EXAMINE COMMUNICATION ACTIVITIES EMPLOYED TO PROMOTE ROUTINE IMMUNISATION IN NAIROBI COUNTY

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DECLARATION

I declare that this research project is my original work and has not been presented for award of any degree in any university

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This project has been submitted for examination with my approval as supervisor of the University.

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DEDICATION

I dedicate this research to the love of my life, my blood and flesh, my heart, my reason for living, my sons Levi Kariuki and Eli Kunyiha. When I felt like giving up, I remembered why I did this in the first place. I did this for you my sons.

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To my good friend, Sarah Wacera Kamau - Wangome, for looking after my young children when I was away in school. Friends like her are hard to find, her presence and kindness meant a lot to the boys and I. May God bless you abundantly.

To my classmates and colleagues who encouraged me in this process, thank you.

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ABSTRACT

This research examined the communication activities that were undertaken to promote Routine Immunisation in Nairobi County. Immunisation is a basic right and a life-saving intervention and one of the most successful and cost effective public health investment. The government of Kenya has prioritised Immunisation as one of the key health interventions, with 63% of public health facilities offering Immunisation services. Despite this, the country has not been able to achieve the national and global Immunisation coverage targets, with half of the counties achieving less than 50% coverage. Other health programmes, like HIV/AIDS, nutrition, and breastfeeding among others continue to surpass targets. To understand the dynamics of the topic, the research used theory of reasoned action and ecological model of communication. Specifically this study examined communication activities undertaken, determineed what gaps the strategies were addressing and described components of communication that should be addressed. The study adopted a mixed research approach. Key informant interviews were conducted with implementers using a Key Informant Guide; interviews were conducted using questionnaires to collect data from caregivers. Qualitative data was analysed through thematic content analysis to get main themes. Quantitative data was analysed using descriptive statistics and presented in graphs and percentages. The study was undertaken in four sub-counties in Nairobi County namely; Langata, Mathare, Embakasi East and Makadara. In 2016, Langata and Mathare had the lowest Routine Immunisation coverage whereas Embakasi East and Makadara had the highest coverage. Nairobi was selected because it is among the counties with low Immunisation coverage. The study found out that most respondents had interacted with communication activities promoting Immunisation, and that targeted health facilities and communities. Communities preferred use of interpersonal communication and radios, as opposed to use of newspapers and online platforms. Quality and quantity of information provided by the health workers to the caregivers was a major determinant of uptake of Immunisation services. Negative attitude and poor communication skills of health workers were noted as the major gaps existing at health facility level. Low risk perceptions and existing behaviors by the caregivers was the major gap identified in the study. Mapping and engagement of local stakeholders including communities was noted as key in advocating for the Immunisation agenda in the community. For behavior change to be achieved, Ministry of Health opts to understand and work within the existing community structures. Social mobilisation and community-led social change can be achieved by using sustainable programmes and activities jointly implemented by the health workers and caregivers. This research recommends inclusion of communities during planning, implementation and evaluation of communication activities undertaken to promote Immunisation; consideration and use of existing local structures; implementation of sustainable communication activities and development of a monitoring and evaluation framework for communication activities.

CHAPTER ONE

INTRODUCTION

1.0 Overview

This chapter provides background of the topic, stating what is under investigation under problem statement. It describes objectives to be achieved and questions to be answered at the end of the study. It also provide a justification for conducting the study, the rationale on why the study is important, the scope and possible limitations the research might encounter.

1.1 Background

Diseases burden affects productivity of a country (Laurela, 2011). Thomas and Ilona (2013) argue that global health directly affects a nation's security, economic growth and development rates. Further, they argue that good health promotes human dignity. Laura and Lisa (2011) also note that focus on health leads to global economic and political growth. Whereas a nation has a responsibility to protect and promote good health among the people within its borders, infectious diseases might move from one nation to another.

Global health focuses on health issues and health of population, without necessarily looking at the national boundaries. Laura and Lisa (2011) argue that it is difficult to focus on health of just a nation, especially in humanitarian environments. According to Thomas and Ilona (2013), international commerce gives room to people to move from one nation to another, increasing chances of spread of infectious diseases.

Unfortunately, they note, national policies and quarantines have not been able to control infectious diseases during movement of people from one country to another.

Development in Africa has been affected by disease burden. Laura and Lisa (2011) identify HIV/AIDS, Tuberculosis and Malaria as the leading, hence the need to continue investing in health care to help ease the burden.

Globally, attention is shifting to disease prevention, promotion of health and wellbeing as opposed to mere provision of curative services (UNICEF, 2015). Immunisation is one of the key disease prevention measures. It is a basic right and a life-saving intervention; and is one of the most successful and cost effective public health investment. According to WHO (2015), globally, Immunisation saves 2 to 3 million lives every year. Through Immunisation, fatal small pox has been eradicated, polio is almost eradicated in the world while deaths related to neonatal tetanus have been reduced from 200,000 in year 2000 to 49,000 in 2013 (UNICEF, 2015).

Immunisation aims at eradicating or eliminating diseases in the affected nations. Although previous attempts to eradicate malaria in 1950s and yellow fever in 1920s by WHO and Rockefeller respectively failed, Rotary succeeded in eliminating small pox in the 1979 (Tamara et al, 2013). Since then, governments and donors have put in resources to eradicate and eliminate life threatening diseases. Numerous medical studies and documents have indicated that Immunisation of children is important in reducing deaths related to vaccine preventable diseases.

Although the government of Kenya has laid down different strategies to reach every child within its borders within Immunisation services, approximately 400,000 children are not reached every year (UNICEF 2015). In 2014, fully immunised children in Kenya (aged between 12 to 23 months) were 79%, an improvement from 2008/2009 fully immunised child at 75% (KDHS 2014). The KHSSP (2017) indicates that in 2016, fully immunised children in urban areas were at 83% whereas rural were at 77% against a global target of 95%. The Kenya Constitution Article 43 dictates that every citizen has a right to quality healthcare, including Immunisation. In addition, the Sustainable Development Goals (2015) goal three aims at ensuring healthy lives and promoting wellbeing for all regardless of age.

Many countries, including Kenya are also adopting a strategic approach that calls for more engagement and participation with the general public. To align with these shifts, methods such as health education, social mobilisation and health communication are gaining prominence. In Kenya, Ministry of Health has invested in Advocacy, Communication and social mobilisation strategies to ensure that all children are reached with lifesaving vaccines. According to UNICEF (2016), the main challenge that most caregivers face in ensuring that children complete the Immunisation schedule, is lack of information on when to, where to and why complete the schedule. Most of the unreached children come from informal settlements, inaccessible areas and from less educated households (MOH, 2016).

Laura and Lisa (2011) note that different people interpret, cope and find solutions differently for health related issues. Further they argue that for health topics to be understandable in communities, there is need to move from a medical view point to a socially acceptable angle. Afiong et al. (2017) argue that heath communication is more than just passing messages and receiving feedback. This is because it touches on people's knowledge, attitudes, beliefs and practices and advocating for good health seeking behaviors.

Kenya has invested in advocacy, communication and social mobilisation activities, with the aim of improving coverage. Effective communication addressing knowledge, attitude and practices affect demand for Immunisation services. In Immunisation, communication is participatory, to inform, influence and support communities to adopt and sustain health seeking behaviors.

Advocacy strategies affect support for the Immunisation programme by political and social leaders. It helps include the Immunisation agenda in policy dialogue and decision making. Active engagement of all social players ensures communities are mobilised to seek Immunisations services. It empowers communities to become active and accountable stakeholders in the Immunisation programme; as well as rallies communities around a common goal.

Although the Ministry of Health continues to invest in communication activities, Immunisation coverage continues to stagnate or drop in some counties. Kenya has never reached the global targets of 90% coverage. In Immunisation reports compiled to

understand the communication aspect of the programme, inadequate knowledge among caregivers, poor communication skills by health workers, lack of engagement of stakeholders especially at community level, lack of information, educational and communication materials, low funding, lack of communication plans and poor monitoring of communication activities have been identified as the key problems affecting the Immunisation programme.

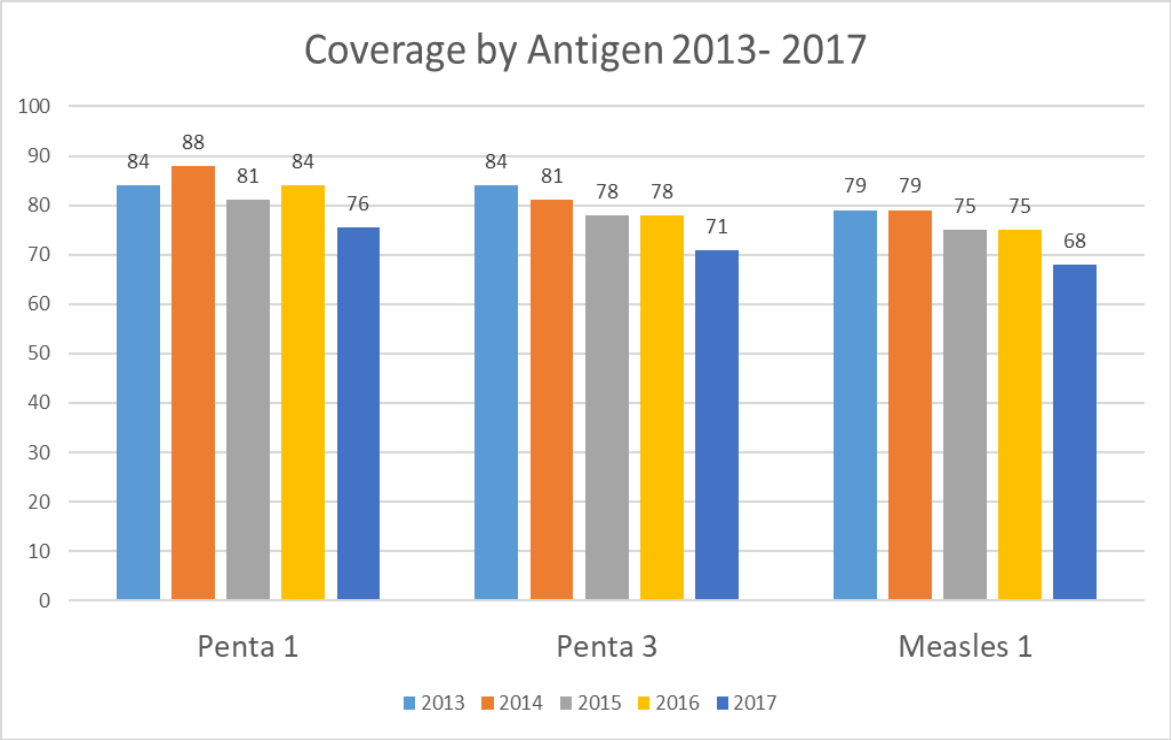


Figure 1.1: Immunisation Coverage for Kenya 2013 – 2017

Source: DHIS 2017

During Immunisation campaigns, partners come together to plan, implement and monitor communication activities to promote the antigen been given at that particular moment. The focused campaigns have continued to attain over 90% coverage, with some counties recording 100% (MOH, 2016). Given that awareness levels and coverage rates are

usually very high during campaigns, this research sought to examine communication activities that were undertaken to promote routine Immunisation, determine the existing communication gaps and describe specific components of communication needs that need to be addressed.

1.2 Problem Statement

The Government of Kenya, through the Ministry of Health, has prioritised Immunisation as one of the key health interventions. Currently, 63% of all health facilities provide Immunisation as part of their routine services (KDHS, 2014). Despite Kenya's Ministry of Health investing in vaccine supplies, trained workforce and improved infrastructure, over 460,000 children missed the vaccine in 2017, an increase from 400,000 missed in 2014 (MOH, 2015).

In the past, during Polio and Measles Rubella campaigns in 2015 and 2016 respectively, awareness level was above 90% with coverage of over 98% (UNICEF, 2016). Given that it was a campaign, on paper the communication activities were elaborate, well-coordinated, heavily funded and implemented at both the national and county levels. Routine Immunisation has however not achieved the global targets of over 95%. In 2017, only Kiambu County attained an Immunisation coverage of over 80%, with over 25 counties out of 47 attaining less than 50% and national coverage of 55.5% (DHIS, 2017). Although the government has laid down communication activities to reach every child within its borders with routine Immunisation services, many children are still not reached every year (UNICEF, 2016). Few researches focusing on communication, have been

undertaken to look at why Kenya is not achieving global targets. For communication to be effective in health programmes (including Immunisation), audience characteristics need to be identified, gaps need to be addressed and activities need to work towards creating and sustaining demand among caregivers. Resource allocation, implementation of sustainable programmes, health education, social mobilisation, health communication and health worker capacity building affects success of communication activities to be undertaken to promote routine Immunisation.

1.3 Research Objective

1.3.1 Main objective

The main objective of the study was to examine communication activities and practices used to promote Immunisation in Nairobi between 2016 and 2018.

1.3.2 Specific Objectives

1. To examine communication activities undertaken to promote Immunisation in 2016 and 2017.
2. To determine communication gaps the communication activities sought to address.
3. To describe specific components of communication that need to be addressed.

1.4 Research Questions

1. What are the communication activities undertaken in 2016 and 2017 to promote Immunisation?
2. What communication gaps exist in the routine Immunisation programme?

3. What specific components of communication need to be addressed in the Immunisation programmes?

1.5 Justification

The Government of Kenya through the counties has availed supplies and stocked health facilities that provide lifesaving Immunisation services. Despite availing supplies, demand for the services remain low. In 2014, there was a 2% improvement on Immunisation coverage (KDHS, 2014). Coverage dropped from 66% in 2016 to 55.5% in 2017 (DHIS 2018).

The Ministry of Health has invested in advocacy, communication and social mobilisation activities, but Immunisation coverage remains stagnant or has dropped in some areas. The country has also not been able to achieve global targets. Studies have been conducted in Kenya to identify challenges facing the Immunisation programme as a whole. Demand generation has been listed among the challenges facing the Immunisation programme. There was need therefore to study further and examine the specific communication activities undertaken in 2016 and 2017, describe communication gaps and specific communication components that need to be addressed in the Immunisation programme.

The results of the study are key in informing the Ministry of Health on effective and efficient communication activities that can be undertaken to improve Immunisation coverage and ultimately reach the global targets. It will also help the national and county governments understand how to best involve stakeholders especially communities in promoting Immunisation and increase number of children vaccinated in their localities.

The results also describe what communication activities were undertaken and the gaps that were being addressed. This way, communicators at the community level are able to tailor their messages to suit their audience knowledge, beliefs, attitudes and practices. This study seeks to inform the Ministry of Health on how best to invest resources for communication on Immunisation. Findings from this study will also help communicators on how best to improve as they continue implementing their activities to bring about positive change.

1.6 Significance of study

Despite the Ministry of Health investing on communication activities, coverage continues to stagnate and in some counties decline. As a result of this, it was important to revisit the communication activities, understand existing communication gaps and describe components of communication needs that need to be addressed for the Immunisation programme. This would help inform the Ministry and partners on effective communication activities that can be implemented to elicit favorable responses.

Kenya continues to be among the countries that have not attained global targets (KDHS, 2014). It is also among the ten (10) leading countries with the highest number of unvaccinated children in Africa Region together with Chad, Democratic Republic of Congo, Ethiopia, Mozambique, Niger, Nigeria, South Africa, South Sudan and Somalia (WHO, 2015). International donors including Rotary and Bill and Melinda Gates Foundation have invested in promoting Routine Immunisation in Kenya (MOH, 2015). The government has established Division of Immunisation and Vaccines at national and

county levels. Presence of health officials promoting and undertaking Immunisation services has been documented in most parts of the country. However, there is a gap in terms of creating and sustaining demand ensuring every single child is reached with all lifesaving vaccines (MOH, 2016).

High numbers of unvaccinated children put the whole country at risks of outbreaks of vaccine preventable diseases. National government, county governments and partners have continued to fund Immunisation activities including communication activities, but coverage remains stagnant or drops in some areas. Communities are the key beneficiaries in the Immunisation programme. There was need therefore to understand the communication activities undertaken, determine communication gaps and specific communication needs to be addressed in the Immunisation programme.

1.7 Scope and Limitation

The study looked at the different communication activities implemented to promote Immunisation, address hesitancy and increase uptake of Immunisation services. A critic was be done on the communication activities employed by the Ministry of Health in the year 2016 -2018. The study was be carried out in four (4) Sub counties in Nairobi County. The sub counties were selected based on their performance (coverage), the highest two and the lowest two.

Ministry of Health implements different communication activities for different areas, based on the needs and characteristics of the target audience. Examining the communication activities and practices will assist the Ministry in developing tailored communication activities ensuring as many caregivers as possible are reached with the correct message in the right form and time. However, Nairobi County might not be representative of counties that have other issues including vaccine shortage, lack of health facilities, access, security and poor infrastructure among others.

1.8 Operational Definition

Campaign – An Immunisation conducted within a specific time frame, in specified areas to improve immunity; also called Supplementary Immunisation activities

Caregiver - Anybody taking care and making decisions for a child (one caregiver per household regardless of number of children in the household)

Community - People living in the same geographical area sharing some religious, cultural, or social characteristics.

Elimination – Complete and permanent reduction of diseases to zero through deliberate efforts

Eradication – Reduction to zero of new disease cases in a defined geographical area

Morbidity – The frequency at which a disease appears in a population

Mortality – Measure of number of death due to a particular cause

Routine Immunisation – A sustainable, reliable and timely interaction between the vaccine, those who deliver it and those who receive it to ensure every person is fully

immunised against vaccine-preventable diseases; always scheduled by age of recipient; schedule developed by government

Vaccine – Biological agents intended to stimulate immunity; administered through oral drops or injection

Vaccine Preventable Diseases – These are disease that can be prevented through Immunisation. They include Hepatitis B prevented by BCG vaccine; Poliomyelitis prevented by Polio Vaccine; Diphtheria, Tetanus and Pertussis (whooping cough) prevented by DPT vaccine; Measles, Mumps and Rubella prevented by MMR vaccine; Pneumococcal infections prevented by Pneumococcal vaccine; and Rotavirus prevented by Rotavirus vaccine.

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

This chapter has three sections. The first section will give an overview of health, focusing on child health and narrowing down to Immunisation. The second section highlights activities in the 2016 and 2017 Routine Immunisation communication plan, determine existing communication gaps and describe communication components that need to be addressed. This section will also look at relevant theories for this study and develop a conceptual framework to highlight the relationship between the different variables.

2.1 Health

When addressing the health of a nation, scientists look at happenings within and outside its borders. Laurela (2011) states that global health focuses on health issues among population, with and outside a nation's border. Further, he argues that it seeks to reduce disparities, improve population health and protect populations. Porous borders have been a health issue in countries that are faced with health emergencies (MOH, 2016). This is further seen to not only put the population at risk of communicable disease, but also risk disease outbreaks.

Disease burden has been documented as one of the major problems in Africa especially in countries with low GDP. Tamara et al. (2013) observed that compared to other regions, disease burden is very high in Africa. Due to this, many organisations including governmental, non-governmental, public and private organisations have invested

resources to lessen the burden. Different players have invested in supplies and commodities to ensure that populations have access to proper medical care in the correct quality and quantity.

2.1.1 Child Health

Although under-five mortality rate in Kenya had dropped significantly from 74 deaths per one 1000 live births in 2008 (KDHS, 2008) to 52 deaths per 1000 live births in 2014 (KDHS 2014), 1 in every 26 children die before reaching age 1; and one in every 19 do not survive to their fifth birthday (KDHS, 2014).

In child health, the world is shifting from provision of curative services to provision and promotion of preventative measures. Kirati et al. (2017) further note that focus is shifting from treating diseases to protecting populations, looking at the economic burden that diseases have on a nation. Immunisation has been documented in many studies as one of the most effective disease prevention mechanisms. Rohan et al. (2012) noted that weighing between Immunisation and morbidity and mortality prevention has been instrumental in selecting intervention to undertake.

2.1.2 Immunisation

Tamara et al. (2013) note that global health targets eradicating diseases through Immunisation and other preventive interventions. Diseases affect a nation's productivity negatively in various ways. To safeguard the populations, Immunisation has been documented as the most effective life-saving mechanism, especially among children

under 5 years. Rohan et al. (2012) emphasised that Immunisation reduces disease burden and mortality, makes economic savings in terms of cost of treating compared to cost of preventing (Immunisation), increases productivity among immunised populations, decreases incidences of disability associated with vaccine preventable diseases, improves and increases school attendance, reduces risks of disease outbreaks and increases lifetime productivity. Understanding the difference Immunisation makes in development goals is key in establishing how Immunisation affects each country.

UNICEF (2016) notes that for Immunisation to be successful in any given country, different programme components come into play. Vaccines management (supply, storage and administration), resource allocation (financial and human) and demand generation (advocacy, communication and social mobilisation) have to be well coordinated and properly undertaken to ensure populations benefit from Immunisation.

2.2 Communication Activities Promoting Routine Immunisation

Allocation of budgets for Immunisation and other health programmes is instrumental and critical in making decisions in regards to supporting the Immunisation programme. Rohan et al. (2012) noted that governments and donors supporting low income countries have to choose between purchasing vaccines and investing in other preventive interventions. The disease burden and mortality rates also affect the support given to the Immunisation programme.

Sustainability of health programmes has been an issue for many years. Capacity and ownership by health workers and community contributes to poor sustainability of the programmes, strategies and activities, including communication activities. Tamara et al. (2013) note that diseases come back to bite nations whenever donors stop funding health programmes, including Immunisation programmes. This is because health workers and communities are not empowered enough to make use of gains made during implementation of the intervention mechanisms to reduce disease burden.

Communication affect health service delivery, specifically Immunisation coverage. Dianne (2007) argues that effective communication helps improve health indicators. Ineffective communication can lead to patients not engaging the health care provider, not adhering to medical advice, not coming back for follow up and review. Afiong et al. (2017) noted that most health care workers only talk of managing effects of Immunisation (such as fever) to the caregiver during an Immunisation session. Lack of proper or adequate information by the health worker to the caregiver affects the behaviors caregivers' exhibit in relation to Immunisation. Health workers should be equipped with job aids and information, education and communication materials that capture all aspects of Immunisation especially what is to be communicated to the caregiver during the Immunisation session. Afiong et al (2017) further stated that the reason why health workers were not communicating with caregivers on VPDs was because they too had limited knowledge on Immunisation.

2.3. Gaps Addressed by the Communication Activities

2.3.1 Overview

Many countries are adopting a strategic approach that calls for more engagement and participation with the general public. To align with these shifts, methods such as health education, social mobilisation and health communication are gaining prominence. Ames et al. (2017) suggest that communication is an integral part in community participation and healthcare delivery.

Health communication involves communicating issues to the public advocating for management of public health issues. Marijke et al. (2013) noted that previously, public health communications was a one way where health officials passed messages to audiences. With time, this has changed to a two way interaction, to give room for information to be discussed further by both the sender (health officials) and the receiver (the caregivers).

2.3.2 Communication gaps among Health teams (Supply side)

Quality of service delivery at the health facility was noted by Afiong et al. (2017) as a key contributor to low Immunisation coverage. Poor attitude and communication skills among health workers were among reasons why caregivers had low regard to Immunisation. This coupled with long waiting hours and long distances to reach health facilities made the situation even worse.

Communication affects health service delivery, specifically Immunisation coverage. Dianne (2007) affirms that effective communication helps improve health indicators. Ineffective communication can lead to patients not engaging the health care provider, not adhering to medical advice, not coming back for follow up and review. Lack of proper or adequate information by the health worker to the caregiver affects the behaviors caregivers' exhibit in relation to Immunisation. According to Afiong et al. (2017), most health care workers only talk of managing effects of Immunisation (such as fever) to the caregiver during an Immunisation session.

Health workers were instrumental in Immunisation campaigns, in not just administering vaccines but in educating and mobilising communities. However, they are not proactive in delivering information on Routine Immunisation (UNICEF, 2016). Further, the study showed that health workers are the most credible source of information, but do not give all the relevant information during an Immunisation session. Afiong et al. (2017) noted that the reason why health workers were not communicating with caregivers on VPDs was because they too had limited knowledge on Immunisation.

Sustainability of health programmes has been an issue for many years. Capacity of health workers and community contributes to poor sustainability of the programmes, strategies and activities, including communication activities. Tamara et al. (2013) argues that diseases come back to bite nations whenever donors stop funding health programmes, including Immunisation programmes. This is because health workers and communities

are not empowered enough to make use of gains made during implementation of the intervention mechanisms to reduce disease burden.

2.3.3 Communication Gaps at Community level (Demand Side)

Caregivers make decision on whether to vaccinate their children or not based on the information that they have. Ames et al. (2017) observed that one of major barriers to uptake of Immunisation services is lack of proper or adequate information on vaccine effectiveness and safety. Afiong et al. (2017) noted that poor knowledge on VPDs by caregivers contributed to low Immunisation coverage. Poor knowledge led to low confidence and trust among caregivers, which in turn increased resistance and hesitancy. UNICEF (2016) agreed with this by stating that the amount and detail of information received by caregivers by the health worker determines whether the caregiver will return or not.

Marijke et al. (2013) argued that one way communication affects uptake of Immunisation services. Lack of a platform for discussing Immunisation past just the benefits, has a negative impact on Immunisation coverage. Sanford (2001) suggests that health workers should provide information to caregivers every time a child gets vaccinated. Further, caregivers should be given a chance to ask questions to reduce misconceptions.

UNICEF (2017) showed that Immunisation coverage is dependent on vaccine availability, adequate allocation of resource, community engagement initiative and proper human capacity. Further, it notes that although the services are provided and all supplies available at the health facility, the parent needs to have the initiative to take the child to the facility. Health seeking behaviors, including uptake of Immunisation services is highly dependent on the caregiver initiative. Conflicting priorities can make a parent forget on the return dates for the next session. Afiong et al. (2017) noted that Parental attitude, lack of time or conflicting priorities limit caregivers from seeking Immunisation services. Diego et al. (2014) states that any challenge faced by the caregiver including lack of vaccination booklets or forgetting return date could be detrimental in improving Immunisation coverage. Lack of remembrance on the appointment dates therefore affects if the child will be brought back or not.

Caregivers need to know the benefits of Immunisation and risks of having a child not immunised. Ames et al. (2017) argues lack of information addressing concerns on benefits and harm of vaccination among caregivers was noted to contribute to low Immunisation coverage. Caregivers look for reassurance and convincing on why a particular behavior is important to not just them, but to the communities they live in. Diego et al. (2014) noted lack of motivation by caregivers to take children for Immunisation contributed to low Immunisation coverage. This was largely attributed to religious and cultural believes that also have a link to educational level of caregivers.

2.4 Specific Communication Components that need to be addressed

Communication is a key contributor to the success of any health programme including Immunisation. Ames et al. (2017) argued that improving communication helps improve vaccination outcomes. For a communication activity to be termed as effective, it is key to look at the outcome after the implementation of the activities. Rafael (2012) argues that desired behavioral change should be noted during the evaluation, for a campaign to be termed effective. Based on the challenges noted, at both health facility and community level, communication activities should be implemented to address them.

2.4.1 Advocacy

Advocacy aims at mobilising key stakeholders who have an influence on the programme. Rafael (2012) emphasised that advocacy will mobilise stakeholders especially policy makers to support health programmes including Immunisation as it is persuasive and aims at changing attitudes and actions, with the aim of getting funding, favorable regulations and legislations.

Stakeholders characteristics and needs vary from each other. Stakeholders of the Immunisation programme include governments (local and central), communities, health programme players, and media among others. Ames et al. (2017) noted that understanding stakeholders (parents, communities and health workers) perspective is important in guiding communicators design an effective communication strategy and ensure parents are adequately informed. According to Kirati et al. (2017), both public and private sector play an active role in promoting a given health seeking behavior.

Rohan et al. (2012) noted that stakeholder's engagement is key in advancing Immunisation agenda among low income countries. This can be achieved through understanding information stakeholders need, and using this to guide on how to engage them. Once a communicator understands the stakeholders, it guides on how to engage each to achieve results for the programme. Effective communication with stakeholders (including health, finance and external donors) is key in promoting Immunisation agenda. Participatory communication gives an opportunity for the different players involved to exchange information and understand their respective viewpoints. Given that participatory communication is interactive, it provides a platform for different stakeholders to share and exchange their views. Thomas et al. (2009) suggest that for participatory communication to succeed, free and open dialogue must be present, must give room for the views of the marginalised, must be action oriented and empower communities to take up a new initiative.

2.4.2 Behavior Change Communication

Effective communication on the first encounter helps establish good relationships between patient and health care worker and this in turn reassures the patient. Dianne (2007) notes that for communication to be effective between the health care provider and the patient, it should be right from the beginning at the first encounter. Ames et al. (2017) add that proper communication between healthcare workers and caregivers contribute towards improving Immunisation coverage, particularly in low and middle income countries.

It is important for the communicator to understand the prevailing attitudes among the sender and the receiver and the environment in which the message is to be delivered. Afiong et al. (2017) noted that communication in Immunisation goes beyond delivering a message. Kirati et al. (2017) argue that the sender, message, channel and receive determines the success of health communication. To ensure all the audiences are captured well and effectively, Dianne (2007) argues that each audience should have their own tailored messages to match their characteristics and needs.

Lack of adequate information on Immunisation affects uptake of Immunisation services. Sanford (2001) noted that people seeking Immunisation aim at preventing the disease but only after knowing the benefits and risks of each vaccine given. Information answering caregivers' questions and focusing on benefits should be developed and delivered in the most appropriate channel to ensure awareness is created and the translated to action.

Health worker attitudes affect communication. Poor or lack of communication skills by the health worker affects how caregivers perceive the Immunisation programme. Communication skills can be learned. Dianne (2007) argues that training healthcare workers on effective communication assists them on how to ask questions, how to listen to patients and how to respond effectively. All these are part of the communication process. Dianne (2007) also notes that Interpersonal communication involves communicating with others, done orally or written. Intrapersonal communication on the other hand involves self-reflection and evaluation. Effective interpersonal communication

between health care worker and caregiver should be able to guide the intrapersonal communication by the caregiver.

Health workers play a critical role in building and maintaining public trust. The way health workers and other service delivery personnel communicate to caregivers determine the uptake, continuity and completion of Immunisation services. Afiong et al. (2017) noted that when treated with impolite behavior by health workers, caregivers stayed away from facilities denying a chance for children to complete their Immunisation schedule. Poor interpersonal communication skills among health workers was noted as a key hindrance to completion of Immunisation schedule by caregivers. A friendly environment was noted as an incentive to women bringing their children back to the facility on the stipulated dates.

2.4.3 Community Led Social Change

Communities are the key stakeholder in the Immunisation programme. This is because the children targeted are part of the community. Kirati et al. (2017) emphasised that successful health education involves educating the community, communicating relevant information and promoting desired behavior. Ames et al. (2017) also argued that when undertaking communication in Immunisation, it is important to provide information to parents in their setting, reassuring them of vaccine safety and highlighting potential side effects.

Different communities have different beliefs and attitudes towards the Immunisation programme. As noted by Laura and Lisa (2011), social and familial networks are a key determinant of uptake of health seeking behaviors in Africa and the world in general. For an initiative or programme to succeed, it is important to understand the community dynamics and structure. Kirati et al. (2017) also noted the importance of community leaders and public health volunteers in persuading communities to adopt healthy seeking behaviors. Given that communicators cannot engage every single member of the community, opinion leaders becomes instrumental.

Different communities ascribe to different cultural and religious beliefs. Afiong et al. (2017) argued that people respected religious and traditional leaders and thus believed what they said on different topics including Immunisation. These groups of people are instrumental in advocating for Immunisation in communities. Diego et al. (2014) noted that education is correlated to religious and cultural beliefs and should be put into consideration when designing a communication strategy to promote Immunisation. Africa is largely patriarchal thus males make decisions on all issues including health issues. UNICEF (2016) adds that involvement of men was also noted as a factor that determines uptake of Immunisation services.

Catherine et al. (2017) argued that vaccination safety scares have a potential to interfere with public confidence on Immunisation. Participatory communication provides a platform where information can be shared and reassurance done especially in communities that have concerns on vaccine safety. David et al. (2011) noted that

effective communication would highlight characteristics of the new intervention, address community questions and concerns and build trust around Immunisation. It fosters a conducive environment to conduct Immunisation. Afiong et al. (2017) emphasised that effective communication with parents is critical in overcoming barriers of Immunisation, handling vaccine hesitancy and improving coverage.

Communication in Immunisation involves dialogue between the health workers and communities. Diego et al. (2014) argued that Immunisation is a shared responsibility between health workers and caregivers, with caregivers taking the active role of availing children to the health facility. Caregiver beliefs, attitudes and practices however affect the uptake of Immunisation services. Marijke et al. (2013) emphasised that interactive communication gives communities a chance to not only share their views and opinions, but also inform health workers on how to communicate to them and aid in processing information given and received.

Countries should plan communication activities that increase demand among caregivers. Diego et al. (2014) argue that for Immunisation coverage to improve, public perception on VDPs and importance of Immunisation should be addressed. They further argued that creating messages that appeal to the emotions of caregivers, emphasising on dangers of VDPs and addressing misconception of Immunisation is instrumental in improving Immunisation coverage.

2.4.4 Social Mobilisation

Social mobilisation entails mobilising communities to be active participants in promoting Immunisation at the community level. To achieve universal Immunisation coverage, it is important to provide services, avail information and emphasise on benefits of Immunisation at the community level. Sahu et al. (2009) observed that availability of information, education and communication activities (IEC) at the facility level are key determinants of Immunisation coverage.

For effective health communication, a media mix should be undertaken. This entails undertaking different communication activities to complement each other helping achieve results effectively and efficiently. According to Marijke et al. (2013), mass media plays a key role in shaping perceptions of communities. Traditional and new media can help deliver tailored messages to a wide and diverse audience. Diego et al. (2014) also suggest that communication activities should be undertaken to promote Immunisation include media (radio and television), educational sessions, and printed information, education and communication materials including banners and posters and interpersonal communication between health workers and caregivers. According to Kirati et al. (2017), for health communication to be successful, it is important to combine a variety of activities including ‘community media (folk media, local radio, local mass media, wire broadcasting and bulletin boards), specialised media (pamphlets, posters, clothes, stickers), personal media (public health officers, local administrative officers, peer educators, public health volunteers, and community leaders), Activity media (a project or

an activity that is related to health communication), social media (websites, search engines such as; Facebook, Line, YouTube).

Audience segmentation ensures communicators develop audience specific messages, putting into consideration audience needs and characteristics. Laura and Lisa (2011) note that different people interpret health problems differently, based on their social and cultural settings. Health messages can be complex for people with no health background to understand. Kirati et al. (2017) argued that simplification of messages, promotes understanding of complex health messages and ideas. Simplification helps break down complex messages to simple messages that the audience can understand in their context and based on their level of understanding.

Forgetting on return dates and on the Immunisation schedule is a major hindrance in children completing their stipulated schedules on time. It is important to create recall among caregivers on not only the benefits but on when children should receive the different vaccines. Diego et al. (2014) argue that a successful communication campaign should be informed, purposeful and repeated. It should motivate caregivers to seek continued vaccination services for children. Frequency of message determines recall among caregivers. Afiong et al. (2017) affirmed that most caregivers wanted to be reminded on benefits of Immunisation, not just during the campaign periods but also during non- campaign periods. High recall led to reassurance and increased uptake of Immunisation services.

Caregivers are informed of Immunisation through visits to health facilities, media and public announcements. Afiong et al. (2017) noted that health workers are a credible source of vaccination information. However, they further note that although health workers were the highest source of information, they talked about other health programmes including nutrition, childcare and personal hygiene, but very minimal on Immunisation. Lack of information on VPDs by health workers limit the amount and depth of information shared with caregivers. Health workers should be trained on not just administering vaccines but also on crucial information to pass to caregivers.

Understanding audience needs and characteristics ensures that a communicator looks at how they communicate with each other in their setting. Dianne (2007) noted that communication is social as it involves interaction between different parties, helps in influencing opinions and perceptions and helps guide relationships. Language plays a key role as it is instrumental in ensuring that messages are passed in a way that can be understood by the receiver and the interaction is flawless. Afiong et al. (2017) note that, in rural areas, communication efforts were a success when information was provided in local languages and focus was made on mothers with newborn babies.

With the advent of new media, emails and SMS have been widely used to communicate different messages to different audiences. SMS in Africa is slowly picking up, with many private health facilities reminding caregivers of their upcoming appointments. Afiong et al. (2017) affirmed that most caregivers would prefer to be not only reminding of upcoming appointments but also get educational information on Immunisation through

SMS on their phones. This they argued was also a chance to escape negative attitude by health workers.

2.5 Theoretical Framework

The topic touches on describing communication activities that can be implemented to improve communication (awareness creation and demand creation) and ultimately improve Immunisation coverage. To better understand the dynamics, the research looked at theories that address at both supply side and demand side. The research therefore selected the Ecological Model and Theory of Reasoned Action.

2.5.1 Ecological Model of Communication

The model argues that decision making is influenced by different players occupying different spheres in people's lives. According to the social – ecological model, the views of individuals are affected by individuals and relational processes that are interconnected. The model seeks to understand how individuals interact with their environment, which determines behavior. It argues that it is important to understand social norms when planning and implementing communication activities. The hierarchical layers of social ecological model are individual, Interpersonal (formal and informal social networks), community (relationships within defined boundaries), organisation (social institutions) and policy (laws).

In this study, the theory is important from both the supplier side and the demand side. Individual, Interpersonal, Community and policies affect uptake of health seeking behaviors, including Immunisation. Individual circles including the community, social norms, and social cultural characteristics affect how one perceives a message or behavior. Understanding how these layers affect uptake of Immunisation services will help choose activities that will have a positive impact. When choosing communication activities, a communicator should understand the different spheres/spheres that affect the decision of the beneficiary. This model is relevant to this topic as the study looks at how this spheres affect the communication activities undertaken and the decision making process of caregivers.

2.5.2 Theory of Reasoned Action (TRA)

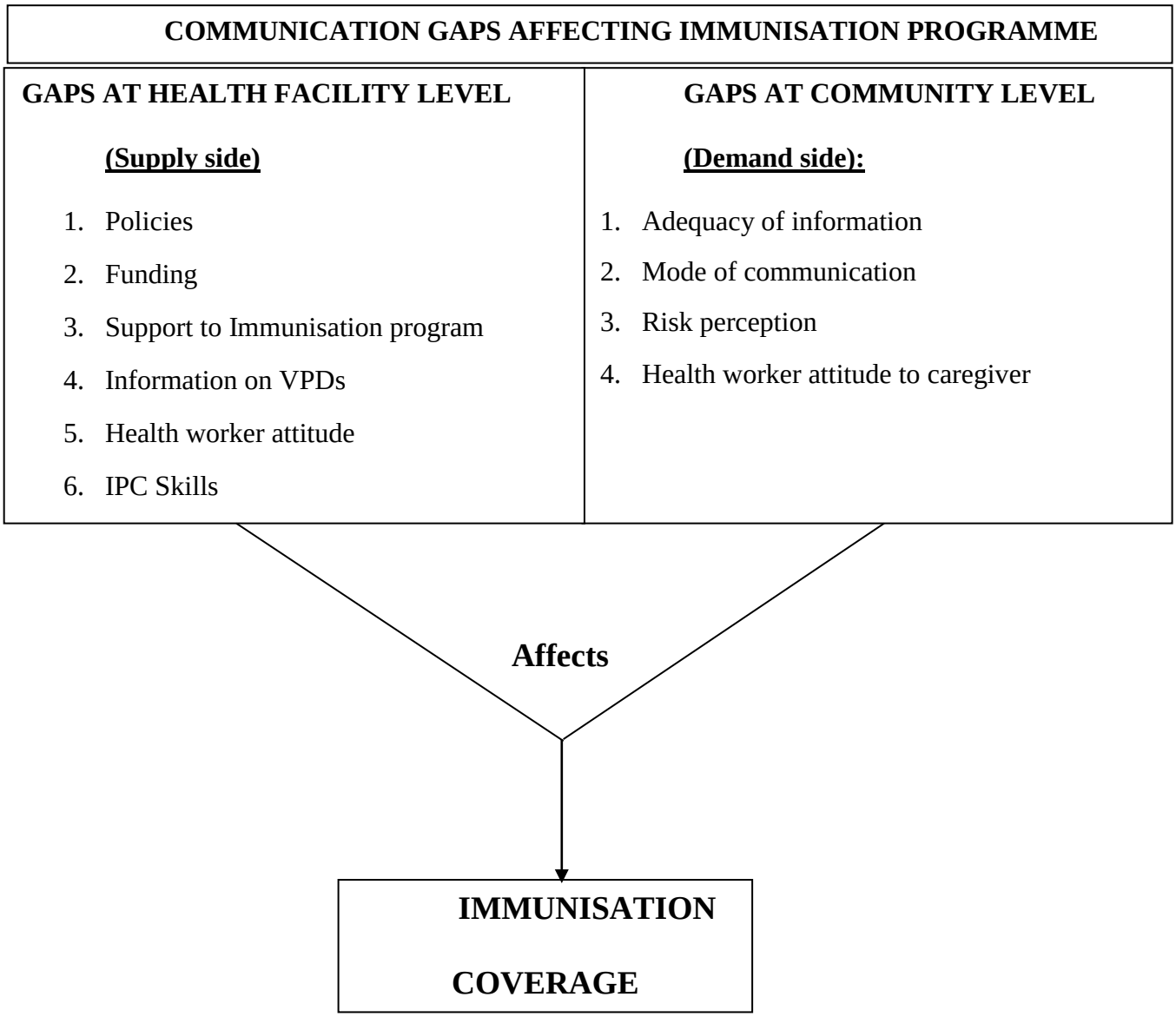
The theory of reasoned action predicts someone's health behavior based on existing attitudes and beliefs. It was developed in 1967 by Martin Fishbein and Icek Ajzen. They argued that someone's behavior is determined by two main components- their attitude and the existing norms. The attitudes and norms are socially acquired and they motivate individuals to perform certain behaviors.

In this study, the theory is applicable in understanding what motivates uptake of Immunisation services by caregivers. From the literature review, attitudes by both caregivers and health workers affected Immunisation programme negatively. Also, the community structures, practices and norms determined the uptake of the services by the caregivers. The theory helps understand why communication activities done are

performing poorly, why the caregivers uptake of Immunisation remains low despite the communication efforts and why both the health worker and the caregivers behave the way they do to contribute to the Immunisation programme.

The theory has been used to understand health seeking behaviors specifically what theories predict condom use; understanding sexual behavior among teenage girls; understanding behavior of pediatricians towards Human Papillomavirus (HPV) vaccine; and understanding people's behavior towards reducing obesity. Understanding the prevailing attitudes, practices, knowledge and beliefs, from both the caregiver and the health worker, will guide on identifying the most effective and efficient communication activities to undertake to increase uptake.

2.6 Conceptual Framework



CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Overview

This chapter presents the methodology used in the collection and analysis of data. Specifically, this chapter consists of site description, research design, the target population, sample size and sampling technique, data collection tools and techniques, validity and reliability, data analysis and research ethics.

3.1 Site Description

The study was undertaken in four constituencies of Nairobi County namely; Langata, Mathare, Embakasi East and Makadara. Embakasi East and Langata are considered as low density and moderately middle to high income estates compared to Makadara and Mathare estates.

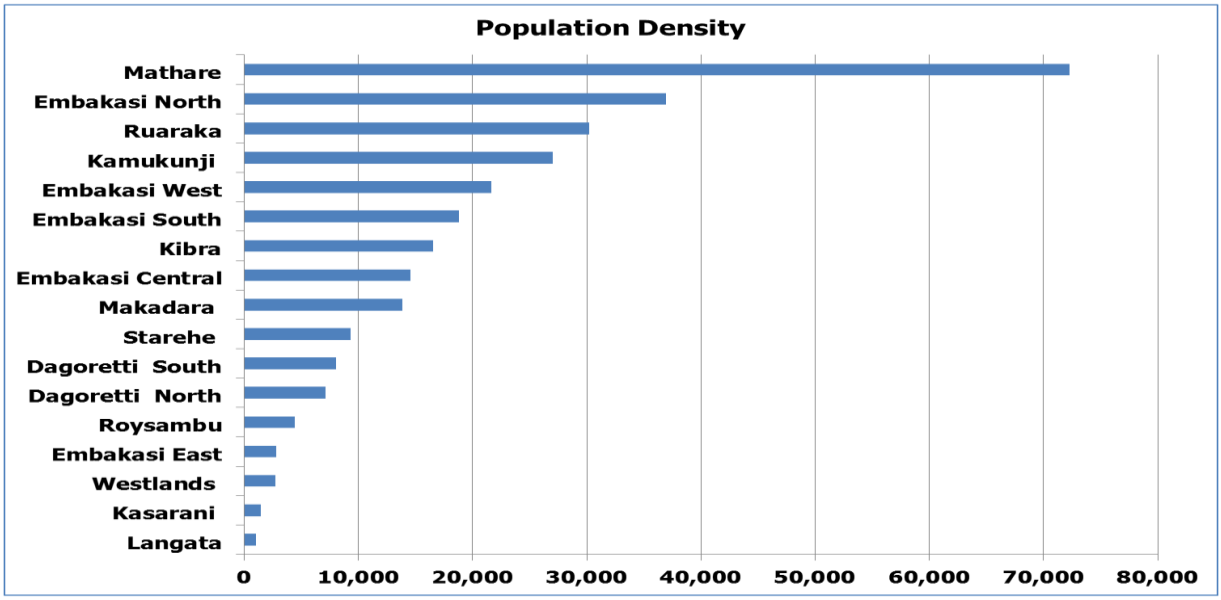


Figure 3.1: Nairobi County's Population density by constituency

Source: Kenya National Bureau of Statistics (2010)

Of the four constituencies, Mathare is the one considered to be highly populated and with some residential areas therein being considered as unplanned.

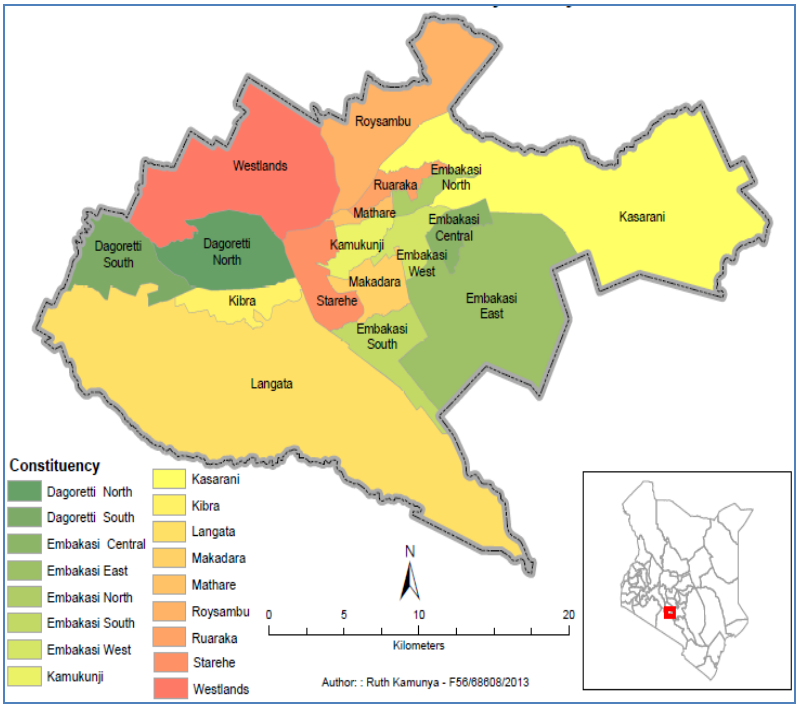


Figure 3.2: Map of Nairobi County showing different constituencies.

Source: Kenya National Bureau of Statistics (2010)

3.2 Research Design

This research study adopted a descriptive research design. Descriptive research involves obtaining information about a current status of a phenomenon in order to describe 'what exists' in relation to conditions and variables in a situation (Bryman 2003). This design was selected as it provides room for feasible evaluation of the results. Further, it gives an in-depth and comprehensive exploration required in research studies. The study involved in-depth analysis and examination of the different communication activities undertaken to

promote routine Immunisation, determine existing communication gaps and describe specific components of communication needs that need to be addressed in the Immunisation programme.

3.3 Research Approach

The research is a descriptive research. The research adopted a mixed research method (both qualitative and quantitative). Creswell (2006) argued that mixed methods collects and analyses both qualitative data. A combination of the two is instrumental in addressing challenges faced by using only one method.

3.4 Data Collection Tools and Techniques

This study made use of primary data. According to Greener (2008), primary data is the data collected directly from first-hand occurrence which has not been exposed to processing or any other handling. Patten (2004) contends that primary data can be collected by means of qualitative data collection instruments (interview guide) and quantitative data collection instruments (questionnaires). The study employed both qualitative data collection instruments (interview guides) and quantitative data collection instruments (questionnaires).

3.4.1 Key Interview Guides

The study used a key informant interview guide (see appendix 1). A key informant interview guide is a qualitative in-depth interview with people who understand what is going on in a community in relation to the objective of a research study (Kathleen and

Lapan 2004). The main aim of a key informant interview is to obtain information from a wide range of individuals in a community, including professionals, who have first-hand information on a community and its activities. In this research study, key informant interviewees included community health personnel, health promotion teams and NGOs.

3.4.2 Questionnaires

This study made use of semi structured questionnaires to collect quantitative data (see appendix 2). The questionnaires comprised both closed-ended and open-ended questions so as to enable the respondents to express their views without being affected by the researcher. Kothari (2004) indicated that a questionnaire is a cost efficient method to collecting information particularly from a huge group of respondents. It also facilitates anonymity. Questionnaires were utilised in this research for anonymity as some of the information needed is sensitive relating to each family livelihood. In addition, questionnaires were utilised in this study because they are extremely economical on the basis of time, energy and finances.

3.5 Unit of Analysis

Unit of analysis refers to the major entity that will be analysed in a study. In this research study the unit of analysis was selected households in four constituencies in Nairobi County. These are households with children aged below five (5) years.

3.6 Target Population

The population of the study area is estimated to be 1,237,687 people distributed as follows (Table 3.0)

Table 3.1: Demography in the study area

Constituency	Total Population	No of Households	Density (pop/km2)
Makadara	218,641	31,234	9,484.69
Langata	355,188	44,398	1,591.63
Embakasi East	163,858	33,717	4,551.6
Mathare	500,000	62,500	18,537
Total	1,237,687	171,849	Average=8,541.23

Source: Modified from Kenya National Bureau of Statistics (2010)

There are 171,849 households in all the four constituencies with the largest constituency consisting of 62,500 households. The population of this study was all the 171,849 household heads or caregivers drawn from the four constituencies.

3.7 Sample Size

Sample size must be large enough to be representative of the universe population. Kothari (2004) stresses that sample size chosen by the researcher should be capable of giving enough information about the population and one which can be analysed with ease. The sample size was determined using Slovin's Formula. This formula is used to calculate the sample size (n) given the population size (N) and a margin of error (e) (Creswell 2006). It is a random sampling technique formula to estimate sampling size. The formula was

selected as it puts into consideration the population size. The target population was estimated at 171,849 household heads or caregivers in the 4 constituencies.

$$n = \frac{N}{1 + NE^2}$$

Where:

n = no. of samples

N = total population

e = error margin / margin of error (0.05)

$$n = \frac{171849}{1 + \left(171849 * 0.05^2\right)}, n = 399$$

Therefore, the sample size for a survey in this study was 399 caregivers in households with children below five (5) years.

3.8 Sampling Technique

The key informants of the study were selected through purposive sampling. According to Kothari (2004) sample members are selected on the basis of their knowledge, relationships and expertise regarding a research subject. The study used stratified and purposive sampling to select 399 caregivers from the 171,849 households in the four constituencies. The main advantage of using stratified sampling is that it gives a representative sample. It involves the classification of a population into lesser sub-groups known as strata. These strata were developed on the basis of the members' shared characteristics or attributes. In this study, the strata was the estates or villages in each

area. After classification, proportionate stratification formula was used to allocate sample size in each of the strata. In proportionate stratification, a random sample from each stratum is taken in a number proportional to the stratum's size when compared to the population (Kathleen and Lapan 2004). These strata subsets are then pooled to form a random sample. The sample size in each of the strata was determined by use of the following formula;

$n_h = (N_h / N) * n$

where;

$n_h$is the sample size for stratum*h*,

$N_h$is the stratum*h* population size,

N is total population size,

and n is total sample size.

Using stratified sampling technique, a sample of 399 was distributed across the four constituencies as follows:

Table 3.2: Determination of sample size in each stratum

Constituency	No of Households	Proportion	Sample Size
Makadara	31,234	$\left(\frac{31234}{171849}\right) * 399$	73
Langata	44,398	$\left(\frac{44398}{171849}\right) * 399$	103
Embakasi East	33,717	$\left(\frac{33717}{171849}\right) * 399$	78
Mathare	62,500	$\left(\frac{62500}{171849}\right) * 399$	145
Total	171,849		399

Within each stratum, purposive sampling was employed such that only households with children below five (5) years were considered. These households were identified with the help of community health workers and volunteers.

Qualitative data was collected through key informant interviews involving snow balling among the implementers of Immunisation programme. Although sample size is not core to qualitative studies as compared to quantitative data, the study approximated that in order to involve a diversity of implementers, a total of 18 key informants were interviewed. The eighteen consisted of Health Promotion representatives from National (1), county (1) and sub county teams (4), Community health strategy focal persons from National (1), County (1) and sub county level (4), Health Facility representative (4) and Local (1) and international (1) NGO representatives.

3.9 Validity and Reliability

A pilot study was conducted to test the validity and reliability of the research instruments. This helped in identifying and rephrasing any ambiguous, misinterpreted or misunderstood questions. In addition, the pilot test facilitated the removal of typographical errors and determination of whether the questions asked were relevant and appropriate. The pilot group of 40 people was sampled randomly and equaled to 10% of the sample size.

According to Creswell (2006), validity is the degree to which results acquired from process of analysis of the data actually embodies the phenomenon under study. There are two types of validity: content validity and face validity. Face validity refers to probability

that a question is misinterpreted or misunderstood. According to Cooper and Schindler (2006) pre-testing is a proper way to increase the possibility of face validity. On the other hand, content validity, also referred to as logical *validity*, refers to the degree to which a measure depicts all facets of a given social construct. In this study, the content validity was improved by seeking the opinions of experts in the field of study, particularly the supervisors. Also, the face validity of the research instrument was improved by carrying out a pilot test and changing any unclear and ambiguous question.

3.10 Data Analysis

Data analysis process entails the process of packaging the collected data, putting it in order and structuring its major elements in a way that the results can be easily and efficiently communicated (Creswell 2006). The research instruments in this study generated both quantitative and qualitative data.

Quantitative data was analysed by use of both descriptive and inferential statistics with the help of statistical package for social sciences (SPSS). Preceding the analysis, a codebook for the different quantitative variables was prepared on the basis of the numbering structure of the questionnaires. All the questionnaires were numbered (per sub county) prior to data collection for easier referencing.

On the other hand, qualitative data was analysed by use of thematic analysis, a data analysis method used in analysing qualitative data. This method emphasises on pinpointing, examining, and recording patterns within data. Themes refer to patterns

across data sets that are important in the description of a phenomenon and are associated to a specific research question (Greener 2008).

3.11 Data Presentation

After confirming that all the quantitative data entered was accurate, descriptive statistics such as frequency distribution and percentages was used to analyse the quantitative data. Descriptive statistics help the researcher to significantly explain distribution of measurements and to also explain, organise and review data (Bryman 2003).

For qualitative data, thematic analysis was conducted in six phases, which included familiarisation with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report. The results were then presented in a prose (text) form.

3.12 Research Ethics

Ethical issues were put into consideration in this study to avoid the loss of credibility of the study. This included acknowledgement of all ideas that were borrowed from other authors in an effort to avoid plagiarism. A certificate of fieldwork (see appendix 3) was obtained from the University before proceeding for data collection. Also, only the household heads who were willing to take part in the study were given questionnaires to fill. Those who did not wish to take part in the study were not compelled to participate in any way. The respondents who participated in the study voluntarily were required to have an informed consent. Generally, this indicated that potential research respondents were fully aware of the procedures involved in the research. Thus, they gave their consent to

take part in the study. To this effect, all the respondents were fully aware of the intentions of the study and were given the assurance that it was entirely for academic purposes. All respondents were aged above 18 years. There was no question seeking Immunisation status of children in the household. Strict confidentiality was adhered to. In case the anonymity of a respondent was necessary, assurance was given to respondents on the integrity of their confidentiality. After the research, a plagiarism test was done and a Turnit report obtained (appendix 4) which was used to get the certificate of corrections (appendix 5) after corrections.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTEPRETATION

4.0 Overview

This chapter presents findings from the data collected on the communication activities promoting Routine Immunisation, existing communication gaps and describes communication components that need to be addressed. It also give a summary of the findings and interprets the findings.

4.1 Respondents Demographics

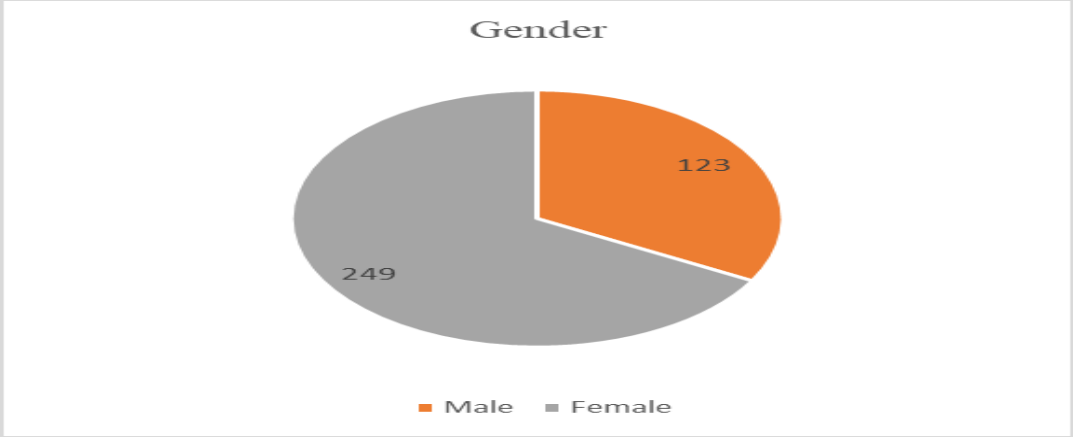
All 18 key informants participated in the research. Key informants were conducted with 1 National Health Promotion Officer, 1 county health promotion, 4 sub county Health promotion officers, 1 National community health representative, 1 county Community health strategy focal person, 4 sub county community health workers, 4 health facility staff and 2 Non – governmental organisation representatives. The research targeted 399 respondents; however response rate was 92% with 372 respondents.

Table 4.1: Number of participants per subcounty

Sub County	**Makadara**	**Langata**	**Embakasi**	**Mathare**	**Total**
Target	73	103	78	145	399
Actual	70	98	77	127	372

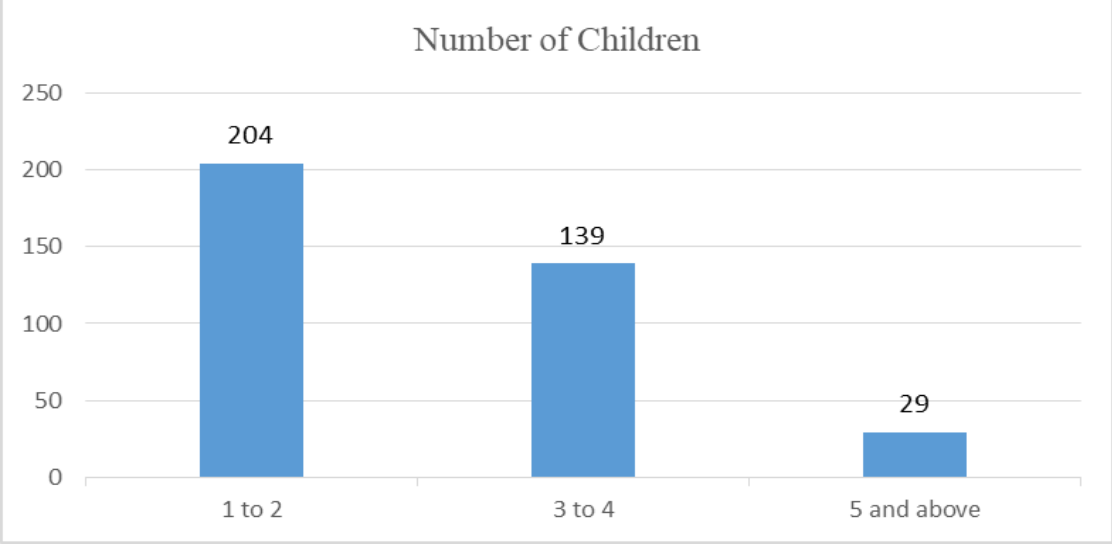
Out of the 372 respondents interviewed, 249 (67%) were females and 123 (33%) were males.

Figure 4.1: Gender of Respondents



Of the 372 respondents, 84 were aged between 18 – 25 years, 178 were between 26 to 40 years and 110 were a[-[bove 40 years. Given that respondents had to be caregivers, out of the 372, 204 had 1 or 2 children, whereas 139 had 3 to 4 children and 29 had 5 and above.

Figure 4.2: Number of children per household

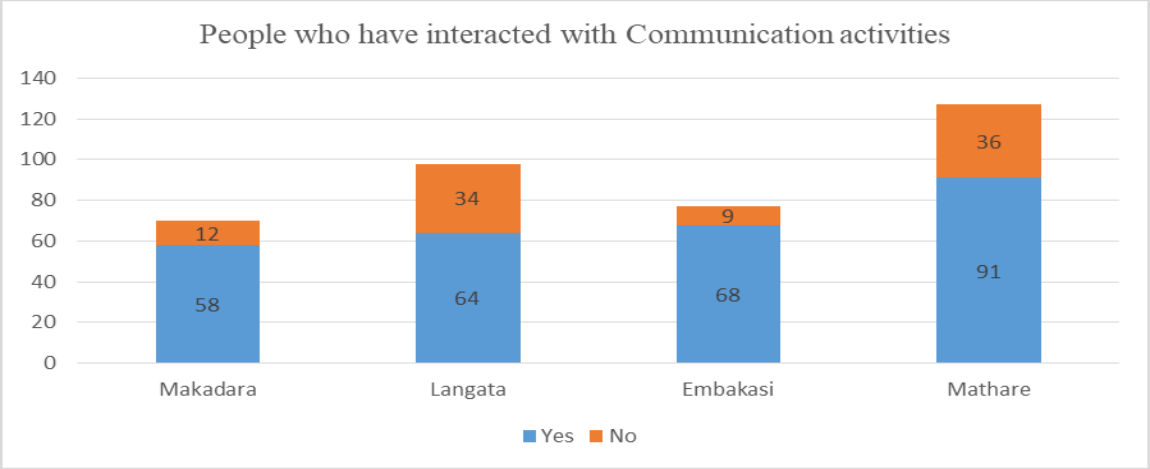


4.2 Communication activities used to promote Immunisation

Communication activities are planned by the government and other health partners to benefit the populations of a country. The activities are implemented concurrently at the health facility and community level. Ames et al. (2017) argue that communication is an integral part of health programmes including Immunisation. Communication activities used should be able to address gaps encountered at health facility and community. Ministry of Health officials at the County level noted that activities are planned at the sub county level, to ensure the different needs of the population in the different areas are fully addressed. In both Langata and Mathare, Community health volunteers and public health talks in the facility were used to reach target populations. In Embakasi and Makadara, communication activities involved health talks in the health facilities and distribution of informational, educational and communication materials including fliers and posters. Community radio stations (for example Mtaani FM) was also mentioned as one of the stations that have health programmes targeting women and children health (including Immunisation).

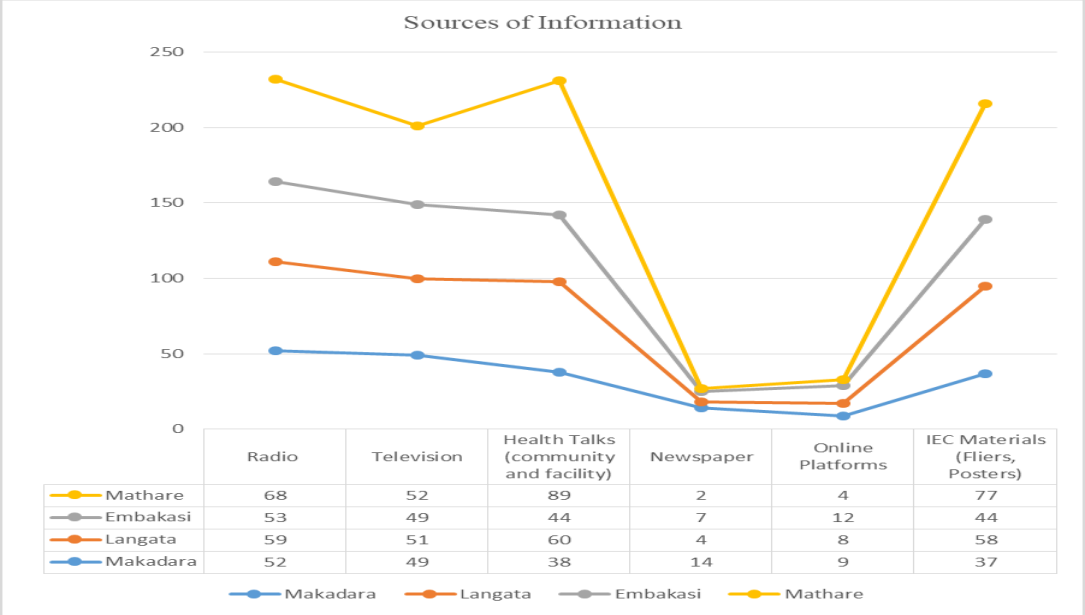
Of the 372 respondents, 76% confirmed they had interacted with a communication activity that aimed at promoting Immunisation, whereas 24% of the respondents had not interacted with any communication activities that were aimed at promoting Routine Immunisation.

Figure 4.3: Number of people who have interacted with communication activities



Activities identified included radio announcements, TV announcements, and health talks at public health facilities, information, education and communication materials including posters, fliers, banners, and pamphlets on Immunisation, health talks at facility and during household visits.

Figure 4.4: Source of Immunisation information



Eighty two percent (82%) of the respondents who acknowledged there were communication activities aimed at promoting Routine Immunisation, noted that the efforts were aimed at mobilising communities. These included the radio messages, TV announcements, health talks at the health facilities, informative materials like fliers and community radio stations. All the messages sent through the mentioned messages aimed at highlighting the importance of Immunisation, rallying caregivers to bring children to hospitals for vaccination and advocating for parents to ensure all children finish the Immunisation schedule.

From 372 respondents, 24% (89 respondents) were aware of communication activities that were aimed at health workers. The activities included provision of materials for use by health workers during health talks in hospitals and community health talks. The materials were previously not there and were provided in 2017. Also, the Community health workers have flip charts which they use during household visits, which show the Immunisation schedule and highlight importance of Immunisation.

When choosing the communication activities to undertake, the Ministry of Health (National, county and sub county levels) aimed at increasing awareness of importance of Immunisation, reducing risk perception among caregivers and increasing the proportion of fully immunised children in Kenya. Local and international partners both highlighted their role of promoting child wellbeing especially health, and thus their support for the Immunisation programme. One of the key informants is quoted saying “a healthy child can fully participate in life activities including education. Every development programme

aims at dealing with healthy people. Vaccine preventable diseases slows productivity, not just among children but also caregivers". The community health officials also noted the importance of involving community members in health programmes to promote ownership and ensure sustainability of the agenda at hand. Health worker attitude was also noted as one of the reasons why the Ministry is investing in training health workers on good interpersonal communication skills.

Respondents from the community level noted that communication activities were undertaken to ensure vaccine preventable diseases like polio and measles are eradicated from the country. Some also noted that deaths of children is a burden to not just the family but also to the community and should be prevented at all costs. At the facility level, respondents felt that the flip charts and posters were aimed at ensuring the health worker has enough and accurate information to share with them when they went to the facility or came to the community. This was in line with Ames et al. (2017) who argued that lack of information addressing concerns on benefits and harm of vaccination contributed to low Immunisation coverage.

4.3 Existing Communication Gaps identified

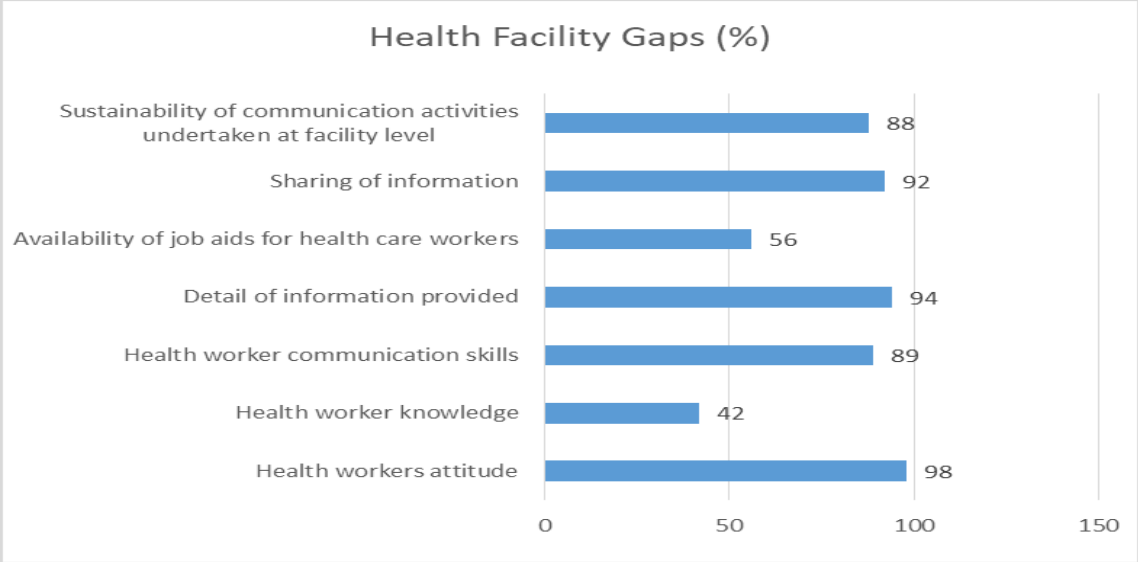
4.3.1 Communication Gaps at the health facility level

Communication affects service delivery and uptake of health seeking behaviors including Immunisation. Ninety eight percent (98%) of the respondents cited negative attitude among health workers as the biggest gap that needs to be addressed at the health facility level. Both national and county health promotion teams noted that negative attitude has

impacted negatively on uptake of Immunisation programme by caregivers. One respondent said:

> "When the nurse treats you negative, you will not come back again. Because it is difficult going to a place you don't feel wanted. They sometime even abuse you. Sometimes they don't answer when you ask a question. They treat you like a bother".

Figure 4.5: Existing communication gaps at facility level



One of the key informants noted that investments have been made on improving health worker skills to ensure children get the right service at the right time. 'Investing in health workforce is also key in achieving Immunisation global targets set, which Kenya has struggled to achieve'. This agrees with UNICEF (2016) that noted that health workers need to be equipped with proper skills on not just administering the vaccine but in

educating and mobilising communities. Poor skills among health workers affect delivery of health services.

Community health workers agreed that health worker attitude has been a deterrent for most caregivers as they opt to not go to the facility when treated negatively. Attitude also came out clearly at the health promotion officials and NGO representative discussion who noted that a lot of investment has been made to improve the attitude of health workers. Reason for the attitude was cited as heavy workload among the health workers and low motivation. This agrees with Afiong et al. (2017) who add that quality of services at the health facility, including attitude of health workers, is a key determinant of uptake of Immunisation services. Right and pleasant attitude creates trust among caregivers and health workers promoting health seeking behaviors.

Ninety four percent (94%) of the respondents identified detail of information provided whereas 92% cited sharing of information by health workers as some of the gaps existing at the health facility level. Sub county health promotion officials noted that health workers are not provided with on job training and job aids that are instrumental in increasing their knowledge of Immunisation programme. Forty two percent (42%) of the respondents viewed health worker knowledge as a gap. Most of the respondents acknowledged that the health workers knew and understood the Immunisation programme but were not willing to pass the information to the caregivers. This agrees with Afiong et al. (2017) who noted that lack of proper or adequate information by the health worker to the caregiver affects the behavior caregiver's exhibit in relation to

Immunisation. When limited information is passed to caregivers, risk perception is usually low and in most cases leads to more questions from the caregiver.

Key informants argued that Ministry of Health has a mandate to equip health workers at the facility level with skills and materials that will ensure smooth service delivery. However, limited funding has hindered these efforts, with the government focusing more on supplies (vaccines and syringes). Development partners have come onboard to support the Immunisation programmes. However, their support comes in when there is a campaign and stops as soon as the campaign ends. With these, sustainability of communication activities has been a challenge. A key informant said:

> "Community engagement needs a lot of financial resources. A lot of community engagement is done during campaigns. Once the campaign ends, the engagement ends with it. This has to wait until the next campaign. And this might take even 5 months".

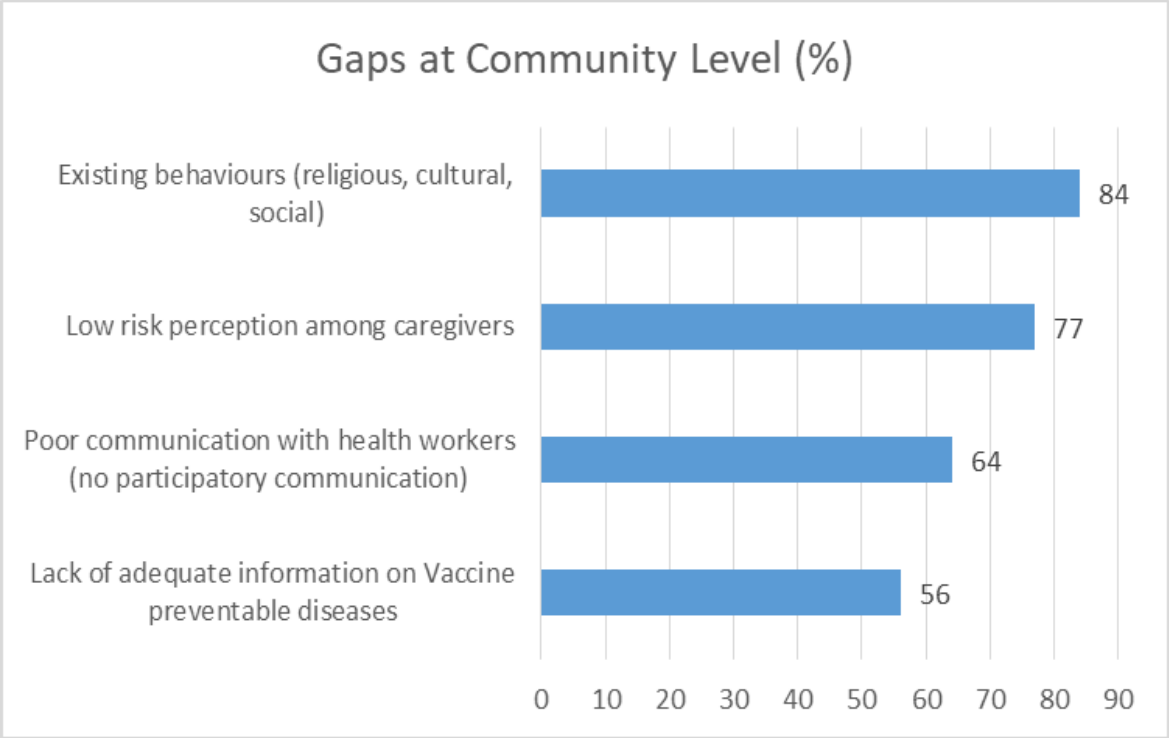
This agrees with Tamara et al. (2013) who argue that diseases come back to bite nations whenever donors stop funding health programmes including Immunisation. They argue that sustainability promotes ownership among communities ensuring people (both health workers and communities) go on with activities after donors pull out.

4.3.2 Communication Gaps at the Community level

Existing knowledge, attitudes and behaviors have a direct impact on uptake of health seeking behaviors including Immunisation. Eighty four percent (84%) of the respondents

felt that existing behaviors among caregivers was a major challenge in taking up Immunisation services. This included the social, cultural and religious beliefs.

Figure 4.6: Existing communication gaps at community level



Religious beliefs have been a hindrance to the Immunisation programme according to the health officials. This is not unique to Nairobi only, but across Kenya and Africa. The Ministry has invested in mapping the special groups with unique behaviors and beliefs, and developed contextualised communication activities to address the populations. One of the sub county health promotion officer said:

> In Nairobi, Dini ya Yesu leaders are part of the sub county key stakeholders meetings, as they have a large following. They do not believe in modern medication and the Ministry is trying as much to bring the sect members on board

Cultural beliefs also affected uptake of Immunisation services. This includes male involvement, cultures around handling of young children and decision making in households. This agrees with Afiong et al. (2017) who note that parental attitudes, based on prevailing knowledge, practices and behaviors affect uptake of Immunisation services. They also note that religious and traditional leaders determine health seeking behaviors among the people. This is in line with Sanford (2001) who notes that health workers should provide caregivers with correct and adequate information to ensure all children get vaccinated.

Low risk perceptions signify communities do not give Immunisation the seriousness it deserves. 77% acknowledged there was low risk perception among caregivers. Low risk perception included not knowing the risk posed by unimmunised children. MOH officials both at national and sub-county levels said that messages delivered to caregivers fail to include the seriousness of children not getting immunised. The national health promotion officer is quoted saying:

> The perception among caregivers is not as serious as it should. Other than Polio, parents do not know there are other diseases, if not prevented, that can cause serious and permanent defects, including blindness, deafness, paralysis and even death among others.

The Ministry of Health has invested in community health volunteers who promote and sensitise people at the community level of vaccine preventable diseases and Immunisation. Limited funding has also affected sustainability of engagement of the CHVs because the CHVs need job aids and monthly stipends. To make use of the

available CHVs, the sub counties have integrated Immunisation with other health programmes that already have funding.

4.4 Specific Components of Communication to be addressed

4.4.1 Advocacy

The Immunisation programme has stakeholders both at national and county level. Key informant interviews noted that there are financial partners, health partners and implementing partners. Financial partners normally offer financial support to the programme. This includes local and international governmental and non-governmental organisations. Health partners offer technical support to the programme both at the national and county level. In Kenya, these include CHAI, PATH and KANCO. Implementing partners assist in planning, implementing and monitoring of activities that support the Immunisation programme. These include Red Cross and Afya Mama. Some partners cut across all three roles.

Sub county level is responsible for identifying and engaging stakeholders at the community level. For all sub counties, key informants shared that religious groups, local administration, and heads of 'nyumba kumi', teachers and women groups were involved. These groups are mainly involved in mobilising caregivers to ensure children are fully immunised. The biggest challenge faced in engaging stakeholders is lack of financial capacity to continuously engage the stakeholders. Also, Immunisation is a technical field that involves a lot of jargons and some community stakeholders might not understand the details involved.

Majority of the respondents noted that engagement of religious leaders as key stakeholders is needed to achieve support for the Immunisation programme. In the informal settlement, involvement of *nyumba kumi* leaders (village elders) was noted as instrumental because they know all the residents in their respective areas. Community leaders, women group leaders, youth groups and business groups were mentioned as stakeholders who had potential to promote Immunisation among the caregivers. They were also noted as key in identifying children whose parents do not take them for Immunisation.

The findings agree with Rafael (2012) who argues that advocacy is important in mobilising key stakeholders especially policy makers to change their attitude and actions and engage them more in promoting health programmes. Also, Kirati et al. (2017) argues that involvement of both private and public sector is instrumental in promoting health seeking behaviors including Immunisation.

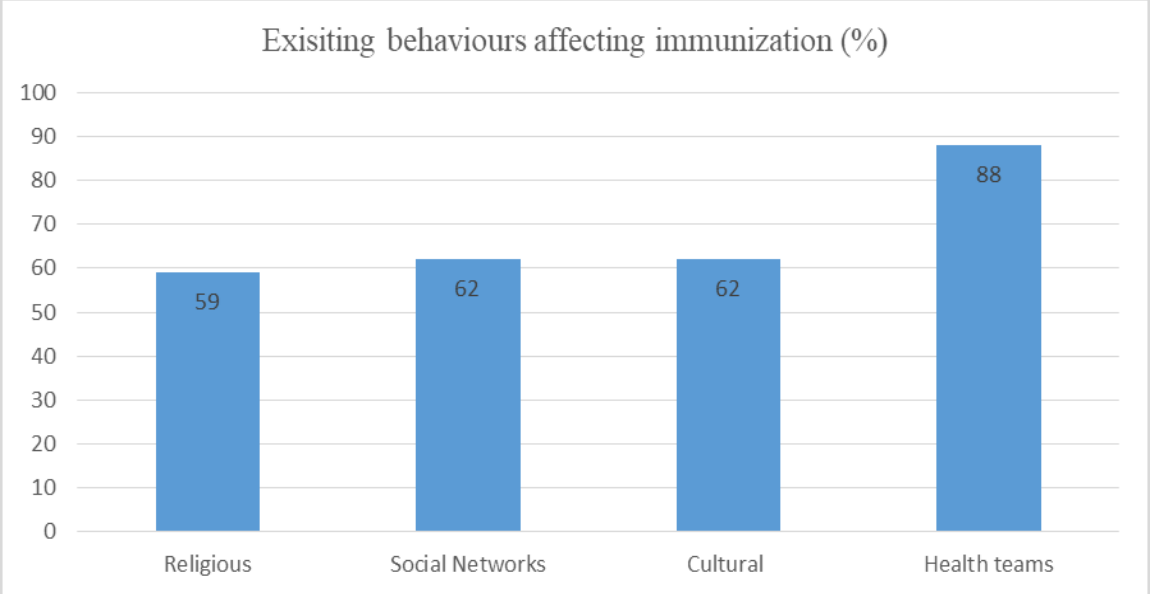
4.4.2 Behavior Change Communication

Existing knowledge, attitudes, behaviors and perceptions affects uptake of Immunisation services by caregivers. Key informants noted that Nairobi has different people from different backgrounds, making it hard to have one generic message or specific activities developed at the county level. However, sub counties have conducted an assessment to determine the existing knowledge, attitudes, behaviors and practices. Communication activities have been planned based on the findings. Key findings included different religious, cultural and social practices. Health workers attitudes and behaviors affect the

Immunisation programme. At the sub county level, health workers at the facility level continue to get on job training to build their capacity. At the community level, community health volunteers are recruited from the community to ensure Ministry enlists people who understand the community best.

Eighty eight percent (80 %) of the respondents noted that health workers behavior determined whether caregivers will come back for Immunisation programme or not. Cultural practices and social networks of the caregivers were also noted to affect uptake of Immunisation services both at 62%.

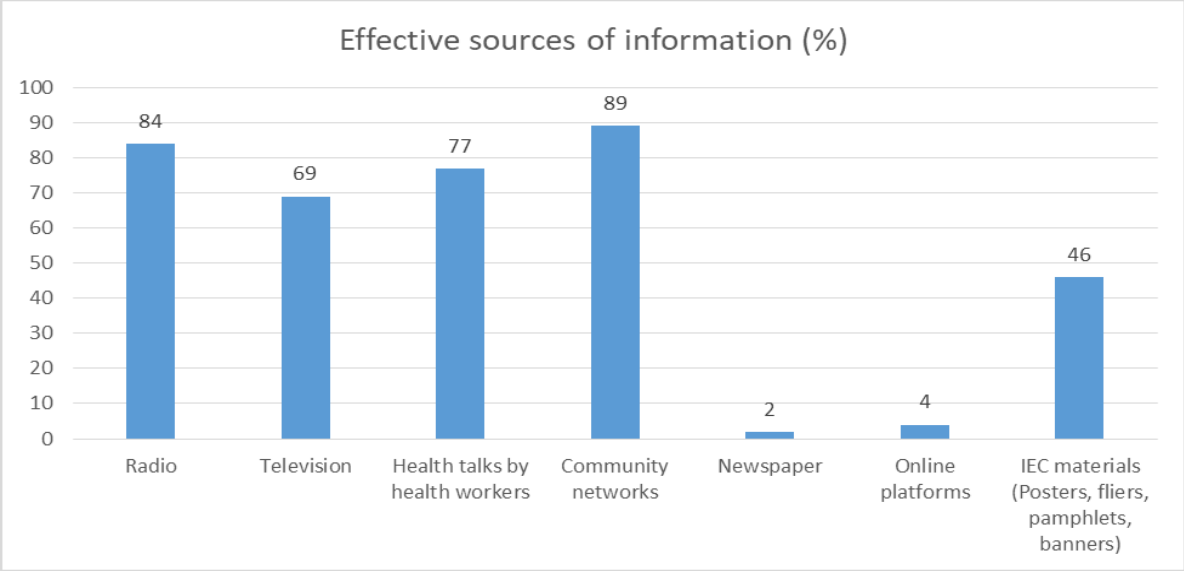
Figure 4.7: Existing behaviors affecting Immunisation uptake



To effectively address the above existing knowledge, attitudes, behaviors and practices, 89% of the respondents suggested use of existing community networks. Community health workers were also cited as sources of information that can be used to address

existing behaviors as they understand the community dynamics more. Least on the list was newspaper and online platforms which were at two and four percent respectively.

Figure 4.8: Effective Sources of information



The Ministry of Health officials, with support from international and local NGOs undertakes audience segmentation, highlighting the needs of each groups. The characteristics of each group determines the channel that will be used to reach them. For informal settlements, community health workers and community radio stations are preffered because most of the population has access to them, as opposed to newspapers and online platforms. The findings agree with Dianne (2007) who notes that for communication to be effective between the health worker and the caregiver, it has to be right at the first encounter. Also, to progress the Immunisation agenda, Afiong et al. (2017) notes that communication has to go beyond delivering a message. Dianne (2007) adds that each audience must have their own tailored messages that capture their needs and characteristics.

4.4.3 Community Led Social Change And Social Mobilisation

Ministry of Health at sub county level continously engage the community in not just Immunisation programme but in all health programmes. Given that not everyone in the community can be actively engaged, social groupings are mapped and leaders engaged. Financial constrains limit the level at which the ministry involves the community. Although the community groups are engaged especially during vaccination campaigns, there is no mechanism to verify whether messages are disseminated or not. Also, the ministry has employed non local as technical people in the sub counties, leaving community health volunteers for the locals. This means that some health workers do not understand the communities or do not have first hand information on what the community wants or needs.

Eighty two percent (82%) of the respodents agreed that the community has a role to play in the Immunisation programme. In addition to ensuring children finish their Immunisation schedule, it was noted that listening keenly to what the health workers say, advocating for Immunisation in their communities, notifying leaders of any parents whose child is not taken to hospitals, adhering to medical advice and serving as advocates to people who do not ascribe to modern medicine can be a role allocated to community members.

Although the respodents acknowledged the role of the community in promoting Immunisation, 54% acknowledged that the government does not involve them. The 48% that agreed that the government involved the community noted that the government involved the communities through their leaders, enlisting community health workers

from the community, participating in health talks at health facilities and public places includuing markets and follow up of children at households. Some of the ways that the government can engage the community more include holding open forums where communities can freely ask questions on Immunisation and health, including small groups as key stakeholders in the health programmes, following up to ensure all children are fully immunised at the community and using local language when dealing with them. Given that the demand is there for not just Immunisation but for the health services, the Minsitry of health officials noted that the ministry enjoys confidence and support from the community. However, incidences of vaccine reactions has impacted negatively on the programme. 94% of the respondents had confidence in the Ministry of Health.

The findings agree with Kirati et al. (2017) who emphasised on involvement of communities in health programmes. It also is in line with Laura (2011) who argued that social and familial networks are determinants of uptake of Immunisations services. Also, it agrees with Marijke et al. (2013) who note that interactive communication with communities provide a chance for the health worker and the caregiver to share information, opinions and views.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Overview

This section presents a summary of the findings, conclusion and recommendations. The first part looks at communication activities undertaken, existing gaps at both health facility and community level and components of communication to be addressed.

5.2 Summary of findings and Conclusion

5.2.1 Communication Activities undertaken

Majority of the respondents confirmed they interacted with communication activities promoting Immunisation. They included mass media activations through radio and television, health talks at health facilities and in communities and education materials including posters and fliers. Ministry of Health confirmed undertaking different communication activities targeting both health workers and communities with the aim of improving Immunisation coverage. The findings also revealed that health talks and informational, educational and communication materials were the most commonly used methods to reach caregivers. Newspapers and online platforms were the lowest. Majority of the respondents were also aware of existing communication activities targeting health workers. Mostly, provision of materials used as job aids was the most notable communication activity targeting health workers.

From the findings, communication activities are planned at the sub county level. This is because caregivers vary in characteristics, needs and wants. It was also noted that Ministry of Health aims at increasing risk perception and encouraging more caregivers to come for Immunisation services. Communities on the other hand acknowledged that communication activities were undertaken to ensure diseases that can be prevented through vaccination are eradicated from the country. Without eradication, disease burden affects the whole community.

Kenya Ministry of Health at the national level provides financial support for the Immunisation programme, with communication activities taking a smaller percentage of the funding. Local and internal donors come in to support the programme, mostly during campaigns. Due to the short time that donors fund activities, most of them die as soon as funding stops, because of issues to do with sustainability.

Kirati et al. (2017) argues that the world is shifting from provision of curative services to provision of preventive services. Communication activities aim at empowering people to take up behaviors that reduce risks associated with vaccine preventable diseases. The findings also agree with Rohan et al. (2012) and Tamara et al. (2013) who argue that disease burden affects a country's productivity. This is because of the deaths and disabilities associated with vaccine preventable diseases.

Although Rohan et al. (2012) noted that investing in preventive interventions like Immunisation services is key in reducing disease burden in a country, Kenya continues to prioritise curative services especially during funds allocation. This study also agrees with

Tamara et al. (2013) who notes that disease come back whenever funding (from donors) for Immunisation programmes ends. Involvement of communities and health workers is argued as one way of promoting sustainability but was not done from the findings.

5.2.2 Communication Gaps addressed by Communication Activities

The research identified gaps at the health facility (supply) and community (demand) levels. Majority of the respondents cited negative attitude by health workers as the biggest gap that existed at the health facility level. Negative attitude by health workers led to majority of the caregivers not going back to finish the Immunisation schedule. Also noted was detail of information provided. Health workers provide very limited information to caregivers when they visit the facility. This means that the caregiver is not provided with information in detail or does not get all the important information needed on vaccine preventable diseases from the health worker. Poor communication skills was also noted as a gap that existed among health workers. The Ministry of Health however has invested in on-job-training for health workers. However, huge workload and poor staffing continue to hinder time available to interact freely and in detail with caregivers. Limited funding has also limited the number of health workers trained on inter personal communication skills.

Existing of gaps at the health facility level agrees with Afiong et al. (2017) who affirm that quality of service delivery, including communication, at the health facility affects uptake of health seeking behaviors. The communication gaps experienced at health facility level contributes significantly to the declining routine Immunisation coverage.

This agrees with Dianne (2007) who advocates for effective communication as a way of improving health indicators including Immunisation indicators. Health worker capacity and high workload, as highlighted by the findings and Afiong et al. (2017), affect the detail and depth of information provided by the health worker to the caregiver. In this light, the Ministry of Health has continued to provide job aids and train more health workers on proper communication skills.

At the community level, existing knowledge, attitude, behaviors and attitude affect uptake of Immunisation services by caregivers, with majority of respondents acknowledging this. Africa, and Kenya in particular is made up of people with deep rooted cultural and religious beliefs and practises. From the study, traditional and religious practices and beliefs play a major role in how communities perceive and take up health seeking behaviors. Low risk perception among caregivers was also a major gap to the Immunisation programme. One way communication (from health workers to caregivers) was also a gap noted by most of the respondents. There was a direct link between limited information provided by the health worker and the low risk perception among the caregivers. From the findings, health workers give limited information to caregivers. Information does not detail the dangers of vaccine preventable diseases. Due to lack of or little knowledge on what they need to know or do, communities do not see the need or give seriousness it deserves, which leads to low risk perception and low uptake of Immunisation services.

To address the existing communication gaps that are present in the community level, the ministry at the Sub County and county level has included religious leaders as key stakeholders when discussing health agenda, including Immunisation. Also, provision of informational, educational and communication materials has been beefed up, but funding has been a major constrain on fully actualising this.

Ames et al. (2017) also argued that communication is important for community participation and delivery of health services. Communication must be participatory to give room for communities to freely exchange information and ideas with health workers and vice vasa. Ministry of Health has invested in community health volunteers who work within the community mobilising communities to take up healthy behaviors including Immunisation. The findings also agree with Diego et al. (2014) who note that due to lack of information, and low risk perception, caregivers are not motivated enough to ensure their children finish the Immunisation schedule.

5.2.3 Specific Components that need to be addressed

The first component is advocacy. Local and international health partners have been brought on board by the Ministry of Health to support the Immunisation programme through technical and financial support. At the lower level (county and sub county), the findings revealed that Ministry of Health officials focus on enlisting community leaders (administrative, religious and local leaders) to promote the Immunisation agenda in their communities. This was because these leaders live in these communities and understand the community dynamics.

These findings agree with Kirati et al. (2017) who argue that public and private stakeholders have a key role in promoting Immunisation agenda. This includes financial and implementing partners and the beneficiaries of the programme. Although Rafael (2012) argues that inclusion of policy makers is instrumental in resource mobilisation and allocation, the national government has not put much effort to include them. However, the lower level includes members of local assemblies who are also policy makers at ward level.

Another component that needs to be addressed is behavior change communication. Majority of the respondents agreed that behavior of the health workers affect their uptake of Immunisation services. Cultural and religious beliefs also play a key role in determining the attitudes of caregivers towards the Immunisation programme. To address this, the Ministry of Health should continue to enlist local community health volunteers to promote Immunisation at the community level. Also, social networks were proposed as a way to achieve more coverage for the programme. Training of health workers was proposed as a way to change health workers attitude and behavior and this will ultimately lead to improved Immunisation coverage.

Different people in the community have different characteristics and needs. The Ministry of Health undertakes an audience analysis to understand how to best address the major groups. From the findings, most people in the informal settlements prefer to have the community networks and radio as channels of communicating Immunisation messages.

The findings were in line with Dianne (2007) who argues that for communication to be effective, messages should be contextualised to the needs and characteristics of the target audience. This is done by sub county Ministry of Health through audience segmentation. It also helps in understanding the audience and ensure communication is done effectively as noted by Kirati et al. (2017). The ministry at the national and county level should continue investing in training health workers on proper communication skills and improve their attitudes as argued by Dianne (2007). This will help in creating and maintaining trust of health workers by caregivers just as noted by Afiong et al. (2012). Community led social change and social mobilisation are also components that need to be addressed. The findings conclude that both the Ministry of Health and the community recognise the role of community in the Immunisation programme. Existing beliefs and practises have an impact on the uptake of health seeking behaviors. However, the respondents felt that the government was not involving them enough as they should. With high confidence level for the government by the community, the community suggested inclusion in programme not just as beneficiaries but also as implementers. The findings noted that the government should move from just mobilising to inclusion of community as implementers and also gatekeepers.

The findings also agree with Diego et al. (2014) that Immunisation should be a shared responsibility between the government and the community. Community should take up an active role in ensuring that children are vaccinated and Immunisation promoted in their communities.

The findings also verify the ecological model of communication that highlights the different players that come into play for an individual to make a decision. Local leaders and community networks though not used in most instances are important in an individual decision making. For the supply side (health workers and Ministry), policies affect funds allocation and work load for health workers. Through audience segmentation, the Ministry is able to identify these spheres and plan on how to address it for the betterment of the programme.

Just as the theory of reasoned action, the findings highlighted existence of different cultural, religious and social practices that directly affect the Immunisation programme. Each culture, religious grouping and or social networks are guided by a set of norms and attitudes. The Ministry is working with the existing attitudes and norms to ensure that the Immunisation agenda is promoted in all spheres.

5.3 Recommendations

Funding and sustainability of communication activities, at both the health facility and community level was evident from the findings. Whereas the Ministry of Health and development partners continue to work towards achieving global targets of the Immunisation programme, the study recommends that the Ministry prioritises communication for the Immunisation programme. Planning of communication activities should be a joint venture between health workers and communities. This gives room for communities to express what will work for them best and long term, promoting sustainability. By prioritising funding for communication activities, the Ministry will be

able to identify and work with existing and new knowledge, attitudes, behaviors and perceptions leading to increase in risk perception thus the uptake of Immunisation services.

Although the health worker enjoys confidence from communities, the information shared was limited and at times not shared. Communities also citied lack of participatory communication between them and the health workers. Communication should be participatory to ensure caregivers get detailed information on vaccination and vaccine preventable diseases. This will also give room for the caregiver and the health workers to exchange as much information as possible with the aim of empowering communities with the right information. It will also reduce the risk perception among caregivers.

Although communities are the beneficiaries of the Immunisation services, they are also key in ensuring that every child in their communities is fully immunised. Therefore, communities should also be engaged on a continuous basis, not just as beneficiaries but as implementers. Communities have an active role to play to ensure all children are fully immunised and prevent vaccine preventable diseases outbreaks. It is important to consider and use existing community structures during the planning and implementation of communication activities promoting Immunisation programme.

Gaps at the health facility level have a direct impact on the community. Existence of gaps at both the health facility and the community has continued to pose a challenge to the country in achieving global set targets. Activities undertaken should be led by the

community to promote ownership and ensure sustainability. Mapping and engagement of national and local stakeholders (including communities) will also contribute to implementation of sustainable activities promoting Immunisation.

The Ministry has continued to plan and implement different communication activities at both the county and sub county level. However, little or no monitoring and evaluation has been done, especially to evaluate the effectiveness of the activities undertaken. Monitoring and evaluation mechanisms should be put in place, with measurable communication indicators. Evaluation should be done on the processes being undertaken, the outcome especially in reducing the number of unvaccinated children and the impact the activities have in the long run. This will provide an opportunity for the Ministry to understand what works best and what is contributing to improved Immunisation coverage and what is not. It will also guide the Ministry on identifying areas that need more support.

5.4 Suggested Areas of Study

Communication remains an integral part in Immunisation and other health programmes. The research findings show that although communication activities and gaps are clear from the supply and demand side, studies have not been conducted to evaluate the effectiveness of the communication activities undertaken.

Research is important in establishing new information. The existing information on existing knowledge, attitude and behaviors is limited and from many years ago. There is need to study these in relation to the new and emerging knowledge, attitude, behaviors and practices and how they affect Immunisation and other health programmes.

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APPENDIX 1: QUESTIONNAIRE (CAREGIVERS AND COMMUNITY HEALTH WORKERS)

Dear Respondent,

I am a finalist student at the University of Nairobi, pursuing a Masters of Arts Degree in Communication studies (Development Communication). In partial fulfillment of the requirements for the award of the degree, I am undertaking a research study entitled 'Evaluation of communication Activities promoting Routine Immunisation'. The information is valuable for both planning and scientific research.

Your response is very important and will help and represent stakeholders and other parties who will not be in the sample. Your responses will be treated with high level of confidentiality and your name will be in no way associated with the findings of this study.

The discussion will take about 1 hour of your precious time.

Thanking you in advance

Scolastica Wanjiku Kunyiha

Name ……..…… (Optional)

Demographic Information

Gender	Male ( )	Female ( )	
Age	18 – 25 years( )	26 – 40 years ( )	Above 40 years ( )
Children Under 5 years	1 -2 ( )	3 – 4 ( )	5 and above ( )

SECTION A: COMMUNICATION ACTIVITIES EMPLOYED TO PROMOTE ROUTINE IMMUNISATION

1. In the year 2017, are there communication activities that you feel were aimed at promoting Routine Immunisation? Yes ( ) No ( ) (If no, skip to question 2)

If yes, which ones? Tick below (you can tick more than one option)

Channel	Yes	No		Channel	Yes	No
Radio				Newspaper		
Television				Online platforms		
Health Talks (at the community and health facility)				IEC materials like Posters, Fliers, pamphlets		

2. Are there communication activities that you think are targeted at supporting health workers?

Yes ( ) No ( ) If yes, which ones? List at least 3

_____
_____
_____

3. What do you think are the reasons why communication activities are done?

_____
_____
_____

SECTION B: GAPS ADDRESED BY COMMUNICATION ACTIVITIES

4. Do you think there are Communication challenges at the Health facility level?

   Yes ( ) No ( ) If yes, which ones? You can tick more than one but not more than 3:

	Gaps Health Facility Level	**Yes**	**No**
	Health workers attitude		
	Health worker knowledge		
	Health worker communication skills		
	Detail of information provided		
	Availability of job aids for health care workers		
	Sharing of information		
	Sustainability of communication activities undertaken at facility level		
	Others:		

5. Are there any challenges that can be addressed by communication at the Community level?

   Yes ( ) No ( ) If yes, which ones? You can tick more than one but not more than 3:

#	**Gaps at Community Level**	**Yes**	**No**
	Absence of participatory communication with health workers		
	Lack of adequate information on vaccine preventable		

	diseases		
	Low risk perception among caregivers		
	Existing behaviors (religious, cultural, social)		
	Others:		

SECTION D: SPECIFIC COMPONENTS OF COMMUNICATION THAT NEED TO BE ADDRESSED

6. **Advocacy**:

a). who are the key stakeholders that can be engaged to move Immunisation forward? List at least 2

_____

_____

b). what should the above be doing?

_____

_____

7. Behavior Change Communication

a. Are there existing behaviors that hinder uptake of Immunisation services in your community? Tick as many as you can

   i. Religious ( )

   ii. Social Networks ( )

   iii. Cultural ( )

   iv. Health teams ( )

b. What specific communication interventions that can be undertaken to address the above noted constrains?

   _____

   _____

c. Which of the below channels should be used to address the above existing behaviors?

Channel	**Tick one**
Radio	
Television	
Health talks by health workers	
Community networks	
Newspaper	

Online platforms	
IEC materials (Posters, fliers, pamphlets, banners)	

d. Why did you select the above option (s)?

_____

_____

8. Community Led Social Change/ Social Mobilisation

a. Do you think the community has a role to play in the Immunisation programme? Yes ( ) No ( ) If yes, List how

_____

_____

_____

b. Does the Ministry of health involve the community enough? Yes ( ) No ( )

If yes, List how

_____

_____

_____

c. Are there other ways the Ministry can involve the community more? Yes ( ) No ( )

If yes, List how

_____

_____

_____

d. Do you have confidence in what Ministry of Health is doing? Yes ( ) No ( ) If yes, which ones? List at least 2. If No, state why

_____

_____

Thank you

APPENDIX 2: KEY INFORMANT INTERVIEW GUIDE

Dear Respondent,

I am a finalist student at the University of Nairobi, pursuing a Masters of Arts Degree in Communication studies (Development Communication). In partial fulfillment of the requirements for the award of the degree, I am undertaking a research study entitled 'Evaluation of communication activities promoting Routine Immunisation'. The information is valuable for both planning and scientific research.

Your response is very important and will help and represent stakeholders and other parties who will not be in the sample. Your responses will be treated with high level of confidentiality and your name will be in no way associated with the findings of this study.
The discussion will take about 1 hour of your precious time.

Thanking you in advance,
Scolastica Wanjiku Kunyiha

Designation: _____

SECTION 1: COMMUNICATION ACTIVITIES PROMOTING ROUTINE IMMUNISATION

1. What communication activities were implemented in the year 2017?
2. What specific communication activities were targeting the community
3. What specific communication activities were targeting the health care workers
4. What objective were the activities aimed at achieving?

SECTION 2: GAPS ADDRESSED BY COMMUNICATION INTERVENTIONS

5. What are the gaps been addressed by the communication activities at the health facility level?
6. What are the gaps been addressed by the communication activities at the Community level?
7. What communication activities have been put in place to address the above gaps?

SECTION 3: SPECIFIC COMPONENTS OF COMMUNICATION THAT NEED TO BE ADDRESSED

a) Advocacy:

8. The Immunisation programme brings together different players to support communication activities.
    a. Who are the key stakeholders for the Immunisation programme both at national and sub national level?
    b. What role do they play?
    c. What are the challenges this has faced?

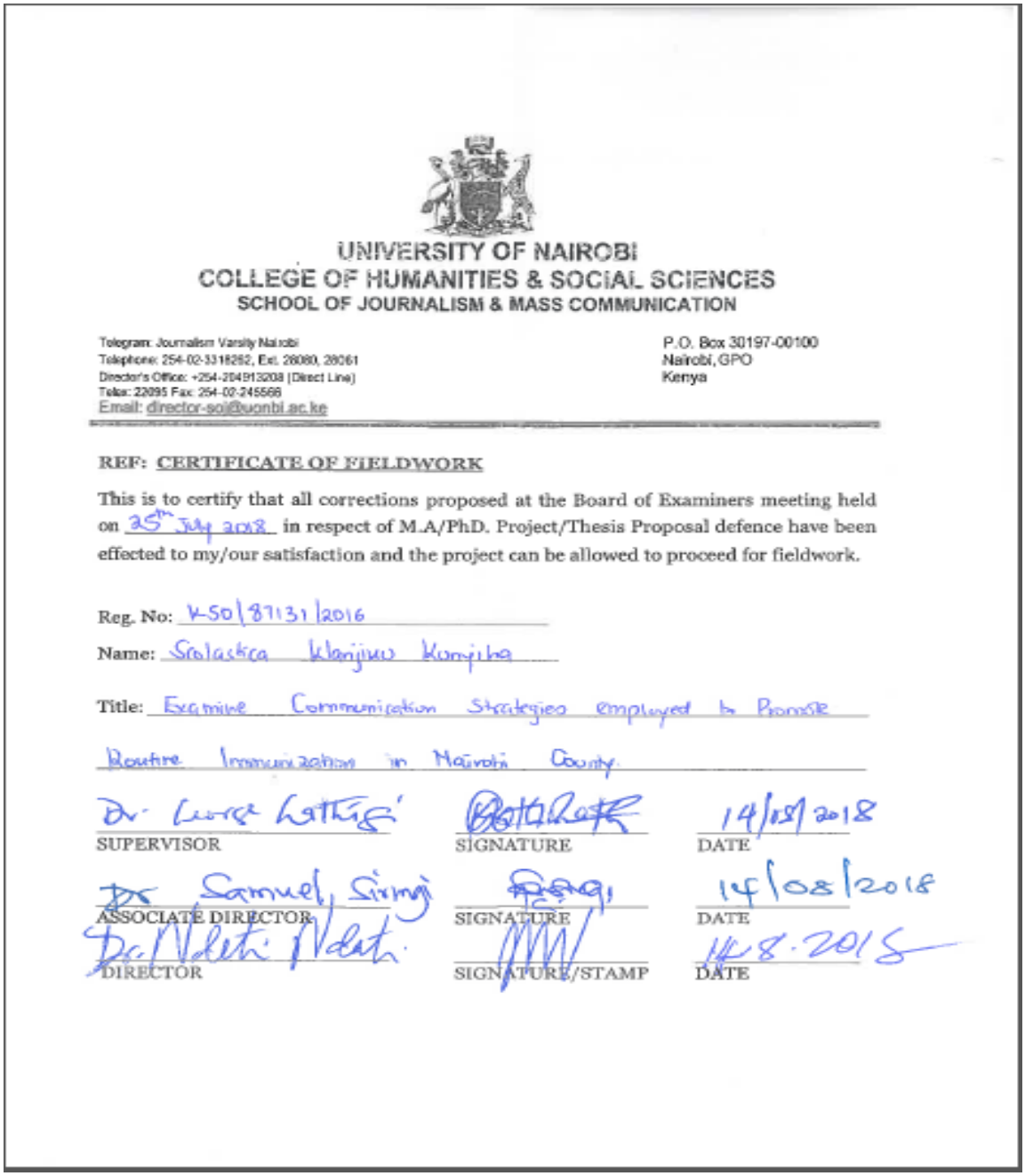
b) Behavior Change Communication:

9. Every community has diverse levels of Knowledge, attitudes, behavior and practices:
    a. What are the prevailing ones that affect the Immunisation programme?
    b. How do you work around them?
    c. What channels of communication do you use in addressing the identified behaviors?

c) Community Led Social Change/ Social Mobilisation

10. What role does the community have in Routine Immunisation?
    a. Are they actively engaged? If yes, how
    b. Are there other ways that Ministry can involve the community more? Why is it not been done?
11. Does the Ministry enjoy confidence from the community?

APPENDIX 3: CERTIFICATE OF FIELDWORK



UNIVERSITY OF NAIROBI
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REF: CERTIFICATE OF FIELDWORK

This is to certify that all corrections proposed at the Board of Examiners meeting held on 25th July 2018 in respect of M.A/PhD. Project/Thesis Proposal defence have been effected to my/our satisfaction and the project can be allowed to proceed for fieldwork.

Reg. No: K-50/87131/2016

Name: Scolastica Kanjuu Kanjiha

Title: Examine Communication Strategies employed to Promote Routine Immunization in Nairobi County

Dr. Lucy Kathigi'		14/08/2018
SUPERVISOR	SIGNATURE	DATE
Dr Samuel Siringi		14/08/2018
ASSOCIATE DIRECTOR	SIGNATURE	DATE
Dr. Ndeti Ndeti		14.8.2018
DIRECTOR	SIGNATURE/STAMP	DATE

APPENDIX 4: PLAGIARISM TURNIT REPORT

Document Viewer

Turnitin *Originality Report*

- Processed on: 07-Nov-2018 08:51 EAT
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- Word Count: 14207
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EXAMINE COMMUNICATION ACTIVITIES EMPLOYED TO ... ***By Scolastica Wanjiku Kunyiha***

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REF: CERTIFICATE OF CORRECTIONS

This is to certify that all corrections proposed at the Board of Examiners meeting held on 12th October 2018 in respect of M.A/PhD. Project/Thesis defence have been effected to my/our satisfaction and the project/thesis can be allowed to proceed for binding.

Reg. No: K50/87131/2016

Name: Scolastica Klanjiwo Kunyita

Title: Examine Communication Activities employed to Promote Routine Immunization in Nairobi County

Dr. George Gathigia		05/11/2018
SUPERVISOR	SIGNATURE	DATE
Dr Samuel Siringi		14/11/2018
ASSOCIATE DIRECTOR	SIGNATURE	DATE
Dr. Ndeti Ndati		14.11.2018
DIRECTOR	SIGNATURE/STAMP	DATE

UNIVERSITY OF NAIROBI DIRECTOR 13 NOV 2018