.pptx: Data Collection utilizing community strategies and technology, selection of frontline workers is gender specific, media campaigns

UNICEF_POLIO_STRATEGY_V08_GLB.pdf: Changing communication strategy to match complexities on the ground, acceptance of OPV but fear of stigma, inaccessibility, mobility, political unrest, culturally target campaigns, celebrate health workers, utilization of fear as a health campaign tactic, understand thoughts and actions of caregiver as it exist in larger community context, perception of vaccinators, increase caregiver Polio education

UNICEF Joint Plan Presentationsep2015-FINAL.pptx: mobility, refusals, mass media campaign, security, misinformation, incorporation of religious leaders, engagement of civil society, recruitment female workers, increased monitoring and tracking, increase Polio Education

Report-Rapid_Qualitative_Survey_Final.docx: community emphasis on sanitation, vaccination perceptions, perception about vaccination staff, inaccessibility, mobility, female recruitment, religion, absence of qualified staff, nutrition, unavailability of other medical services, elders more traditional ant-vaccine, participation by care givers in vaccination process

Comms-2014 Low Season Strategy.docx: inaccessibility, mobility, community trust, female recruitment, community engagement, expanding religious affiliations/support, monitoring and tracking, and sustained capacity

Analysis 2-

Cross-document comparison and the key themes

Once the documents were reviewed and the key themes that UNICEF highlighted were noted, a cross document analysis was undertaken. Common themes, such as 'female recruitment,' 'accessibility,' and 'OPV perceptions' were compared to one another while situated in their initial document context. Each document was comparatively ranked in accordance to how technical the document was, the audience the information was directed to, the type of document, perceived proximity to community viewpoint, and types of imagery utilized in the document presentation. Situating the themes in their initial context

and reviewing how the themes were expressed in accordance to the document ranking revealed interesting findings.

THEMES:

FEMALE RECRUITMENT AS POLIO WORKERS/SOCIAL MOBILIZERS

With regards to female recruitment of polio workers, documents that claimed to have gathered information directly from community stakeholders including the qualitative survey, were more prominent in their expression of why female polio workers faced difficult barriers to reaching household and convincing parents to vaccinate their children. Concern about continuing to focus on recruitment of women as social mobilizers in this instance was explained by what various stakeholders viewed as male sway, religious confinement, conflict with existing female roles, and safety. The most technical documents, which were also the most detached from the 'perceived proximity to community viewpoint', dealt with the issue of female recruitment but did not discuss the barriers, rather the need for female recruitment was stressed as something that just must happen, without any discussion about why female recruitment might be lagging. In these technical documents the female recruiter was placed as the only possibility of vaccinator by placing a female visual that fused customary clothing with 'UNICEF Vaccinator costume' as the center stage of the social mobilizer movement, despite the fact the female recruiters only present 20% of the vaccinator work force (figure 1).

RELIGIOUS INVOLVEMENT AS BARRIER TO ERADICATION STRATEGY

In a series of documents which represented and tried to capture community thoughts and actions, religion was viewed as something that had individual and family implications. Religious interpretation of vaccine as dangerous or forbidden by family members was highlighted as a main driver for why individuals and families were unwilling to vaccinate.

“Our men say vaccines are non religious. They are harmful and cause emotional disturbances in children. We believe what our men tell us. We know they are important but we are not allowed”. (Female group, Bannu FR, anti-vaccination)

In the more technical documents, such as the briefs, religion was seen purely as structural given for Pakistan. The emphasis was only on the leaders of the community, without incorporating the community’s embodied practice of religion as part of their daily lives. While the briefs only considered religion as a structure that could be manipulated through the simple affirmation of the religious leaders, the community-driven documents placed individuals and families as the primary agents in their religious interpretation, participation, and performance. The qualitative survey also incorporated the importance of these religious leaders, but presented them not as a singular-minded blockade but rather individuals acting in the interest of their religion and the community. Indeed, deeper consideration of the role of the religious leaders may highlight a more nuanced perspective on the vaccine. “There are some people who say that Polio drops contain pig fat and is haram, but I do not trust them. If something saves lives, then even if it is haram it becomes halaal.” (Religious leader, DI Khan)

INACCESSIBILITY AS AN ERADICATION STRATEGY BARRIER

UNICEF's continued framing of the term "inaccessibility" as a major barrier to eradication efforts was consistent throughout the documents. Inaccessibility on one hand simply means 'the inability for vaccinators to access children', however it was alluded to in the documents, in varying degrees, that inaccessibility was linked to many important but different barriers including security issues, mobility, and absence of children during house visit. The arrangement of the priority list of barriers as well as which barriers were stressed as part of inaccessibility altered by document type and level. At the qualitative survey level, security risk to the vaccinator was mentioned as part of the community feedback. The community valued that the vaccinators worked hard despite the risk to their safety. The appreciation for the vaccinators was a prominent theme embraced by the community despite a sense from community that vaccinators were poorly or not trained, often lacked knowledge, skill or "buy in" to the vaccination effort. Still these documents reflected the community sense of pride and admiration towards the vaccinators because they were seen as diligent workers and that were brave – again implying security and safety at the heart of these concerns.

Inaccessibility defined in more executive level documents discussed security broadly, but not as specifically focused on social mobilizers. Instead inaccessibility in these documents devalued the social mobilizers and their entanglement with the community and saw security as a factor that shifted the population dynamics by creating highly mobile populations. Security issues were seen as a pervasive

and frequent issue in the brief, while security at the community level was something that was more sporadic.

MISCONCEPTIONS:

“Misconceptions” related broadly to eradication campaigns were highlighted as a main barrier to OPV in all documents. However, what the misconceptions were and to what detail were these misconceptions conceptualized and understood varied by document type. Most documents that were briefs, or overview presentations merely listed misconceptions as something to overcome without any more insight or specificity. The way in which the misconceptions were discussed, if at all, in these documents was linked to religious misconceptions or notions that the vaccine was unnecessary or ineffective. It was only in reviewing the qualitative community based documents that a listing was created which specified the nature of these misconceptions. . These documents detailed notions that OPV was linked to early maturation in girls, decreased sex drive for boys while increasing sex drive for women, and infertility for boys. It was alarming to see how OPV was clearly linked to sexuality and fertility, and yet this essential community concern was diluted in importance. This very strong theme of how OPV was linked to controlling the essence of the defined female and male roles was left out of all other documentation.

“We have heard and noticed that if we take vaccines puberty onsets earlier. We have also heard that it reduces sex urge among males and increases the same among females. This causes more female children and less males. We are unable to produce as many children as our elders”. (Male group, Khyber Agency, Anti-Vaccination)

Analysis 3-

UNICEF's representation of C4D compared to external documents

When the themes reflecting the barriers, existing structures, and community circumstances as understood by UNICEF's GPEI C4D plan were compared to external documents that had alternative perspectives on the situation, certain knowledge gaps became apparent. External documents included a selection of materials obtained from a course taught on Behavioral and Communication Strategies for Remerging Diseases: Focus on Polio and Ebola through NYU's Global Institute of Public Health which included experts from academia and global agencies (UNICEF Medical Anthropologist was part of course faculty) Some of these materials were the stories of UNICEF employees, and thus reflected another aspect of UNICEF culture that would not be obtained from published materials or internally circulated documents. The course included staff members from UNICEF along with other institutions and organizations. In particular a member that was part of the security detail of UNICEF described the situation on the ground in Pakistan. This was the first time that legitimate security issues came up and were heavily stressed. This individuals' summary "on the ground" reflected in some way the security issues that arose in the media following the deaths of numerous vaccinators. Nowhere in the 12 documents was there discussion of the killings of the Polio vaccinators. The issue of inaccessibility both in terms of realm of population mobility and security to vaccinators were the most elaborated in studies produced outside the context of UNICEF GPEI C4D approach.

Framing the theme of gender within a larger cultural context utilizing other materials, highlights far more multifaceted situation than what is expressed by the

UNICEF documents. The push to recruit women, even through the lens of the qualitative study, underestimated the barriers to recruiting female mobilizers and instead greatly emphasized the progress and potential. The potentiality of female social mobilizers was key to the C4D approach, campaign and publicity. This emphasis on women may have been stressed because UNICEFs could utilize the employment of women workers in a realm where this is rare/exceptional as a means to demonstrate progress and gender equity in Pakistan despite the influx of Polio cases. Thus, there is a seeming shift towards gender equity goals when health goals are not met. These documents do not reflect that, in certain regions, women are not at all permitted to work, nor do these documents explicitly state that in many cases women are essential to the OPV campaign because they are needed to talk to mothers. In other words, the documents demonstrate a troublesome lack of context, instead applying a blanket approach to the issue. Instead, efforts could focus on isolating those localities where women are *indeed* best-positioned to disseminate vaccines, and distinguish these from regions where, due to local factors, women will not actually succeed in such dissemination.

Further, there is no sense in the documents of the role of Polio eradication campaigns within the larger health infrastructure of these communities. These documents reflect UNICEFs imposed culture that Polio is the highest priority. Indeed even the qualitative analysis does not reflect the any option for communities to disagree with Polio eradication as a major health priority or dissent to involvement in campaigns, which is one of the greatest critiques of GAVI based programs. In other words, despite C4D's commitment to involving the community it

serves, there has been a failure in incorporating the community into the agenda-setting process itself.

Finally, there is also an overarching theme reflecting the nature of the term “eradication”. This term and its associated expectation of an acute finality to polio under the condition of successful campaigns may result in unintended burnout and fatigue of community advocates. Failure to demonstrate eradication after a campaign may frustrate communities and make individuals within communities more vulnerable to peer misconceptions.

Discussion

The thematic analysis conducted over varied document types and document levels demonstrated a loss of nuanced knowledge as the documents progressed to a more executive level. This in part can be explained by the fact that the intention of the documents increased in scope. The qualitative review of documents that represented the source of community knowledge focused simply on that, the community, and thus was the closest to the actual needs of the community. They did not incorporate a larger programmatic perspective. Even if one is to consider the breadth of material that needed to be covered, as well as the scope and audience addressed, the lack of nuanced knowledge conveyed in the executive or technical brief seemingly delegitimized the focused efforts on community engagement and community voice. Instead, despite the knowledge that there is substantial intercultural variation in behaviors, knowledge and practices,¹⁴ UNICEF has diminished its initially-diverse knowledge-base to make it fit efficiently within the structure of a brief. This exhibits a lowest-common-denominator approach whereby only those solutions are sought and promoted that can benefit the most amount of people in the shortest time. Unfortunately, the complexities surrounding Polio eradication do not permit such approaches, as historical failures have consistently demonstrated.

The document analysis also demonstrated considerable knowledge gaps through generalization of barriers, loss of specificity and nuance of community level voice, and placed unbalanced emphasis on progress of the campaigns. Documents focused on eradication programmatic review lightly addressed issues or barriers

that arose from campaigns. Indeed, the lack of specificity of the barriers encountered because of the flaws in the GPEI were seemingly swept underneath the rug and do not appear to have been articulated or evaluated. One of the clearest examples of this was the minimization of a country environment of insecurity that resulted in the loss of 80 vaccinators. Security as a general theme was coded under inaccessibility and placed in vague terms, and the deaths were never once mentioned.

This main overarching focus highlighting “progress” is in keeping with Closser’s observations and findings within the WHO, which resembles UNICEF in culture and structure. She found that the organizational culture surrounding Polio eradication within the World Health Organization was one of optimism. This framing of documents in a progressive and positive light ensured the continuation of the project by convincing donors and officials that eradication was immanent. While it was successful in maintaining resources, the lack of pragmatism obstructed objective and critical analysis that could push initiatives forward. Eradication programs are seen as the ultimate contribution for sustainable health development, though they have a high risk of failure and a high degree of difficulty. “Hirschman has a concept described as the ‘hiding hand’ in development projects. The ‘hiding hand’ means that potential problems were often underestimated in the planning stages, but when problems arose creative solutions were found. James Ferguson argues that throughout project planning, development officials consistently frame the problems that are targeted as ones in which a solution exists. By focusing on the idea that a solution exists, this creates projects that are not suited to meet stated

goals. Quarles van Ufford argues that development projects rely on maintaining [and] creating sufficient ignorance about what was happening locally.”¹² There has been persistent long-term communication gap between anthropologists and health care policy makers and practitioners. In general there has been frustration that health system policy makers and practitioners pay little attention to understanding the cultural beliefs and knowledge systems of the people they are meant to serve.¹⁴ One of the earliest attempts at addressing this issue was the Alma-Ata Declaration of 1978 that called for greater recognition of the importance of ‘community participation’ and the role of indigenous healers in the organization of health care programs.¹⁴ Yet, the same problem persists, almost untouched by “innovation.”

Optimism is not just about procurement of donor funds. The culture of optimism in UNICEF and WHO can be documented across the spectrum of person-to-person interactions through conversation and tone. These agencies are focused on concrete benchmarks and indicators assigned to particular dates. Each success, although there are actually few complete success stories, serve as another notch in the belt for the global eradication agenda. As for other ongoing initiatives a mind frame of eventual completion and success must be maintained because of the way these eradication programs are set up. Eradication does not allow for flexibility in the occasional outbreak of cases, rather it prides itself on the realm of zero and done. “Even at the highest levels of leadership there was a belief that eradication of Polio was right around the corner.”⁸

This type of mentality feeds into population fatigue. The focus on the short term goal of reaching case zero and pushing forth only one health agenda through a

singular stressed method of immunization instead of dealing with structural issues exhausts a population and increases likelihood of misconception when the 'magic bullet' appears ineffective. Of all the vaccines administered, OPV is by far the most commonly administered to the point where certain children will receive the vaccine multiple times despite other children lacking access. As demonstrated by the documents, misconceptions are certainly prolific as vaccinators rarely receive proper training and communities are not even sure if the person vaccinating their children believes in the vaccine. In the qualitative survey, the link between OPV and sexuality/fertility was mentioned by numerous community members that were hesitant about the vaccine. UNICEF marked these as misconceptions, but upon further analysis this sort of understanding and linkage of a vaccine points to a broader issues of the fear of external international control of a population. The population is perhaps wrong in that the vaccine does not cause sterility, but this underlying theme reflect a a sense of disempowerment of agency and control of body. Related to the framework of unyielding determination to eradicate lies the UNICEF decisions to focus on heavy recruitment of females as social mobilizers. With heavy pressure to make sure every child is immunized, UNICEF makes this decision that the female would be able to convince other females to let their children to be immunized and that females may not reap repercussion or religious pressure. However, thematic analysis points to a voice that suggests the opposite. The focus on empowering themes, even some visuals that highlight females despite them comprising only 20% of the force, speaks to underlying mission of UNICEF as an organization. It's mission statement is focused on equity and empowering

women as providers for their children. This kind of messaging is important to helping women become autonomous, but it may be a slippery slope when it becomes a replacement for actually eradicating disease. The focus on women as social mobilizers may really reflect the culture of UNICEF overwhelming a culture of common sense in this very sensitive region. If the focus was not about Polio eradication, but about health strengthening, this focus may have been better served by concentrating on women as social mobilizers.

Conclusion

Though this study was very particular in its topical focus as a mean of assessing the culture of UNICEF, C4D highlights some of the best components of the UNICEF structure in overcoming a plethora of barriers in highly complex but widely publicized issues. The GPEI program in Pakistan has received tremendous attention within the past couple of years, placing an even greater spotlight on UNICEF's need to demonstrate progress and reduce the history of setbacks to a donor audience and to the public. A thematic analysis of a diverse set of UNICEF documents related to Polio eradication demonstrates an overarching lack of rigorous evaluation of its programmatic flaws, and the externalization of internal misconceptions onto the community. UNICEF deals with its significant security issues related to Polio campaigns with the term "inaccessibility". UNICEF appears never to ask the community what it actually wanted with regard to Polio eradication and additionally appears to marginalize or obscure community voice in the role of community health overall. Within the realm of community engagement, open questions that allows for other public health concerns to be raised should be considered essential. In fact, in non-UNICEF funded Polio literature it appears that one of the greatest grievances issued by the community was why so much money and resources were being spent on a disease that was not at the top of the priority. A program that only has the capacity to target a particular problem should be met with uncertainty and disapproval. Within the recent years GAVI has tried to increase and strengthen health systems by using immunization programs as a starting point. Still without a proper infrastructure what so ever in a war torn area with

tremendous political unrest, perhaps UNICEF's thinking is that the only way to improve and maintain funding for an area is to demonstrate progress by decreasing case numbers and ticking off the number of immunized children in a particular campaign. The goals are clear and straightforward, but is the culture of UNICEF as demonstrated in its portfolio of strategic programming on Polio eradication really the optimal approach or a trajectory towards failure in the Global Health arena? Theoretically, C4D moves in the right direction by emphasizing the necessity of engaging the voice of the community. What needs to be guaranteed is that the voice of the community weaves its way through all levels, and does not just sit still wrapped up on one survey report and clouded by a culture of obstructive optimism, and an unyielding determination to eradicate. Without concrete reforms that can eliminate the informational loss due to aggregation, C4D's commitments remain just that – commitments. Past examples have shown that good intentions only are not enough for public health purposes.

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Tables
Table 1 of dataset

Document	Type
UNICEF_POLIO_STRATEGY_V08_GLB.pdf	Produced by advertising agency, discusses how to shape and pick appropriate public health messages surrounding Polio, contains graphics and previous health cases
unicef creative concepts 022515 opt.pdf	Produced by an advertising agency, images of how to advocate and publicize Polio vaccine utilizing religious/cultural references, branding strategy
MGH_UNICEF_MESSAGING_GRID.pdf	Working draft of tables that go through each member and their role in Polio, broken into an overview, desired role, potential concerns, messaging focus, and message
C4D Strategy 2014-2015.pptx	Visual display of success of C4D approach in Pakistan, FATA, Borno, and Nigeria, discusses other partners such as CDC and WHO, lays out areas that need to be improved
C4D Global Support Priorities.pptx	powerpoint presentation that graphically depicts Polio data uptake and data submission through technology and individuals, very technical(Selection, training, tools...)
Comms-2014 LOW SEASON STRATEGY.docx	provides overview of COMNet program and how it was structured in FATA and KP areas, provides steps to improve upon existing structure for the low season
Copy of High risk UCs list with COMNet presence.xlsx	excel list of province, district, district priority, Tehsil, UC, Target Population, and UCCSO
High risk UCCSO Contact Info.xlsx	contact information that corresponds to the UCs list with COMNet presence
Pakistan C4D Narrative 2014 V4.docx	Provides the intent, focus and structure of COMNet, highlights the progress of COMNet
Rapid Qualitative Survey Final.pptx	PowerPoint that synthesizes the findings of a qualitative study that looked at perceptions from various lenses concerning OPV
Report-Rapid_Qualitative_Survey_Final.docx	document that details the health and hygiene practices/maintenance, attitude of the community toward vaccines, and general Polio perceptions of FATA and KPK
UNICEF Joint Plan Presentationsep2015-FINAL.pptx	powerpoint lays out plan for low transmission season targeted towards high risks populations that are inaccessible, such as security compromised areas

Figures
Figure 1

