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REACH

RESOURCES
FOR CHILD
HEALTH

TRIP REPORT
COMMUNICATIONS ASSISTANCE:
KENYA

Republic of Kenya

25 April - 8 May 1992

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ACRONYMS

CHW	Community Health Worker
DHMT	District Health Management Team
DPHN	District Public Health Nurse
FGD	Focus group discussion
FIC	Fully immunized child(ren)
HW	Health worker
KAP	Knowledge, attitudes, and practices
KEPI	Kenya Expanded Program on Immunization
MOH	Ministry of Health
MU	Management Unit (of KEPI)
NGO	Nongovernmental organization
PHT	Public Health Technician
PLOP	Plan of Operations
SDP	Service delivery point

I. EXECUTIVE SUMMARY

REACH/Washington Communications Advisor Mike Favin visited Kenya on April 25 through May 8, 1992. The purpose of his visit was to work with the REACH/Kenya Communications Advisor Grace Kagondi to draft a social mobilization strategy and workplan for the years 1993-97 and to provide technical assistance on communications aspects of EPI at a strategy formulation workshop for South Nyanza district.

The first week of the visit was spent in Nairobi, reviewing existing documents and research findings from the Kenya Expanded Programme on Immunization (KEPI) for their relevance to EPI communications and social mobilization. These materials, as well as discussions with staff from KEPI, USAID, UNICEF, and DANIDA, helped identify barriers to high immunization coverage, formed the basis of a five-year social mobilization strategy and indicated gaps where further research into knowledge, attitudes, and practices is needed. A draft of this strategy was left in country and is included in this report (Annex A).

During the second week, the consultant travelled to Migori, South Nyanza district, to participate in a UNICEF-sponsored workshop on EPI. The objective of the workshop was to translate findings from qualitative and quantitative research into a plan of action for the district.

II. PURPOSE OF VISIT

From April 25 to May 8, 1992, REACH/Washington Communications Advisor Michael Favin visited Kenya to work with REACH/Kenya Communications Advisor Grace Kagondi to:

- Draft a national social mobilization strategy and work plan for the period 1993-1997, to be incorporated into the KEPI Plan of Operations (PLOP), which is scheduled to be written during June-August 1992;
- Facilitate and provide technical assistance to a strategy formulation workshop in South Nyanza district; more specifically, assist workshop participants in using findings from recent quantitative and qualitative studies to prioritize problems impeding higher immunization coverage and to prepare plans for their solution.

USAID/Nairobi also requested that the REACH team draft a set of knowledge-attitudes-practices (KAP) questions that could be added to the district-by-district coverage surveys that are planned to be conducted later this year.

III. ACTIVITIES

From April 27 to May 1, 1992, the REACH team worked at KEPI headquarters in Nairobi to draft a social mobilization strategy and the basic steps in social mobilization/communications for 1993-1997. To supplement discussions, a number of documents that indicated factors impeding higher immunization coverage were consulted (see Annex F). During this week, the REACH team also worked on the agenda for the South Nyanza workshop and drafted KAP questions to be added to the upcoming coverage survey.

On Sunday, May 3, Mike Favin rode (with other participants) to Migori, South Nyanza in a vehicle provided by UNICEF. He participated actively in the workshop from Monday to Thursday, flying back to Nairobi on Thursday night. On Friday he debriefed with USAID and worked on the draft strategy and KAP questions, leaving drafts with KEPI and USAID.

IV. FINDINGS

A. Social Mobilization Strategy

To prepare the draft social mobilization strategy, the REACH communications advisors first reviewed what had been accomplished and learned from previous studies.

Immunization coverage in Kenya has increased steadily over the past decade to a nationwide level of approximately 60% fully immunized children (FIC) by one year of age, with substantial regional variation. Initial access (95% nationwide) is not a problem but completion is, with a large dropout, particularly between DPT3/polio3 and measles. 90% or more of immunizations in Kenya are given at fixed facilities, a major factor favoring sustainability. Immunizations are supposed to be offered daily at some 1300 service delivery points (SDPs). The main service delivery problems are related to management and quality of services. Maintenance of demand (i.e., completion of the vaccination schedule) is another area requiring attention.

KEPI has a full-time health educator, as well as a full-time REACH communications/social mobilization advisor. Existing materials include a logo, health facility posters, and a booklet, "Communication Reminders for Health Workers." Radio messages are broadcast in national and local languages. School children and boy scouts and girl guides have been used in social mobilization. All districts have social mobilization plans which they have implemented to various degrees. Materials have not necessarily been designed based on formative research or pretested with target audiences, but these steps have begun and will continue.

On the basis of its analysis, the REACH team proposed three broad objectives for communication/social mobilization, as well as indicators and the major steps recommended to achieve the objectives. These are presented in Annex A. The main strategic objectives are:

- to increase the percentage of children fully and correctly immunized by age one,
- to sustain increased coverage levels over time, and
- to support disease control activities.

The REACH team examined a number of existing qualitative and quantitative studies on reasons for acceptance or refusal of childhood immunization. On the basis of these studies (summarized in Annex A), the major deterrents to higher coverage appeared to be the following:

- Health workers refuse to immunize ill children, and parents refuse to bring ill children for immunization.
- Mothers perceive that health workers treat them rudely.
- Mothers either don't know or forget to bring children back to complete the series.
- Immunization is often unavailable because of health system organizational problems (lack of vaccine or vaccinators, lack of cards, hours more limited than specified by MOH policy).
- Current messages are not effective enough in motivating mothers.

It is noteworthy that neither fear of side effects nor travel cost/time/distance appear to be general, nationwide problems, although they may be problems of local concern.

The proposed communications/social mobilization activities directly address the major barriers to higher coverage through additional qualitative research (see Annex B); effective communication of information and motivational messages to health workers, mothers, and persons who influence their immunization-related behavior; and improvements in training, supervision, and logistics.

The communications strategy presented in Annex A attempts to support the priority of the KEPI Plan of Operations (PLOP) of fostering decentralization and district-level responsibility. Individual districts are exhorted to review communications and social mobilization activities already conducted and to devise or revise their own communication activities through barazas (community assemblies called by chiefs), Community Health Worker (CHW) training, etc.; to improve inservice training and supervision; to devise local ways of recognizing fully immunized children (e.g., stickers, bracelets); to implement local strategies to remind/motivate people to return for follow-up doses, including channeling (following up defaulters); to adapt nationwide materials (posters, job aids, etc.), making them locally appropriate.

It is obvious that communications/social mobilization activities cannot be divorced from many other activities that will be included in the PLOP. The REACH team therefore decided not to go into too much detail at this time on the steps, timing, resources, etc. for communications but rather to complete these details in conjunction with completion of the PLOP in a few months.

B. Strategy Formulation Workshop

With funding from UNICEF and technical input from REACH/Kenya Communications Advisor, quantitative and qualitative studies were recently conducted in South Nyanza District in the southwestern corner of the country. The fully immunized rate of 38% in 1987 was the lowest of any district in the country.

Approximately 55 people attended the workshop, mostly from the district (including local MOH staff, NGO staff, private practitioners, representatives from the Ministry of Education), as well as a dozen or so people from KEPI headquarters, UNICEF, REACH, DANIDA, etc.

South Nyanza is the site of a UNICEF-funded child survival initiative that incorporates CHW training, community water projects, EPI, ORT, community pharmacies, and community-based distribution of contraceptives. An issue that arose early in during the workshop was how to work with existing district plans for EPI and for the UNICEF child survival project. It was decided to set aside the existing plans initially, in order to devise an appropriate strategy based on the fresh research findings, and then to modify existing plans to the extent necessary.

Research Findings

In 1992, UNICEF conducted four coverage surveys in South Nyanza that found the following coverage levels among children 12-23 months old:

BCG	92.0%	OPV1	87.8%
DPT1	88.0%	OPV2	77.7%
DPT2	79.5%	OPV3	69.3%
DPT3	70.0%	Measles	59.7%
OPV0	76.4%	Fully immunized	56.0%

1.2d The KEPI MU and the training officer will develop new support materials (e.g., an official statement from the KEPI Manager) and send them to districts in sufficient numbers for all SDPs.

1.2e The training officer will monitor training to assure that improvements have been incorporated.

Activity 1.3: The KEPI MU will use posters for SDPs and radio messages to support HWs' actions regarding contraindications. Districts should be encouraged to plan and implement complementary activities.

1.3a The KEPI MU will design posters and radio spots and plans to use them (distribution to government and NGO facilities, broadcast schedules).

1.3b The KEPI MU will pretest and revise materials as necessary.

1.3c Communications plans will be implemented and monitored.

Activity 1.4: The KEPI MU will suggest that provinces and districts make an assessment of compliance with contraindication policy a routine part of supervision. This should be done in meetings and in official written communications.

Activity 1.5: Implement communications aimed at the public that address contraindications.

1.5a As warranted by research findings, the KEPI MU will design messages and materials to address mothers' (and fathers') attitudes in appropriate media (radio, counseling, opinion leaders, etc.).

1.5b Provinces and districts will be encouraged to use and/or adapt these messages and materials.

Activity 1.6: The KEPI MU will monitor trends through coverage surveys and small SDP observation studies and will encourage districts to do the same.

Activity 1.7: The KEPI MU will enlist the support of professional bodies (e.g., association of pediatricians or similar groups) to overcome false contraindications. This will be accomplished through distribution of information to such groups and/or presentations at meetings.

Activity 2: Devise and implement a strategy to improve the manner and content of interactions between HWs and mothers.

Activity 2.1: The KEPI MU will organize brief observational studies in several districts to verify the problem and encourage districts to do their own observations. This research will be combined with research on contraindications. See Annex B.

Activity 2.2: The KEPI MU will incorporate findings into pre- and inservice training and routine supervision and encourage provinces and districts to do the same.

Activity 2.3: Supervision guidelines will be modified, as necessary.

Activity 2.4: The KEPI MU will recommend that supervisors routinely observe HW/client interaction and give feedback and suggestions.

1. Problems Within the Community

PROBLEM	MAGNI- TUDE	IMPACT ON COVERAGE	FEASI- BILITY	IMPACT ON OTHER PHC SERVICES	TOTAL
Lack of essential information [This is mainly a problem of lack of counseling by health workers.]	5	5	4	5	19
Insufficient community participation/involvement [The study showed that many community leaders knew little or nothing about EPI.]	5	5	4	5	19
Samwoyo [This concept of laziness/no particular reason seems to blame the mothers. One astute participant made a cartoon showing that while the mother said that the reason her son was not immunized was "samwoyo," in fact she didn't want to go because her son's diaper was dirty; his hair was changing color (from malnutrition), so she was afraid the nurse would be mad at her; she was afraid the nurse would tell her she had too many children and needed to plan her family; the child missed the scheduled date, so the health worker would be upset; and the health worker was "kali" (mean or rude).]	5	5	3	5	18
Child sick [Despite a clear KEPI policy on this, this is a widespread fear among both health workers and mothers.]	5	4	3	4	16
Lack of confidence in measles vaccine [Mothers reported both that many children had measles before they were due for their immunization and also that many children had measles even after receiving the shot.]	3	5	3	5	16
Long waiting time [This varies greatly by SDP but the head of the district hospital said that it was not unusual for mothers and children to spend 8 hours or more!]	4	4	2	4	14
Distance to SDP [This appears to be a problem in certain specific communities.]	4	3	2	4	13
Other commitments [The main ones mentioned were planting and harvesting and attending funerals.]	3	3	1	3	11
Inconvenient hours [Most mothers appeared to have more time in the afternoons but reported that many SDPs refused to immunize then.]	3	3	4	1	11
Fear of side effects	1	2	4	3	10
Card retention [Card retention was 83.3% according to the coverage surveys.]	1	1	3	4	9

PROBLEM	MAGNI- TUDE	IMPACT ON COVERAGE	FEASI- BILITY	IMPACT ON OTHER PHC SERVICES	TOTAL
Cultural beliefs	2	1	1	4	8
Too many young children	2	2	1	3	8
Economic constraints	2	2	1	2	7
Mothers' ill health	1	1	2	2	6
Negative influence of other family members [Mainly fathers -- both mothers and fathers agreed that it was totally inappropriate for fathers to bring babies for immunization. As one mother said, they don't have breasts to nurse babies and they don't know how to change diapers.]	1	1	1	2	5
Fear of contracting diseases at SDP [In many facilities sick and well children are crowded in together for long periods.]	1	1	1	1	4

2. Problems Caused by Health Workers (HWs)

PROBLEM	MAGNI- TUDE	IMPACT ON COVERAGE	FEASI- BILITY	IMPACT ON OTHER PHC SERVICES	TOTAL
Missed opportunities [This overlaps with several of the other reasons mentioned below.]	5	5	4	5	19
Disrespectful/ discourteous HWs [Mothers voiced numerous complaints that HWs embarrassed them in front of other mothers, yelled at them, etc.]	5	5	3	5	18
Laxity of HWs	5	4	3	5	17
Failure to provide key information	4	5	3	4	16
Inadequate record keeping and utilization	4	3	4	4	15
Inadequate knowledge and skills [This refers to basic skills as well as knowledge of policies/ procedures.]	3	5	4	2	14
Unofficial immunizers without training [CHWs apparently give immunizations in some facilities. Nurses are reportedly happy to have assistance and CHWs pleased to have a more "medical" function. There was much discussion on whether this was a problem or was beneficial.]	2	1	1	1	5

3. District Health Management Team Problems

PROBLEM	MAGNI- TUDE	IMPACT ON COVERAGE	FEASI- BILITY	IMPACT ON OTHER PHC SERVICES	TOTAL
Ineffective supervision	5	5	3	5	18
Ineffective planning and management	4	5	4	5	18
Irregular delivery of supplies	4	5	3	4	16
Lack or inaccessibility of funds [EPI funds are diverted to other programs. The DPHN, in charge of EPI, cannot authorize expenditures.]	5	5	2	4	16
Failure to communicate new information to field staff [There appears to be a reluctance to give or receive policy or programmatic information at all levels. Unofficial communication and rumors are common but are not acted upon.]	4	3	3	4	14
Inadequate documentation and utilization of records	3	5	3	3	14
Unclear policy on self-reliance and sustainability [This is essentially a restatement of the lack of community participation.]	5	3	2	3	13
Failure to integrate PHTs (public health technicians) in EPI [PHTs are trained in EPI and other areas but are not active in EPI; their supervisor seemed skeptical that they had time to become more active.]	3	4	2	1	10

4. Problems Involving KEPI and Donors

PROBLEM	MAGNI- TUDE	IMPACT ON COVERAGE	FEASI- BILITY	IMPACT ON OTHER PHC SERVICES	TOTAL
Failure of agencies to plan with DHMT as a team	4	4	5	4	17
Inadequate manpower (KEPI)	4	4	1	4	13
Inadequate health facilities (KEPI)	3	4	3	3	13
Ineffective communication of new information (KEPI)	4	3	4	2	13
Procurement delays (KEPI and donors)	2	2/4 NGOs	2	3	11/13

Comments

A great deal was learned during the workshop both about the functioning of KEPI in one district and about some apparently systemic problems of funding, management, and use of information at all levels of KEPI. The reasons for non-immunization were primarily the lack of more attractive, friendly, and convenient services, not any major problems of access, cultural beliefs, etc.

The workshop was well on its way to using the study findings as a basis for understanding the factors impeding higher coverage and for devising a strategy and workplan to address these barriers, but deliberations progressed quite slowly, probably for several reasons:

- There were many participants (55-60) and all were encouraged to participate actively.
- The levels of education and sophistication among participants were highly varied; explanations for various exercises had to be given very slowly and carefully, and repeated to assure that everyone understood the exercise.
- On Wednesday, problems identified were prioritized, but on Thursday, the subgroups were asked to analyze all of the problems, not just those considered to be the most important.
- Some problems and issues were included that were really beyond the ability of one single district to affect, e.g., national problems of resources, management, communication, etc.

Since the consultant could not stay until the end of the workshop (because of the need to debrief in Nairobi before departing from Kenya), it is difficult to judge how successful it was in reaching its objectives. It did appear that the studies discussed at the workshop were generally well done and

that they confirmed or refined previous knowledge of barriers to immunization. It is also clear that the workshop was very participatory, a factor favoring the South Nyanza participants' willingness to implement the final plans.

C. KAP Questions

The KAP questions proposed to be added to district-level coverage surveys are found in Annex C. KEPI, USAID, UNICEF, DANIDA, and other appropriate parties should be given an opportunity to comment and make suggestions, and the questions should be pretested before use.

V. CONCLUSIONS AND FOLLOW-UP ACTIONS

A. Social Mobilization Strategy

1. The Social mobilization strategy and workplan drafted during this visit should be shared with KEPI, USAID, DANIDA, and UNICEF and comments solicited. It should not be completed in detail until June-August, so that it is totally consistent with and supportive of the overall PLOP.
2. USAID intends to request a follow-up visit of the REACH/Washington Communications Advisor to work with the PLOP team directly. This could occur if the funding, logistics, etc. can be worked out. If the follow-up visit is not possible, the REACH/Washington Advisor should support the input of the REACH/Kenya Advisor through faxes, telephone calls, and correspondence.

B. South Nyanza Strategy

1. It is critical that current momentum not be lost. It is hoped that at the conclusion of the workshop the respective responsibilities of all interested parties (KEPI donor/technical agencies, DHMT, health workers, NGOs, representatives from other sectors, etc.) were laid out very clearly. With so many parties involved, there is a danger that once participants leave the workshop and return to their daily problems and demands, much hard work and many good plans might not be brought to fruition.
2. The REACH/Kenya Advisor should play an active role in advising the DHMT on communications/social mobilization activities.

C. KAP Questions

As noted above, interested parties should be given the opportunity to comment on the proposed questions (found in Annex C), and then the revised questions should be pretested.

ANNEX A

EPI COMMUNICATIONS STRATEGY, 1993-1997 (April 1992 draft)

Situational Analysis

Immunization coverage in Kenya has increased steadily over the past decade to approximately 60% FIC, with substantial regional variation. Initial access (95% nationwide) is not a problem but completion is, with a large dropout, particularly between DPT/polio3 and measles. 90% or more of immunizations in Kenya are given at fixed facilities, a major factor favoring sustainability. Immunizations are supposed to be offered daily at some 1300 service delivery points (SDPs). The main service delivery problems are related to management and quality of services. Demand (i.e., completion) is another area of need.

KEPI has a full-time health educator, as well as a full-time REACH communications and social mobilization advisor. Existing materials include a logo, health facility posters, and a booklet, "Communication Reminders for Health Workers." Radio messages are broadcast in national and local languages. School children and boy scouts and girl guides have been used in social mobilization. All districts have social mobilization plans which they have implemented to various degrees. Materials have not necessarily been designed based on formative research or pretested with target audiences but these steps have begun and will continue.

Communication activities should support other KEPI activities and objectives, and communications research should be the basis both for improved demand creation strategies and for improvements in service acceptability. Communication activities planned for the next five years should support all major KEPI objectives, including important process objectives such as increased district-level responsibilities, increased integration of EPI with other PHC programs, improved coordination with NGOs, and improved management and quality of services.

Major Communications Objectives and Activities

Objective 1: INCREASE PER CENT OF CHILDREN FULLY AND CORRECTLY IMMUNIZED BY AGE ONE.

Indicators: (1) increased coverage and decreased dropout rates, measured by periodic coverage surveys; (2) reduced missed opportunities to immunize (MOI), measured during routine supervision visits and MOI studies (exit interviews); (3) improvements in knowledge and attitude responses to questions appended to standard coverage surveys.

The essential approach to achieving this objective is the following: on the basis of quantitative and qualitative formative research, national and district-level strategies will be formulated and implemented aimed at promoting and facilitating desirable behaviors, primarily on the part of mothers and health workers. Communications/demand creation activities that address the specific knowledge gaps and negative attitudes that cause less-than-optimal coverage will be complemented by other activities that improve the acceptability of immunization to Kenyans.

A great deal is already known about the barriers to higher coverage, although additional qualitative and district-specific information is still needed. Below is a list of the major barriers, along with some of the evidence supporting the need for special attention to them:

1. HWs refuse to immunize ill children and parents refuse to bring ill children for immunization.

- July 1997 Nandi District survey: #1 reason for non-immunization was "child sick on immunization day" (19% of total reasons).
- 1987 national coverage survey: reasons #1 and #3 were "sent home because child sick" (21%) and "didn't go because child sick" (13%).
- 1989 coverage survey of Elgeyo Marakwet District: same reasons were #1 and #3 (22.1% and 12.2%).
- 1990 missed opportunity (MOI) survey in Marsabit District: of 7 MOIs in 26 children, 5 were for sick children with no card and 2 for sick children with card.
- 1988 Nairobi urban study: 10.3% of HWs said a slightly ill child should not be immunized, 54.5% said a child with fever should not be immunized, and 39.7% said a child with diarrhea should not be immunized.
- 1990 nationwide coverage surveys: by far most common reason was "child ill not brought," followed by "family problem, including mother sick" and "ill child brought but not immunized."
- 1992 Measles Initiative (MI) research in Kisumu (urban and rural) and Siaya: ill child accounted for 34.7%, 28.4%, and 41%, respectively, of reasons cited for non-immunization in the 3 surveys; only 28%, 23.9%, and 34%, respectively, of mothers said it was okay to immunize a child with fever or diarrhea.
- 1992 S. Nyanza coverage survey: 20.6% of reasons given for partial non/partial immunization. The qualitative study confirmed this as a very significant problem.

Because this appears to be a common problem throughout Kenya, national - as well as district - or community-level initiatives are warranted.

2. Mothers perceive that health workers treat them rudely.

- Mothers voiced many complaints in Siaya child-to-child FGDs.
- MI research: Only a few responses coded as HWs rude or unpleasant but this may be because surveyors introduced themselves as being from the MOH and mothers were embarrassed to criticize their health workers.
- 1992 S. Nyanza qualitative study: According to mothers, disrespectful and discourteous health workers were a major cause of low immunization. There were numerous reports of nurses insulting mothers because of the way they or their babies are dressed, because the children are dirty or malnourished, because mothers bring several young children (and therefore are not planning their families), etc.

It is likely that the magnitude of this problem varies significantly from district to district and even SDP to SDP, but taking national action might benefit immunization coverage as well as utilization of SDPs in general.

3. Mothers either don't know or forget to bring children back to complete the series.

- Nandi District: #2 reason for noncompletion was "mother not told to bring child again" (13%).

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- 1987 national survey: 9% of reasons for noncompletion were "not told to come back."
- Elgeyo Marakwet: "lack of adequate information" accounted for 26.8% of reasons (not broken down).
- Nairobi: 28.2% of mothers not told what immunization their child had just received, which implies that many mothers are not given essential information.
- MI surveys: 5.7%, 8.1%, and 1.4%, respectively, of respondents said they were unaware of the need for measles immunization.
- 1992 South Nyanza survey: 15.4% of the reasons for partial immunization were unaware of need for immunization or of need to return for 2nd or 3rd dose. The qualitative study revealed that nurses often tell mothers to come back monthly for growth monitoring, without mentioning whether the child is due for another immunization.

This appears to be a significant problem that should be addressed, although this response may mask other reasons for not returning.

4. Immunization is often unavailable because of health system organizational problems (lack of vaccine or vaccinator, lack of cards, restricted hours).

- The 1989 KEPI review team observed this to be a significant problem.
- Training assessment: 35.3% of mothers in Kisumu reported that they had come to a SDP for immunization but did not receive it that day (some, one assumes, because of false contraindications); 6 of 20 SDPs observed in Kisumu did not provide EPI services all day long, 5 days a week as specified by MOH policy.
- S. Nyanza: The qualitative study found that many facilities did not offer immunizations all day and were most likely to turn children away in the afternoon, which is the most convenient time for many mothers.
- 1987 national, Nandi, and S. Nyanza surveys: 6%, 5%, and 5%, respectively, of reasons were absence of vaccine or vaccinator.
- MI: in urban Kisumu, 4.6% of mothers said "vaccine not available"; in Siaya 2.5% said "vaccinator absent."

These problems probably vary substantially among districts. DHMTs should be encouraged to assess and correct them.

5. Current messages are not effective enough in motivating mothers.

- S. Nyanza coverage survey: "lack of motivation" accounted for 27.2% of reasons for non/partial immunization.
- MI: specific response of "lack of motivation to make effort" accounted for 25.6%, 21.6%, and 14.1% of reasons.

The actual extent of this is difficult to gauge because these responses may mask other reasons and vice versa. Certainly, it appears that messages alone will not have a major impact unless services become more convenient, reliable, and friendly.

Factors that do not appear to be important:

1. **Fear of side effects:** Although this is very infrequently given as a reason for non-immunization, HWs should routinely discuss what to expect and do regarding side effects.
2. **Travel cost/time/distance:** Although not a major nationwide problem, this is probably a significant problem in certain districts and communities. Each DHMT should be encouraged to assess the distribution and operating hours of all SDPs. To assist specific communities with particularly difficult access, DHMTs should work with them to establish new outreach points or to facilitate transportation to existing SDPs.

Because, on the basis of existing information, the five factors described above are believed to be significant reasons for non- or partial immunization, the draft communications/social mobilization strategy addresses them specifically. In addition, qualitative research with mothers, health workers, and others is proposed to refine and add to existing knowledge, and the research findings are expected to lead to modifications and additions to proposed activities.

The following five activities address the five barriers already identified.

Activity 1: Devise and implement a strategy to assure that contraindication policies are followed.

Activity 1.1: The KEPI MU will plan and manage professionally conducted qualitative research (FGDs and in-depth interviews) with HWs to understand their KAP and the suggestions/reactions to ideas for improving KAP; and with mothers to understand the reasons and source of their fears (HWs, fathers, themselves) and consequent ways of reducing these fears. A more detailed proposal for this research is found in Annex B.

- 1.1a The KEPI MU will develop a scope of work.
- 1.1b The KEPI MU will interview potential research groups, solicit brief proposals if necessary, and select the group.
- 1.1c The KEPI MU will work with the group to prepare question guides, quota sampling plan.
- 1.1d The research group will train moderators and interviewers, and will pretest and finalize instruments.
- 1.1e The KEPI MU will facilitate cooperation of DHMTs.

Activity 1.2: Incorporate findings into HW training.

- 1.2a The KEPI MU will disseminate the findings and recommendations to KEPI's annual meeting with DPHNs and urge them to follow up in their districts.
- 1.2b Provincial, district, and NGO training centers will use these findings to modify preservice and inservice training to teach this and other key contraindication policies more effectively (i.e., giving a measles immunization to a child who the mother says already had measles, immunizing a child without a card) and to motivate HW compliance.
- 1.2c The KEPI training officer will examine current KEPI curricula, recommend modifications, and oversee their implementation.

Some other noteworthy findings are:

- The full immunization of 56% of children 12-23 months old represents a significant improvement since 1987, although still short of KEPI's 1990 target of 75%.
- Only 4.7% had no immunization, but the dropout from DPT1 to measles was an extremely high 28.3%.
- 83.3% of children had immunization cards.
- The major reasons for incomplete immunization (children with no immunizations or only partially immunized) were:
 - family problems, including, illness of mother, 11.1%;
 - child ill, not brought, 11.1%;
 - child ill, brought but not given immunization, 9.5%;
 - unaware of need to return for 2nd or 3rd dose, 9.0%;
 - time of immunization inconvenient, 8.2%;
 - postponed until another time, 7.4%;
 - mother too busy, 7.4%.

Many of these barriers to higher coverage were explored much more fully in the qualitative study, which included numerous focus group discussions (FGDs) as well as some in-depth interviews and observations at service delivery points (SDPs). The study found that the major factors promoting immunization were positive prior experience to immunization, the attraction provided by other services, the desire to raise healthy children and a clear understanding of immunization. However, many factors inhibit higher coverage, especially ones related to the manner in which health workers treat mothers and the information they give them, the convenience of services, and many competing demands for mothers' time.

Major reasons for incomplete immunization included mothers' putting off going for no apparent reason (a local cultural concept called "samwoyo"); missing appointments because the child is sick; mothers' fears that health staff at the clinic will scold them; frequent postponement of immunization activities, mainly as a result of shortages of supplies; long distances to health facilities; other commitments of mothers, and fear that healthy children taken to the clinic may be noticed by envious people and be bewitched. Annex D, the draft summary of the qualitative study, provides more detail.

Problem Prioritization

During the first two days of the strategy formulation workshop, national and international EPI objectives and the main methods and results of the two studies were presented. On day three, the participants were instructed to use this information as the basis for prioritizing EPI problems. The criteria developed by the group included magnitude of the problem, its impact on vaccination coverage, the feasibility of solving it, and its potential impact of solving the problem on other primary health care services provided at the same facility. The prioritization criteria, scores for each criterion, and combined total scores for each problem were decided by the group as a whole, and are as follows:

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Activity 3: Devise and implement a strategy to assure that mothers are aware of the need to return and when to return for follow-up doses.

Activity 3.1: The KEPI MU, provinces, and districts will improve health worker counseling through inservice and preservice training, supervision, and evaluation.

Activity 3.2: The KEPI MU will develop (draft, pretest, print, distribute) a counseling card and also orient provinces and districts to train HWs in their use. It is recommended that the counseling card have the key messages on one side for the mothers to see and the key HW behaviors (how to treat the mother) on the back for the HW only to see. Pages 55-56 of KEPI's new Immunization Manual for Medical Students and Physicians is a very good start on the content of such a card.

Information

- * which vaccine(s) was administered.
- * the disease(s) it protects against.
- * which side effects are common and what to do about them.
- * the date and importance of returning for subsequent immunizations.
- * the importance of keeping and bringing the Child Health Card.

Manner of Treatment:

- * be polite and helpful.
- * make mothers comfortable and at ease.
- * use simple language (no jargon).
- * listen and encourage mothers to talk of their experiences and concerns and to ask questions.
- * ask "open" questions rather than "yes" or "no" ones.
- * use teaching aids and actual objects like vaccine vials.

Activity 3.3: The KEPI MU will encourage districts to devise their own schemes for reducing dropouts. These might include: defaulter tracing by CHWs, scouts, school children, or NGOs; giving out prescription sheets for follow-up immunizations; devising a culturally appropriate way (bracelet etc.) to recognize a fully immunized child, etc.

- 3.3a The KEPI Manager will sign a memorandum to the DHMTs concerning the dropout problem and possible solutions and encourage districts to develop plans and activities to address the problem. (This is expected to be a key activity of the MI in the districts in Kisumu and Siaya.)
- 3.3b The KEPI MU will disseminate successful schemes through newsletters, special mailings, etc.
- 3.3c The KEPI MU will routinely distribute to the districts information generated by the Computerized EPI Information System (CEIS). This may include ranked data on dropout rates to aid each district in monitoring its own progress relative to that of other districts.

Activity 4: Devise and implement steps to correct health system inefficiencies that contribute to reduced coverage.

Activity 4.1: Each DHMT will assess how many facilities are providing immunization all day, daily and reasons why some are not.

Activity 4.2: In conjunction with KEPI MU, each DHMT will take steps to correct the problems.

Activity 4.3: In parallel with improvements in cold chain management, individual SDPs and supervisors will report shortages of vaccine or cards to their DHMT, which will work with the KEPI MU to solve problems.

Activity 5: Devise and implement a strategy to motivate mothers and families more effectively to assure that children are fully immunized.

Activity 5.1: The KEPI MU will search for existing information (including interviews with social scientists) on these topics, evaluate its completeness, and then organize small qualitative studies in several districts. A brief proposal for this research is included in Annex B.

Activity 5.2: Findings will be incorporated into appropriate mass media, counseling, and other materials, after pretesting.

Objective 2: SUSTAIN INCREASED COVERAGE LEVELS OVER TIME

Indicators: (1) steady or improving coverage achieved through fixed SDPs and outreach from them; (2) improved immunization knowledge among school children and adults; (3) sustained funding and political support for EPI.

This objective concerns sustaining widespread popular support for the immunization program and moving toward making full immunization a "social norm." In terms of communication activities, this requires advocacy and long-term efforts to educate the population concerning immunization, as opposed to more focussed, short-term communication aimed at motivating immediate practices.

Activity 1: Plan and implement activities to maintain public awareness of immunization and its importance (advocacy).

Activity 1.1: Maintain ongoing liaison with the press and broadcast industry for immunization advocacy.

Activity 1.2: Organize periodic high publicity activities in conjunction with Children's Day, World Health Day, etc.

Activity 2: Teach about immunization in schools.

Activity 2.1 The KEPI MU will work with the Ministry of Education (MOE) to revise the curriculum concerning immunization.

2.1a The KEPI MU and MOE will set up a joint committee to propose revisions and will work to have the changes accepted.

2.1b MOE will either substitute the new curriculum for the old one or use the new lesson plans to supplement the current curriculum.

Activity 2.2: The KEPI MU will work with the MOE to develop new written materials on immunization, if needed.

2.1a A joint KEPI/MOE committee will be established to evaluate current materials.

2.2a The committee will recommend keeping, replacing, or supplementing existing materials.

2.2c The committee will monitor implementation of its recommendations.

Activity 2.3: The KEPI MU/MOE will encourage district-level education authorities to motivate all teachers to cover immunization and other PHC topics.

Activity 2.4: KEPI-MU will continue to work with the University of Nairobi Medical School, Department of Pediatrics, to assure the distribution and use of the new EPI manual for medical students.

Activity 3: Incorporate immunization into adult education.

Activity 3.1: KEPI-MU and districts will work with the national literacy program to revise and expand immunization lessons.

Activity 3.2: KEPI-MU and districts will work with women's groups to encourage groups to learn about and discuss immunization.

Activity 3.3: KEPI-MU and districts will work with NGOs that support women's groups, literacy classes, etc. to incorporate or expand immunization in lessons and discussions.

Activity 4: Encourage and assist districts to involve the community in planning and implementation of EPI.

Activity 4.1: KEPI-MU will prepare and send a memorandum to provinces and districts (PHMTs and DHMTs, as well as development committees) emphasizing the importance of community participation, providing concrete suggestions for ways of facilitating it, and requesting that districts incorporate some of the activities into their workplans. Some of the activities will involve ways of providing feedback to communities on program status and achievements.

Activity 4.2: KEPI-MU will disseminate innovative ideas, positive results, and lessons learned reported by the districts.

Objective 3: SUPPORT DISEASE CONTROL ACTIVITIES

Indicators: (1) more complete reporting of measles, tetanus, and polio by both communities and health workers (based on new, clear case definitions); (2) adequate community knowledge and cooperation with mop-up or other immunization of high-risk groups.

As KEPI moves beyond a concentration on coverage and towards disease eradication and control, new communication tasks will emerge.

Activity 1: Support improvements in disease surveillance.

- 1.1 The KEPI MU, provincial, and district health staff will work with HWs, private physicians, NGOs (such as Rotary), and community groups to increase community participation in reporting of suspected cases of polio, tetanus, and measles. The KEPI MU will prepare, pretest, and print a simple manual on polio, tetanus, and measles monitoring and surveillance for use at the local level.
 - 1.1a The KEPI MU will draft, pretest, revise, print manual.
 - 1.1b The KEPI MU will orient PHMTs, giving them booklets on the surveillance system and respective roles and responsibilities.
 - 1.1c PHMTs will orient DHMTs, giving them booklets.
 - 1.1d DHMTs will orient in-charges of health facilities, giving them booklets.
 - 1.1e DHMT will orient PHOs and PHTs, who in turn will orient community leaders, giving them booklets.

Activity 2: Support outbreak measures.

- 2.1 Once KEPI's outbreak policies and procedures are developed, communicate them to PHMTs and DHMTs.
- 2.1 KEPI-MU will prepare a brief manual giving suggested messages and potential media to use to mobilize public cooperation with outbreak measures.

Activity 3: Support introduction of new policies or technologies

During next five years, KEPI is likely to introduce a number of important policy changes or new technologies. The introduction of each of these will need careful planning and implementation of communication and support materials aimed at both HWs and the public. Some of these possible changes may include:

- a 5-dose TT schedule for females (which also requires the introduction of a woman's health card).
- addition of hepatitis B immunization to the basic series.
- possible introduction of a 2-dose measles policy in some settings, and of routine measles immunization for children upon admission to hospitals.

Activity 3.1: Plan and conduct operations research to gauge the acceptability of the new policy for technology and to learn important areas for communications messages.

Activity 3.2: Develop a communication plan -- audiences, messages, materials, training. The plan will carefully plan the communication and reinforcement of the changes to all levels of the health system as well as to the public.

Activity 3.3: The KEPI MU will work with provinces and districts to implement the plan.

ANNEX B

PROPOSED QUALITATIVE RESEARCH, 1992-1993

A qualitative research study is proposed that will explore both areas of potential barriers to higher coverage and effective motivational statements and themes for communications.

Basic Research Plan

Qualitative research in each of 6 areas of the country (Eastern, Rift Valley, Central, Coast, North, Nairobi) is proposed. (The Western area has already been covered in the S. Nyanza qualitative study and will be further investigated in Measles Initiative qualitative research.) In each of the six areas, one district with a high dropout rate will be selected as the study area. In each of the study areas, focus group discussions (FGDs), in-depth interviews with health staff and community leaders, and observations at SDPs will be used. In each of the six districts, there might be:

- 2 FGDs with nurses who immunize
- 1 FGD with SDP in-charges
- 1 FGD with trainers/district supervisors
- 2 FGDs with mothers of partially immunized children
- 1 FGD with mothers of children with no immunizations
- 1 FGD with mothers of fully immunized children
- 2 discussion groups of mothers and HWs together
- 10 interviews with health workers and community leaders
- 3 observations at SDPs.

Areas to Explore

The qualitative research will emphasize the following areas:

- (1) immunizing sick children;
- (2) how health workers (HWs) and mothers interact;
- (3) important competing demands on mothers' time, and how services might be structured to minimize them;
- (4) effective motivations to immunization acceptance, both psychological and service-related (e.g., a more reliable drug supply available when the mother takes the child for vaccination.)

Immunizing sick children: FGDs will cover current behavior, reasons for it, feelings about it, people who influence HWs' and mothers' KAP. To what extent does this problem result from HWs lack of knowledge or understanding of KEPI policy? To what extent are HWs unwilling to follow policies they know but are afraid to implement, and why? To what extent are HWs acting because of what they fear mothers will think and vice versa? Participants' suggestions for reducing fears and their reactions to possible suggestions will also be solicited.

HW/mother interaction: In each study district, interactions will be observed in 3 SDPs and will also be explored in the FGDs. Each group will explore participants' perceptions of the interactions, reasons why it occurs as it does, feelings about it, ways in which it might change for the better. A special topic will be ways in which HWs explain when the child needs to return for a follow-up immunization, mothers' understanding of this information, and possible ways of improving the communication of this information. Individual interviews with HWs will explore their confidence

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in their skills and knowledge to carry out immunization-related tasks, their job satisfaction, causes of unrest or stress, satisfaction with the support they receive, etc.

On the basis of the findings, in each study district an agenda will be prepared for two discussion groups comprised of HWs and mothers together. They will discuss their interaction, the reasons why they act and feel as they do, and explore areas of consensus in which the interaction can become more satisfactory to both parties.

Demands on mothers' time: In-depth interviews with mothers as well as FGDs will explore routine, seasonal, and special demands on mothers' time that make it difficult for them to comply with the immunization schedule. Mothers will be asked to suggest ways in which services can be modified to accommodate these difficulties.

Motivating better acceptance of immunization. Reinforcing many of the other reasons given by mothers for non-immunization is lack of motivation or confidence in immunization or the health system. FGDs and interviews will explore:

- attitudes of mothers, fathers, and opinion leaders toward the health facilities and the immunization program;
- strongly held cultural values (attitudes toward illness, the value of a child having measles, prevention, children, the future, value of education, etc.) that might be used as unifying national themes to motivate mothers to have their children fully immunized;
- symbols (political, cultural) that are widely known and valued.
- participants' exposure to, understanding of, and disposition to act because of existing communication interventions.

One technique will be to explore with mothers of fully immunized children why they did it and what benefits they feel they derived.

On the basis of findings, the research group will recommend ways of motivating immunization completion. These may include a logo, unifying symbols or phrases, a fictional or real spokesperson, effective motivational messages that connect the fully immunized child with strongly positive popular values.

Mechanism

It is proposed that this qualitative research be conducted by AMREF, PATH, or some other group experienced in such work. Input will be sought from UNICEF and others in planning the research. Once it is completed and analyzed, KEPI MU will organize a national workshop with representatives from the 6 participating areas, the KEPI MU, UNICEF, NGOs, etc. to formulate a broad communications/training/supervision/community involvement strategy that seeks to overcome these barriers to higher coverage.

It is suggested that the REACH Communications/Social Mobilization Advisor in KEPI manage this research and work closely with the group carrying it out.

ANNEX C
MEMORANDUM

TO: Connie Johnson, USAID/Nairobi
FROM: Mike Favin and Grace Kagodu, REACH
SUBJECT: Suggested KAP Questions to Add to Coverage Surveys
DATE: April 30, 1992

As you requested, we have prepared a list of KAP questions that could be added to the upcoming coverage surveys in all districts. We believe that these questions could yield extremely interesting information to supplement findings from past studies and new insights that we hope to gain through upcoming qualitative research.

We have assumed that these questions would follow the standard coverage survey questions, including the one on reasons for non-immunization. For all questions, the interviewer will have to select one from among the choice of responses that best fits what the respondent answered. For question 7 only will the interviewer read the possible responses, in this case asking for a yes or no response to each. These questions are intended to be asked to all respondents.

It would be extremely useful to have the responses analyzed by immunization status of the child (i.e., no immunizations, partially immunized, and fully immunized).

These questions are a first draft. Naturally, KEPI, USAID, UNICEF, DANIDA, and other appropriate parties should be given an opportunity to comment and make suggestions, and the questions should be pretested before use.

1. What is your most important source of information about immunization?

- a. doctor
- b. nurse
- c. community health worker
- d. poster
- e. radio
- f. neighbor
- g. other
- h. don't know

2. If your child has fever, is it okay for him/her to get immunized?

- a. yes
- b. no
- c. depends
- d. don't know

3. If your child has diarrhea, is it okay for him/her to get immunized?

- a. yes
- b. no
- c. depends
- d. don't know

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4. Is it easy for you to travel to the place where your child gets immunized?

- a. yes
- b. no
- c. depends

5. When you bring your child to be immunized, how do health workers treat you?

- a. fine
- b. okay
- c. poorly
- d. not applicable (child never immunized)

6. Do health workers tell you when your child should return for follow-up doses?

- a. yes
- b. no
- c. sometimes
- d. not applicable (child never immunized)

7. Do you participate in:

Yes No

- a. barazas?
- b. women's group?
- c. literacy class?
- d. other class?
- e. other group?

8. Who gives you the most advice about whether to have your child immunized?

- a. husband/wife
- b. mother/mother-in-law
- c. neighbor
- d. chief
- e. traditional healer/TBA
- f. other
- g. no one

9. Do you listen to radio at least once a week?

- a. yes
- b. no

10. What language do you prefer to listen to on the radio?

- | | | |
|------------|-------------|-----------|
| a. English | f. Kamba | k. Meru |
| b. Swahili | g. Kalenjin | l. Kikuyu |
| c. Luo | h. Kisii | m. other |
| d. Luhya | i. Kuria | |
| e. Kamba | j. Masai | |

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11. Do you think measles is a serious disease?

- a. yes
- b. no
- c. sometimes
- d. don't know

12. Do you think that measles kills many babies?

- a. yes
- b. no
- c. don't know

13. Do you think measles can be prevented?

- a. yes
- b. no
- c. sometimes
- d. don't know

14. How?

- a. immunization
- b. another way

15. How old should a child be when it gets his/her measles immunization?

- a. don't know
- b. when health worker says
- c. under 6 months
- d. 6-8 months
- e. 9-11 months
- f. over 1 year

ANNEX D

DRAFT SUMMARY OF SOUTH NYANZA QUALITATIVE STUDY

CHAPTER ONE

1.0 SUMMARY AND RECOMMENDATIONS

1.1 SUMMARY

1.1.1 Immunization services

Immunization activities have been implemented in South Nyanza for some time and the activities of the KEPI programme are well established in that district. Out of a total of 108 hospitals, health centres and dispensaries in the district, 92 are either providing immunization or will shortly begin to provide this service when appropriately equipped and staffed. Out of these, 62 are old immunizing points, 25 were recently equipped and 5 more are in the process of being equipped for immunization activities.

Like other districts in Kenya, health facilities in South Nyanza run integrated MCH services which include immunization. Many of the facilities have a family planning (FP) component as well. According to the Ministry of Health (MOH) policy, the clinics are expected to provide these services on a whole day basis, five days a week. Although this policy is well known to those associated with KEPI activities, in practice, some health centres provide immunization services only on certain days of the week. It has become a tradition in many of them that services are provided only during morning hours. In the afternoons MCH/FP clinics are either closed or are open but staff manning them are reluctant to serve clients.

Clinics routinely conduct health talks in the morning before they provide services. Mothers who come in the afternoon are "scolded" by health staff who ask them where they were in the morning and warn them to come in the morning next time. This is in spite of the fact that most mothers would prefer to attend to health and immunization activities in the afternoons, when the work at home is lighter (see chapter nine).



1.1.2 Immunization IEC

The people of South Nyanza obtain information on immunization and other health issues through a number of channels. These include seminars, health talks at clinics, church group meetings, women group meetings, barazas (public meetings), funerals and from school children. Other channels include radio, TV and school home science books (especially for young mothers who have been in school recently). Key promoters of health education in the district are Family Health Field Educators, Nurses (mainly at the clinic), Community Health Workers (locally known as "Nyamrerwa"). Traditional Birth Attendants and Traditional Healers are reported to be working closely with the health facilities and routinely advise mothers to take their children for immunization. The latter readily give the advice because they "have no other protection against immunizable diseases." While this confession is largely true, it was reported that some mothers take Yadh agulu when they are pregnant. This herb is said to protect pregnant mothers and their unborn children from a wide variety of diseases.

Use of herbs and traditional medicine is well established in South Nyanza and there was a consensus among all the subjects interviewed that many diseases could be treated exclusively or better by traditional medicine. Measles, TB and polio were listed among those diseases that could be treated better by traditional medicine.

In a society with such a strong belief in traditional management of diseases, it is important that the community's own health consultants are enlisted to support health programmes if these are to succeed. To this end, Traditional Birth Attendants (TBAs) have been trained motivated to refer clients to health facilities for services such as immunization. However, Traditional Healers are yet to receive similar exposure. Sometimes clan elders, chiefs and Assistant chiefs encourage people to take children for immunization, but they do not have adequate information on immunization to permit them to become effective motivators. These and local counsellors request that they be equipped with

adequate information to pass on to other people. They also request greater involvement in health promotion.

According to respondents, the most respected health and immunization motivators are health workers (nurses) followed by Community Health workers. Health talks at health facilities, home visits and IEC activities at the lake beaches seem to be the most popular communication settings with mothers. Fathers prefer to receive IEC at barazas, during home visits and in small groups. Chiefs, councillors and other leaders prefer to receive IEC in a seminar setting while students prefer to receive IEC from health staff visiting their schools. Radio was the distance media channel preferred by most target groups.

While Community Health Workers (CHWs) have done a good job, their role and potential seems to be inadequately understood by both themselves and community leaders. During this study, CHWs presented a long list of the equipment they needed to be supplied with, and leaders requested that this category be integrated in the MOH establishment as salaried staff. The leaders also requested that TBAs be paid as a "mark of appreciation".

1.1.3 Knowledge, attitude and behaviour

Non-Ministry of Health employees

All respondents interviewed had heard of immunization, knew that immunization gave protection against diseases and thought that the protection given through immunization was useful. Different targets' level of knowledge on other aspects of immunization differed as indicated in the table below:

Content	Level of knowledge
Immunization Targets	Women and fathers with children 0-23 months had correct information on immunization targets. However, significant number of leaders did not know their children were routinely immunized and only knew about the general immunization given to the general public when there was a disease outbreak.
Immunizable diseases	Most women and fathers with children 0-23 months had accurate information on immunizable diseases. However, some included non-immunizable diseases such as malaria, diarrhoea and vomiting on the list of immunizable diseases. Leaders had distinctly less knowledge about immunizable diseases. Some leaders thought only of mass immunizable diseases of the past e.g. cholera small pox, yellow fever and, more recently, meningitis.
Immunization schedule	No category was sure of this. However, mothers had better knowledge than other categories.
Why immunizations have to be given repeatedly	No category had information on this.

Leaders see immunization promotion largely as a Ministry of health responsibility. While they continue to facilitate the work of the MOH staff, their involvement is minimal. Although they are busy and unable to personally participate in immunization promotion activities, the business community are willing to donate

money and distribute pamphlets from their business premises in promotion of immunization.

Almost all mothers (92%) take their children for immunization at least once. Later, (see Chapter seven), many of them delay taking their children for immunization or stop taking them altogether, giving the programme a drop out rate of 32.3% from BCG to measles.

Ministry of Health employees

Most Ministry of Health employees with roles in the KEPI programme have a good basic understanding of immunization. Public Health Nurses, Immunizers, Family Health Field Educators (FHFES) and Nurse Aids (employed by NGOs) have a good understanding of immunization, immunizable diseases, the immunization schedule and why immunizations should be given several times. However, immunizers are not clear on a number of technical details (See 4.2).

Because of shortages of staff, Family Health Field Educators (FHFES) and subordinate staff immunize children, although they do not have formal training for this role and are not officially allowed to immunize. Both categories are not well informed about immunization contraindications and are widely accused by official immunizers of giving mothers "misleading" information. Some are said to tell mothers that sick children should not be immunized. In addition, they are said not to indicate immunization return dates on the child card and sometimes do not tell mothers verbally when to return the child to the clinic for the next immunization. Partly because they can immunize, some subordinate staff have abandoned their cleaning duties to nurses and are rude to them. While these issues are discussed, all involved are unwilling to report them to the next level in writing. As a result, no action has been taken to correct the situation.

DHMT members whose jobs are not closely related with those of KEPI do not have a working knowledge of the KEPI programme.



1.1.4 Factors promoting immunization

The four most frequently mentioned factors that promote immunization were:-

- i) Prior positive exposure to immunization;
- ii) The attraction provided by other services offered at integrated MCH clinics, such as growth monitoring and the health talks given before services;
- iii) The desire to raise healthy children and
- iv) Clear understanding of the benefits of immunization.

In addition, some mothers take their children to the clinic to ensure they get a clinic card which is often requested at health facilities when a child is taken for treatment, when a child seeks a class one place or applies for a birth certificate. Others take their children to the clinic because neighbours are doing the same; the health facility is near; their husbands urge or support or they would like to benefit from experts who advise them on the health of their children.

Others have their children immunized because they have developed good relations with health staff or because their defaulting children have been identified when in the process of being treated.

1.1.5 Factors hindering immunization

Factors hindering immunization in South Nyanza are more numerous than those that promote it and are summarized in Chapter six. They include the tendency to put off going to the clinic for no apparent reason (Samwoyo); missing appointments because the child is sick; mothers fear that health staff at the clinic will scold them; frequent postponement of immunization activities mainly as a result of shortages of supplies; long distances to health facilities;

other commitments of mothers and fear that healthy children taken to the clinic may be noticed by envious people and bewitched.

Also, mothers are discouraged from taking children to the clinic: when they fear immunization side effects on their children; when they have many under-fives whom they cannot serve adequately at the same time; when they fear being ridiculed by health staff when they take to the health facility children who are thin or have scabbies; when they do not know that it is necessary to take children back for 2nd and 3rd doses of immunization; when they do not have KSh 2/= to contribute towards purchase of paraffin at the health facility; when they feel they do not have good clothes for themselves and their children to wear to the health facility; when waiting time at the clinic is long and when clinic hours are not suitable.

Also mothers fail to take their children for immunization when they believe that herbs provide adequate protection; when the mother, who should have taken the child to the clinic is sick; when they are not convinced of the benefits of immunization; when their husbands and mothers-in-law discourage them; when they fear that their healthy children will contract diseases from sick children at the clinic; when children get measles even after they have been immunized against it and when sick children are refused treatment because they do not have MCH cards.

1.1.6 Planning, management co-ordination and supervision

Project planning at the District Health Management (DHMT) level takes place in two different ways: either the Hospital Secretary plans for Government funded activities or the donor plans directly with the department he plans to fund. Both processes show little evidence of strengthening systematic team planning and implementation. DHMT meetings are spaced far apart and tend to dwell on administrative rather than programmatic issues. Programme implementation and supervision are substantially handicapped by shortages of money, fuel and transport. Except for the supervision activities of the whole DHMT, which are also spaced far apart, supervision activities carried out by other officers, including the District Public Health Nurse, who is in charge of KEPI

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activities in the district, are largely undocumented, and there is little or no note sharing between DHMT members on projects. The DHMT recently developed an 8 page, 250 item Yes/No supervisory checklist that includes all aspects of the health services. This checklist (see Annex Four) has been used by the whole DHMT once and found to take up too much time to fill out.

KEPI activities in South Nyanza are further disadvantaged because although the DPHN is in-charge of all KEPI activities in the district, she does not hold authority to incur expenditure (AIE) and has to go through long, laborious processes to access money meant for her department. And when the money is finally made available, often the whole allocation is not is made available. Some of it goes into "bailing out activities that may be having worse funding shortfalls."

Immunizers feel they are not receiving adequate supportive supervision and, members of the DHMT would like to see greater co-ordination, team planning and team implementation of projects at their level.

1.2 RECOMMENDATIONS

In view of the above, there is need for strategies that can:-

- Strengthen planning, implementation, supervision, documentation and team work at the DHMT level;
- Intensifying mobilization of the entire community, and expand opportunities for individuals and different institutions and sectors in the community to contribute to the promotion of health, with specific reference to immunization;
- Transfer responsibility for health/immunization activities to the community in order to enhance ownership of the programme by the community and promote sustainability;
- Improve the level of knowledge and motivation among key community targets;

- Improve the knowledge and skills of staff involved in the KEPI programme and, address their attitudes and relations with mothers bringing their children for immunization;
- Upgrade management capabilities of the DHMT;
- Address issues of staff shortages, funding, and authority to incur expenditure in relation to KEPI ;
- Improve record keeping follow up and documentation and
- Address the issue of distance to health facilities in some parts of the district.

1.2.1 Planning, implementation, supervision, documentation and team work

As pointed out elsewhere, there is a need for a review of the above areas with a view to strengthening participatory planning and documentation. Participatory planning should in turn strengthen team work give DHMT members an opportunity to acquire working knowledge of projects and motivate them to contribute more effectively towards programme implementation. Strategies generated in this area should also strengthen capacity for supportive, documented supervision which should in turn create a basis for informed decision taking in the DHMT.

1.2.2 Mobilization and community support for health activities

In view of the fact that some potentially key mobilizers (leaders) believe that immunizations are the work of the MOH and in view of the fact that a significant number of leaders and other individuals would like to participate in health promotion but do not have adequate information to empower them to do so, there is a need for initiatives:-

- To provide potential non-MOH mobilizers with the necessary facts about immunization;
- To put in place more efficient mechanisms through which non MOH mobilizers can make an effective contribution and

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- To provide support mechanisms that can help sustain interest of motivators and keep health and immunization high on the community agenda.

To this end, we recommend formulation of an umbrella District mobilization programme, planned and implemented jointly by all agencies working in immunization. The elements of the programme could be wound round the following annual cycle of events:-

- Training and team building activities with DHMT, PHNs and key players from NGOs;
 - Leaders information and mobilization seminars;
 - Information and mobilization seminars for the business community;
 - District planning and fund raising activities;
 - Divisional level planning, fund raising and immunization campaigns. (School children and members of the community would be recruited on a no-pay basis to provide immunization IEC door to door, assess the immunization state of each child and to advise mothers to take children for immunization at static or temporary immunization points set up for the campaign period. The campaigns should preferably take place in the August or December school holidays. An appropriate, student administered form for collecting data to would be designed for use during the campaigns.
-
- Data analysis, campaign post mortem and report writing;
 - Report dissemination to key collaborating groups;
 - Generation of ideas for the next cycle;
 - Planning for the next cycle.

This strategy should not only keep immunization high on the community agenda, but it should also accelerate achievement of

immunization targets. In addition, it should maximize community support by transferring responsibility for health promotion to the community, promoting local fund raising for health activities and creating a basis for programme sustainability. Mechanisms to stem the post campaign slump and promote sustainability would be incorporated in planning by:

- Making the proposed campaigns annual events that work towards a high visibility speech making and prize giving ceremony;
- Introducing competition in the process by awarding prizes and trophies to Divisions, Locations and Village which do well;
- Encouraging campaign planning committees (probably the existing Village Health Committees) to apply methodologies develop during these campaigns to promoting other aspects of health as well;
- Improving on-going immunization services on an on-going basis;
- Exploring possibilities of running income generating activities that can support and community health initiative as well as families.

1.2.3 Improving the knowledge level of immunization targets

The campaigns proposed above should greatly strengthen the work and status of motivators. In addition, appropriate low literacy, pictorial materials aimed at providing primary targets with the needed information should be developed and distributed during the campaigns, through established IEC channels.

1.2.4 Improving health workers' knowledge and skills

Public Health Nurses who have not had KEPI training should be trained in order to boost their confidence as a matter of urgency. It is also important to mount intensive supportive supervision activities, seminars and facility based half day seminars to clarify

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KEPI policy, rules and procedures and discuss how relations between mothers and health staff can be improved.

The role of FHFES and subordinate staff in providing immunization needs to be discussed and clarified. When their role is clear, they should be oriented to it, probably through short seminars. In addition, subordinate staff will need IEC aimed at correcting the incorrect information they currently give to mothers, especially in regard to the role of the child's sickness as an immunization contraindication.

We also recommend distribution of KEPI manuals to the health facilities which do not have them.

1.2.5 Staff shortages

Staff requirements of immunizing health facilities need to be assessed and actioned.

1.2.6 Commodity shortages

To stem frequent postponement of immunization at health facilities, ways and means of making supplies continuously available should be addressed.

1.2.7 Funding , management and expenditure

This has proved to be an area of misunderstanding and frustration for those associated with the implementation of the KEPI programme. ~~To alleviate these difficulties, various respondents recommended that:-~~

- The DPHN be made a sub AIE (Authority to incur expenditure) holder so that she can become fully accountable for the management and performance of the KEPI programme. KEPI vehicles should also be placed directly under her control. (This was recommended by many DHMT members).
- Divisional Public Health Nurses be provided with vehicles to facilitate their supervision activities.

1.2.8 Record keeping, follow up and documentation

At the moment, the immunization status of a child can only be established by looking at the child's immunization card which is kept by the mother. There is need to re-design on the current KEPI register so that the immunization status of children can be established by looking at the clinic register. This should facilitate prompt follow up, and assessment of the immunization coverages.

1.2.9 Distance to clinics

Distances mothers travel to reach health facilities are extremely long in some places. The places affected should be considered for either mobile clinics or additional health facilities.

1.2.10 Measles immunization age

Many respondents reported that children were suffering measles before they attain the age of nine months, some get even at three months. In view of this, there is a need to study the measles attack pattern in South Nyanza and review the national immunization schedule in light of the findings.

ANNEX E

PERSON CONTACTED

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ANNEX F

SELECTED DOCUMENTS CONSULTED

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