Title

KNOWLEDGE, ATTITUDE, BEHAVIOR AND PRACTICE (KABP) SURVEY REPORT ON THE UPTAKE OF IMMUNIZATION SERVICES IN GAMBIAN COMMUNITIES.

Conducted by
Health Promotion and Development Organization (HePDO)
## Glossary of acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CSOs</td>
<td>Civil Society Organizations</td>
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<tr>
<td>DCD</td>
<td>Department of Community Development</td>
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<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>Gavi</td>
<td>Global Alliance for Vaccine and Immunization</td>
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<td>HePDO</td>
<td>Health Promotion and Development Organization</td>
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<tr>
<td>KABP</td>
<td>Knowledge Attitude Behavior and Practice</td>
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<tr>
<td>MoBSE</td>
<td>Ministry of Basic and Secondary Education</td>
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<td>MoH&amp;SW</td>
<td>Ministry of Health and Social Welfare</td>
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<tr>
<td>MDFTs</td>
<td>Multi-Disciplinary Facilitation Teams</td>
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<tr>
<td>PRA</td>
<td>Participatory Rural Appraisal</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<td>RHD</td>
<td>Regional Health Directorates</td>
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<td>TCs</td>
<td>Traditional Communicators</td>
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<td>UNICEF</td>
<td>United Nation Children Fund</td>
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<td>VPD</td>
<td>Vaccine preventable Disease</td>
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<td>VDC</td>
<td>Village Development Committees</td>
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1. Acknowledgement

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HePDO would also like to extend sincere gratitude to all individuals and institutions for their efforts in the conduct of this national KABP survey. Special appreciation is extended to the EPI team for the technical and moral support in the development of the data collection tools. Our thanks and appreciation goes to the Regional Health Directorates, especially the EPI operation officers, Regional Principal Public Health Officers who worked tirelessly during both the tool development and field work. Our appreciation also goes to the Department of community development for their immense contribution in the development of PRA tools and the conduct of PRA in different parts of the country.

Our heartfelt gratitude goes to Lamin FM Barrow of Health communication unit of MoH&SW for the support in the development of the data collection tool, data analysis and report writing. We are also thankful to our data entry clerks who meticulously entered the data in to the SPSS data base.

Special thanks goes to the enumerators who did the field work across the country, and to all respondents in the regions for sharing with us their views, opinions and knowledge on RCH including immunization.
2. Executive Summary

This Report provides an overview of the key results from a Knowledge, Attitudes and Practices (KABP) Survey on Gambian communities towards RCH services including immunization. These results are intended to inform the development of community focus communication strategy that will be executed under the supervision of the EPI of the MoH&SW and with support from relevant stakeholders.

As part of the survey approach for the data collection both qualitative and quantitative methods meant to complement each other were employed. For the qualitative part of the survey Focus Group Discussion and Participatory Rural Appraisal guides were used to collect information from 460 adolescent youths, 460 pregnant women, 460 husbands, 460 women leaders and 460 village heads. In the case of the quantitative method, in depth interview using structured questionnaires were administered to a total of 307 participants comprising 52 women leaders, 52 pregnant women, 52 breast feeding mothers, 46 District Authorities, 52 Village Heads and 53 Community Health workers across the country. The participants to the survey were viewed as key stakeholders either as main beneficiaries of RCH services or those who can be supportive. Participants were selected from all the Health Regions across the country through random sampling.

The survey revealed that the daily activities of men and women vary a lot with women working longer hours than their male spouses through multi-tasking. It was further found out that though women in both urban and rural areas have busy work schedule, those in the urban are impacted more as their daily economic activity is all round whilst those in the rural areas are less busy during the dry season. On the other hand male and adolescent involvement in RCH related services was found low simply because accessing the services is predominantly seen to be responsibilities of women and children.

The survey also showed that 30.8% of the respondents get information on RCH services from the RCH clinics. Another 28.2% indicated a combination of sources such as radio, TV, Community Base Companions and the clinics. Furthermore, many of the different respondents knew that at the RCH clinics children are immunized, however, little do they know the schedule, the different antigens and the diseases which children are vaccinated against. Polio, yellow fever and measles were the most commonly mentioned vaccines whilst other non-vaccine preventable diseases like malaria and HIV/AIDS were also commonly mentioned.

Immunization defaulter rate among breast feeding mothers was found to be higher in the urban settings. For instance from a total of 19 respondents who reported defaulting in taking their children for immunization, 5 (26.3%) and 4 (21.1%) were from West Coast Regions 1 and 2 which have more urban settlements compared to the rest of the country. The survey further revealed that 51.9% of breast feeding mothers accessed RCH service including immunization through public health facilities outreach sites. About 70.4% of those who reported accessing services from outreach sites are from the five predominantly rural health regions. Regarding sources of information majority of the respondent (30.8%) mentioned the RCH clinic as their main sources of getting information on immunization. Another 28.2% mentioned a combination of sources such as radio, TV, RCH clinic, Community Birth Companion as their source of information. Among those who mentioned the RCH clinic as their main source of information majority were women leaders (35.7%) and pregnant women (19%).

Established: June 1997  Motto: Striving to improve lives and living conditions of people
Among the responses, 26.9% mentioned several factors such as not knowing the immunization schedules, carelessness, unfriendly approach of RCH staff, shyness. However, 21.2% said they don’t know the factors whilst another 7% said not knowing schedule of visits as reason for defaulting. Of those who mentioned not knowing schedule of visit, 50% were from WCR1. Nationwide, only 8% could name up 5 VPDs as disease against which children are immunized. Majority 29% and 27% could only correctly name 1 VPD and 3 VPDs respectively.

The client centered social determinants revealed by the KABP survey, women play a critical role in how RCH services including immunizations are viewed and received among Gambian communities. Their work schedules either domestic or for other economic activities impact a lot RCH services especially when children timely immunization is involved. The triple roles of women in reproduction, production and community work seriously affects their participation in development work, particularly on health issues such as completing the immunization cycle of their children.

Interpretation of the results suggest that limited knowledge on the importances of understanding the immunization schedule and benefits of available antigens for various vaccine preventable disease has on implication on RCH clinic attendance. The low awareness can affect the value attached to RCH services including immunization leading to low coverage. To improve and maintain high utilization of RCH services, parents and other caregiver should be aware of the importance of these services. This can motivate them to priorities it over social or cultural events such as wedding and naming ceremonies which in the survey has been reported as some of the reasons for defaulting.

Majority of determinants are based on knowledge, attitude behavior and practice of caregivers and their supportive community leaders. This suggests that more efforts should be directed to demand creation for the services uptake. Therefore, intervention to increase demand and sustainable positive behavioral change should focus on social and behavioral change communication. The active involvement and participation of all stakeholders at household, community and Health Facility level should be coordinated and encouraged by increasing community engagement. To attain successful SBCC intervention, building and strengthening of decentralization structures and community based organization is critical in giving communities strong, accountable and efficient local mechanism that could propel and serve as vehicles to bring sustainable behavior change and demand creation. Radios and Social mobilization materials in the drive to create demand for immunization and boosting coverage is eminent in enforcing and maintaining the gains of community engagement. This study provides a point of view that will enable the immunization services managers and implementers to internalize and appreciate the importance of and deploy comprehensive and effective measures to address the social determinants of immunization services uptake.
3. Introduction

3.1 Country background

3.1.1 Geography
The Gambia, a former British colony, is one of the smallest countries in Africa. It is located on the Atlantic coastline and has a total land area of 10,689 square kilometers. It is bordered on the North, East and South by the Republic of Senegal and on the West by the Atlantic Ocean. The country stretches for 400 kilometers from the Atlantic coast eastwards into the interior. The width of the country varies from 40 Km on the coastal area to 25 Km at the eastern tip. The most distinct geographic feature of the country is the River Gambia, which divides the country into two halves, north and south banks. The country has a typical Savannah climate, with two distinct seasons. The rainy-season starts in early June and ends in early October. The long dry season (November to May) explains the relatively short duration of farming activities in the country.

3.1.2 Administration
There are five provincial administrative regions and two municipalities: Central River Region (CRR), Lower River Region (LRR), North Bank Region (NBR), Western Coast Region (WCR), Upper River Region (URR), Kanifing Municipality and Banjul City. The regions are headed by governors while the municipalities are headed by mayors. In some instances the regions are referred to as Local Government Areas (LGAs). Each Provincial Local Government Area is headed by an elected Chairperson. The provincial regions are further divided into Districts headed by Chiefs, locally called ‘Seyfo’. There are 40 districts in the country and the total number of settlements is about 2,160. Each village is headed by an “Alkalo” (village head). For the purpose of local government, districts and municipalities are divided into Wards. The number of wards in a district varies from two to three. Wards are represented in the Area and Municipal councils by elected representatives. Like Parliamentary and Presidential elections, Local government elections are run on party lines.

3.1.3 Economy
According to the UN Human Development Index ranking2016, The Gambia ranks 173 out of 187 countries, with a Gross Domestic Product (GDP) of US$ 560 (NHSSP 2016). This makes the country one of the poorest states in the world. The GDP growth as at 1998-2001 was 5.3% but by 2005 it peaked up to 7%. Between 2008 and 2011, the GDP dropped again to just over 5%. Despite a per capita GDP of US Dollars 1,921 (2005) 60% of the population lives below the overall poverty line whilst 40% live below an estimated food-poverty line. About 60% of female-headed households fall below the poverty line, compared to 48% for male-headed households (National HIV/AIDS Strategic Framework 2009-2013). Overall 55% live under the poverty line (poverty survey, 2008). Agriculture is the mainstay of the economy. Export of groundnuts is the most important foreign exchange earner but diminishing production levels and aflatoxin infestation of the commodity continue to affect foreign exchange earnings from agricultural produce. Tourism, re-export trade and fisheries are also important foreign exchange earners. There is a vibrant private sector involvement in domestic trade.
3. 1.4 National Health Services

The health care service is delivered through three tiers - primary, secondary and tertiary. The primary health care component comprises a network of primary health care villages that provide elementary outpatient care, mobilizes communities for preventive health action and promote maternal and child health, including referrals. This package is called ‘village health services’. The village health services network is linked to minor public sector health centers and community-managed health facilities spread across the country. The network of primary health care villages minor health centres combined constitutes primary health care. For a village to be designated PHC community it must have a minimum population of 400 but the Government is considering extending primary health care to every village in the country. Primary health care villages are organized into circuits of 4-6 settlements and each village has a Village Health Worker and Community Birth Companion, who are supervised by a professional Community Health Nurse assigned to a PHC circuit. By June 2018 there were 810 designated PHC villages in the country.

Secondary level public sector health services are provided by major health centres and district or general hospitals. There is a clearly defined referral system between PHC villages and basic health facilities and between that level and the district or general hospitals. At the tertiary level, there are six public sector general hospitals and a national referral/teaching hospital. There is a vibrant private sector and non-state actor participation in the health sector, but they are highly concentrated in the West Coast Region and the Kanifing Municipality.

The country is divided into seven health regions, each with a Regional Health Directorate (RHD), headed by a Regional Director of Health. The RHDs have overall responsibility to oversee public sector health service delivery in their regions; ensure and facilitate implementation of national health policies; provide administrative support required for the effective delivery of national health services; mobilize and network with non-state actors in health; mobilize communities for health action and act as liaison between the national health service and other development partners in the regions.

The National EPI Program

The National EPI Program was created in the Ministry of Health and Social Welfare in 1979. Like the other specialized units of the ministry, the EPI underwent significant reforms in response to the country’s adoption of PHC as the strategy for expanding, restructuring and improving the quality of health services. Management of the National EPI consists of the following: program manager; deputy program manager; senior surveillance officer, surveillance officer, data manager, senior logistician, logistician, communication officer, senior vaccine officer, two cold chain technicians, one store keeper, three drivers and a secretary. In addition there is an EPI Regional Operations Officer in each region. Public health officers coordinate immunization services at health facility level and are supported by the RCH teams. The Program advises the national health authority and its partners on matters related to immunization. It coordinates and sets standards for the national immunization program in consultation with the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) Program of the MoHSW.

3.1.5. Immunization Services

Since its inception the EPI has been integrated into RCH services. The objective set in the Health policy 2011-2020 is to increase immunization coverage to at least 90% for all antigens at national
and regional levels by 2015. This is also fully taken into account in the National Strategic Health Development Strategy. The Gambia EPI Program provides eleven antigens to its target population. The service is delivered through RCH clinics as part of the polyvalent health care package. There are two main outlets for service delivery, base and outreach. The health centres are situated at mean distances of 5 to 8 kilometers. Approximately 60% of the immunization service is delivered through outreach clinics. There is also a mobile strategy in which vaccination teams move around to immunize target populations. The mobile approach is used in supplementary immunizations activities (SIA). The EPI program has been conducting SIAs since 1998. During this period the program achieved and maintained high coverage. The measles catch-up campaign registered 98% in 2011 and 98% national Polio coverage in 2012. There has been high political commitment during supplementary immunization activities (SIAs). Records have shown that all the Polio SIAs in 2011 and 2012 were launched by high profile personalities and coverage was above 95% nationally. In order to maximize the utilization of meager resources, vitamin A, De-worming tablets and Bed net Count were integrated into the Polio/Measles SIAs in 2003, 2004, 2005 and 2011. The high immunization rates in the SIAs, coupled with high routine coverage rates, resulted in the attainment, by The Gambia, of polio free status in 2004, as well as drastic reduction in measles cases. Adverse Events Following Immunization (AEFI) Surveillance was also conducted during the 2011 round of Measles SIAs.

3.1.6. Introduction of New Vaccines
The Gambia has been taking the lead in the introduction of new and under-used vaccines. Currently the country immunization program is vaccinating against twelve diseases and overall the coverage rate for all antigens is high, beyond the current GIVS strategic coverage target of 90% national, and 80% in all districts.

The program started with six traditional vaccines namely poliomyelitis, tuberculosis, Diphtheria, Pertusis, Tetanus and Measles Vaccine. In addition to the above tradition antigens, the country has introduced other life-saving vaccines such as Hepatitis b, Haemophilus influenza type b, Pneumococcal conjugate vaccine, Rotavirus, IPV and MR vaccines in 1990, 1997, 2009, 2012, 2015 and 2017. A trial of Human Papilloma Virus (HPV) vaccine, which prevents women from the most common and leading cause of cancer morbidity and mortality in the Gambia, was done in Brikama, West Coast Region.

3.1.7 Immunization coverage
National routine immunization coverage rates have been consistently high, at above 80% over the last two decades. Data from DHS 2013 indicates that approximately 99 per cent of children aged 12-23 months received a BCG vaccination by the age of 12 months and the first dose of Penta was given to 98 per cent of them. The percentage declines for subsequent doses of Penta 3 to 88 per cent. According to the guidelines developed by WHO and adopted by the Gambia, children are considered fully vaccinated when they have received a vaccination against Tuberculosis (BCG), three doses of Penta and Polio and vaccination against Measles. The proportion of children under one year who are fully immunized is relatively low (76%) nationally, with significant rural and urban variations, ranging from 67% in the urban areas to 84% in rural areas. The rate was also higher among children whose mothers have no education (78.2%) or who only reached the primary school level than among children whose mothers reached the secondary school level or higher (68.3%).

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The DHS 2013 Data further shows that literacy levels are higher in the urban areas than in rural areas and the results show that Banjul (58.8%), Brikama (69.5%) and Kanifing (70.9%) which are mainly urban settlements, have lower fully immunized coverage. This finding is puzzling, as many studies report that education influences uptake of health care services, including immunization. Less than 1 per cent of children 12-23 months of age have never received any vaccines. The coverage for measles vaccine at the age of 12 months is lower than the other vaccines, at 87.8 per cent. Although 99 per cent of children received the BCG vaccine, only 87.8 per cent received Measles by their first birthday. As a result, the percentage drop out for BCG/measles is 11. Similarly coverage for the first dose of Penta is 98% only whilst 88% of children went on to receive the third dose of Penta, contributing to a drop out of 11%.

4. Methodology

4.1 Development of the data collection tools

In order to carry out the KABP survey in all the regions of the Gambia, an introductory meeting was conducted with the regional staffs to inform them about the plan survey. As part of the process, a consultative workshop was conducted during which data collection tools for both qualitative and quantitative were developed. For the qualitative part FGD and PRA guides were developed targeting 460 adolescent youths, 460 pregnant women, 460 husbands, 460 women leaders and 460 village heads. For the quantitative (in-depth interview) six sets of questionnaires were developed for pregnant women, women leaders, husbands, village heads, district authorities and village health workers.

4.2 Training of data collectors

Following the development and pre-testing of the data collection tools, data collectors mainly comprising MDFTs and other regional staffs and supervisors from the RHDs, DCD and MoBSE were invited for training on the different data collection approaches and tools. The purpose of the training was to equip the data collectors with the pre-requisite knowledge and skills on how to effectively conduct FGD using the developed guidelines and as well as face to face in-depth interview using developed questionnaires. Similarly, participants from DCD and MoBSE were trained for two days at Tendaba Lodge on how to conduct PRA with emphasis on the objective of the KABP which was mainly on RCH including immunization.

4.3 Data collection

Having completed the training of data collectors for FGD and PRA, and in-depth interviews, data collectors were deployed to the field by swapping them example those from LRR to CRR in order to minimize biases. The activities started with the administration of 307 in-depth interview questionnaires for seven days, followed by the conduct of 350 FGD sessions for ten days and finally the conduct of the PRA for four days in 14 communities.
4.4 Data analysis

**Qualitative:** Information obtained from the FGD and PRA sessions were transcribed for each different target groups. The transcripts were thoroughly read to understand key issues based on participants views, opinion and knowledge and attitude around the uptake of RCH services including immunization.

**Quantitative:** The data obtained from in-depth interviews was entered into Statistical Package for the Social Sciences (SPSS) for analysis. Open-ended responses were coded to arrive at clusters to tabulate percentage responses. The data was analyzed primarily through frequency tables and cross-tabulations to filter the required information as it links to knowledge, attitude, behavior and practice towards uptake of RHC services including immunization.

5 Detail Findings of the survey

5.1 Findings from the FGD

5.1.1 FGD with adolescent

**Issue 1:** Explore whether participants are aware that in The Gambia children under 5 are taken to the RCH clinic regularly for RCH services

Almost all adolescents in the health region in the country are aware that in the Gambia children less than 5 years are taken to the RCH clinic regularly for RCH services. However, few adolescent express that they think it’s only for new born.

**Issue 2:** Explore level of knowledge of services (care package) provided to children under the age of five years at the RCH clinic in the community

Adolescents demonstrated a limited understanding of care packages provided to children at RCH. Some of the care packages that are frequently mentioned are weighing, net distribution, caring of children. Majority of them express lack of knowledge about care provided at RCH to their limited contact with RCH and as such they knew women goes to ‘Nurse’ but what exactly happens there they cannot elaborate on. A limited number also mentioned birth registration, but these are mostly adolescents in the rural areas.

**Issue 3:** Views on primary role/responsibility in the household to make decisions concerning whether, when and how often children 0-24 months old should/can be taken to the RCH clinic regularly for immunization and other services

The issue of responsibility was a highly debated issue among the adolescents in all the regions. They have divided views as to who is responsible in the household to make decisions concerning whether, when and how often children 0 – 24 months old should be taking to the RCH clinic. What stands out is that men are the decision makers and the primary role of taking the child to RCH is the mother. However, there was consensus that men should also help when the women are engaged in something else. Most adolescents relate their argument to the gender role of our society.
Issue 4: Let participants discuss whether once they start having children, they would take their children under 5 years of age to the RCH clinic for immunization; Adolescents unanimously agree that once they start having children they will take them to RCH to receive immunization. This has been the views of all adolescents in all the regions citing that services provided at RCH will render the children healthy and free of diseases. “I when I have children I will take them to the RCH clinic until they have 5 years” says one of them.

Issue 5: Tell participants that in The Gambia (including their community) a significant proportion of parents/families fail to take their children 0-24 months regularly to the ‘RCH clinic for immunization; do they have any idea as to why

The reasons advanced by adolescents when they are asked why parents /families fail to take their children 0 – 24 months regularly to RCH clinic for immunization are negligence on the part of the mother; long distance women has to travelled; short or close pregnancy intervals, long waiting hours at the clinic; too many household chores on women and lack of mobility to transport women to the clinic, limited awareness of the immunization schedule and the importance of immunization on the side of mothers

Issue 6: Probe whether the adolescents think they have a role to play in ensuring that children 0-24 months old are taken regularly (monthly) to the RCH for immunization and other services; let them explain their perceived role

Majority of adolescents said they have a role to play in ensuring children 0 – 24 months of age are regularly taking to RCH. The most common roles mentioned include: taking the child to the clinic if the mother is very busy on some other important things; take care of domestic chores for the mother to have time to go to the RCH clinic.

Furthermore, they mentioned that the importance of RCH clinic cannot be over emphasized and as such, everyone in the family have a role to play in taking children to RCH clinics. “If sickness comes to a child in our compound it could affect us all so yes, I sometimes help my parents if they are busy to take the child to the clinic ”says one of them.

Issue 7: Probe whether adolescents have access to information on RCH including immunization of children under 5 years, if yes tell us how and where?

Majority of the adolescents said their sources of information on RCH including immunization is the radio. Few of them mentioned sources women and mothers who go to attend the RCH clinics as sources of information. A handful of adolescents also mentioned VSGs as their source of information on RCH services. These sources of information on RCH were mostly mentioned by adolescents in URR, CRR and LRR. However, sources such as radio are mainly mentioned in west coast 1 and 2 regions.

Issue 8: Let participants discuss if they would encourage or let their husbands/wives take their children under 5 to the RCH clinic once they get married and start having children; let them give reasons for whatever view they express;

An overwhelming majority of adolescents considers this to be an obvious issue for all parents and care givers. They all argue that they will encourage their husbands/wives to take their children under
5 to RCH clinic once they get married and start having children. Although, they debated on who should take the child to RCH, but at the end it was unanimously agree that it’s the responsibility of both parents to ensure the children are taking to the nearest RCH clinic. Some of the most common reasons stated are: the health of the children is the responsibility of both father and mother; when children are taken to RCH clinic they receive care from health workers and these prevent them from getting illnesses

**Issue 9:** Let participants name the diseases against which children 0-24-month-old in The Gambia are immunized against routinely;
The adolescents have limited knowledge on the diseases against which children are immunized. This is evident by the fact that only few (10%) of the adolescents were able to name more than 2 vaccine preventable diseases. The greater majority of adolescents were only able to correctly state 1 vaccine preventable diseases. Some of the VPDs commonly mentioned are: polio, diarrhea, tuberculosis. It is interesting to note that they made mentioned of several other diseases that are not vaccine preventable such as malaria, HIV and AIDS.

**Issue 10:** Probe how participants respond to the view that the benefits of taking children 0-24 months of age to the RCH clinic for immunization every month outweigh any burden (cost, time, energy, putting other commitments on hold) that may be involved;
All adolescents responded positively to the view that the benefits of taking children 0 – 24 months of age to the RCH clinic for immunization every month outweigh any burden that may be faced in attending clinic. The key issues raised by majority of adolescents are that health comes first in every sphere of life.

**Issue 11:** Open discussion on how RCH services including immunization can be improved.
Some of the main issues advanced by adolescents to improve immunization in the Gambia are;
- A great number said people should be aware of the importance of immunization and this will encourage attendance.
- The issue of distance to RCH site was also mentioned and they suggest that health care workers should go and meet people in their communities.
- Men to support when for example the woman is busy; the man takes the child to RCH as well as provide transport for women to go and attending RCH will motivate women.

5.1.2. FGD with husbands

**Issue 1:** Explore husbands’ knowledge of services provided to children under the age of five years at the RCH clinic;

Compared to pregnant and women leaders, Husbands demonstrated scanty knowledge about the care packages provided at RCH. About, 89% are only able to mention weighing and “**Pengoo**” (immunization) as services provided during RCH clinics. A limited number (11%) were able to mention weighing, immunization, ‘fansidar’ and bed nets as services provided at RCH.

**Issue 2:** Views as to whose primary role/responsibility in the household is it to make decisions concerning whether, when and how often children less than 5 years old should/can be taken to the RCH clinic regularly for immunization and other services
There are varying views as to whose primary role/responsibility responsibilities in the household is to make decisions in taking children to RCH clinic. About half of the participants shared the view that it’s the responsibility of the husband to decide about taking children under 5 years to RCH clinic. About three quarter of the second half of the discussants view that decision to take the child to RCH clinic should be a collective responsibility. However, a quarter, belief that decision making should be the responsibility of the woman, since, is the one who takes care of the child including taking the child to RCH clinic.

**Issue 3: Views as to whose primary role/responsibility in the household is it to take children under 5 to the ‘RCH Clinic’ regularly for immunization and other child health services**

Respondents are divided over whose primary role is taking children under 5 to RCH regularly. Majority state that it should be the responsibility of the mother to take children to RCH clinic. A reasonable number also state that it is the responsibility of both father and mother to ensure children attend regular RCH clinic. Those who stated that it’s the mother’s responsibility based it on our current cultural practice, that women are the people who take children to RCH, if men do; it’s only a handful that does it. Those who argue that it is a collective responsibility advanced that the child belongs to all of them, so they should help each other to ensure the children are taken to the nearest RCH clinic.

**Issue 4: Find out what motivates parents to take their children less than 5 years of age who are not sick to the ‘RCH Clinic’ regularly; allow them to discuss**

What motivates majority of husbands to take their children less than 5 years who are not sick to RCH clinic regularly are for the good health of their child; help prevent childhood diseases; to know the health status of the child through weighing. Interestingly, few mentioned that they are motivated to take their child to the RCH clinic because, when they go, they do not join the queue for the child to receive the required services, but rather are quickly ask to come forward and receive service.

**Issue 5: Explore husbands’ level of Knowledge of diseases against which children less than 5 years of age are vaccinated in the country;**

Husbands’ knowledge of diseases against which children less than 5 years of age are vaccinated in the country is very scanty. A very limited number of husbands were able to mentioned more than 3 diseases. The most commonly mentioned diseases are measles and polio. Diseases such as malaria, stomach pain, anemia that are not vaccinated against in the Gambia are mentioned. Other VPDs are mentioned but by a limited number of discussants and these include yellow fever, diphtheria, diarrhea and tetanus.

**Issue 6: Find out husbands’ knowledge of the immunization schedule and how many times a child should be taken to RCH CLINIC to become fully immunized.**

Majority of husbands knows that RCH clinic is conducted every month and that when a child is born s/he should be attending clinic. However, there is gross in adequacy in knowledge about immunization schedule and the number of times a child should attend RCH clinic to become fully immunized. No husband was able to correctly state the immunization schedule and the number of visits required for a child to be fully immunized. Few of the husbands has intermittently indicated 1 month, 2 months, 3 months but not in a sequential manner.
Established: June 1997  Motto: Striving to improve lives and living conditions of people

Issue 7: Check how many of them have ever been to the RCH clinic in order to acquaint themselves with services provided to children less than 5 years;
Nationally, less than 10% of husbands who took part in the FGDs had ever been to the RCH clinic to be acquainted with services provided to children less than 5 years. Over 90% said they have never been to the RCH clinic. A handful also mentioned that they have ever accompanied their wife to the RCH clinic either on horse cart or motorbikes. However most of these people did not bother to acquaint themselves with what happens at the RCH but they simply help transport the wives/children to clinic. A greater majority of these people are in the rural areas.

Issue 8: Check how many of them have ever taken their child 0-24 months old to the RCH clinic for immunization.
A sizeable number of husbands’ state that they have never taken their child 0 – 24-month-old to the RCH clinic for immunization. Less than 3% said they ever took their child to RCH clinic and most of these husbands are in the urban area. Most of those who said they never take their child to RCH clinic argue that it is the women’s responsibility to take children to the RCH clinic. Few others blame it on the nature of their work and some others said they don’t know that husbands can take children to the RCH clinic.

During the FGD majority of the husbands indicated that they do not attend clinics for some reason that it (RCH) clinic is female dominant, “I carried my child at my back and accompany my wife to the RCH but anytime I do that I hear the women will be murmuring that am jealous with my wife since then I stop doing it” says one of the participant.

Issue 9: Find out if men do accompany their spouse to the RCH clinic to be immunized or benefit from the other RCH package; solicit explanations any how;
A very limited number of husbands’ state that they do accompany their spouse to the RCH clinic to be immunized or to benefit from other RCH care packages. The few who said they have accompanied their spouse to RCH explained that the health of their spouse is also their responsibility as a partner. Most of the men who said that do accompany their spouse are in western health region. Few of those who said they have not done it before explained that RCH is a women issue that is why they don’t go there. Few others also point to the fact that they don’t know that men can also go that’s why they have never tried.

Issue 10: Find out if any of the men has ever accompany their spouse to take their children less than 5 years to the RCH clinic to be immunized or benefit from the other RCH package; solicit explanations any how;
Very limited number of husbands said they have accompanied their spouse to take their children less than 5 years to the RCH clinic to be immunized or benefit from RCH packages. The very few who did say they provided transport in the form of car or ox-cart or motorbike. Only a very minute number said they accompanied their spouses for the child to receive immunization.

Issue 11: Find out if in the past 12 months if men discussed the health of children under the age of 5 who are not sick with their spouses; let them deliberate
An overwhelming majority of husbands said they don’t discuss the health of their children under the age of 5year who are not sick. However, most of them said they do discuss when the child is sick.
The few who said they do discuss, they discuss issues such as hand washing before, eating in a clean environment, not allowing children to work barefooted, sleeping under LLINs. A very limited number also mentions RCH attendance as a discussion point.

**Issue 12: Tell the men that in The Gambia (including their community) a significant proportion of parents/families fail to take their children less than 5 years regularly to the ‘RCH Clinic’ for immunization or other aspects of the RCH package; do they have any idea as to why?**

Majority of discussants state that they are not aware that children are not regularly taking to RCH clinic. However, they advanced many reasons that slightly vary from rural to urban why. The reasons stated are limited knowledge of the importance of services provided at RCH clinic and negligence of the mother. Social events and domestic chores as reasons for families failing to take children to RCH clinic were only mentioned by rural discussants. The child receiving only weighing being a waste of time to go to RCH clinic was also mention by few husbands that mothers do complain. This issue of failing to take children to RCH clinic regularly is squarely blamed on mothers by the husbands.

**Issue 13: Discuss if the men have ever held an IWC card in their hand with an aim to acquaint themselves with the information recorded on it;**

A limited number of husbands stated that they ever held an IWC card in their hand with an aim to acquaint themselves with the information recorded on it. Most of the discussants who state that they ever held the IWC card were in URR (17%). The reasons advanced by the few who ever held the IWC cards state the following reasons; look at the weight of the child; check on the road to health chart. Most of those who said they do not ever hold an IWC card to acquaint themselves with the information on it state they cannot read what is on the card or they don’t understand how to interpretation what is on the card.

**Issue 14: Has any participant ever stopped or prevented their spouse or any other family member from taking their child under five years of age to the RCH CLINIC; if there is any, let them discuss the reason/s**

Almost all the discussants in all the regions strongly argue that none of them or their family members have ever stop their spouse from taking their children under five years of age to the RCH clinic. They cited that what children receive at the RCH clinic help them to become healthy. They mentioned that LLINs are given at the RCH clinic, weighing is also done to know the weight of the child and also medicines are given. All these according to them make the child healthy.

**Issue 15: Find out whether husbands’ feel they have a role to play in ensuring that their children less than 5 years old are taken regularly (monthly) to the RCH for immunization and other services; if they feel they have a role to play, let them explain their perceived role**

All the discussants in the region feel they have a great role to play in ensuring their children are regularly taking to RCH. The most commonly roles they mention include; reminding mothers every month to attend RCH; support mothers by providing fares; Provide means of transportation for women for example ox cart/donkey carts on RCH day. A good number of husbands’ state that they are doing these roles. A limited number also state that their role also includes taking the child to the RCH clinic when the mother is busy or sick.
Issue 16: Find out if husbands’ have ever supported in improving RCH services in their community; let them elaborate;
A good number of husbands in URR, CRR, LRR and NBR indicate that they have ever supported in improving RCH services in their community. The most common support they ever provide includes; free labor; participating in building or refurbishment of the RCH clinic; cleaning exercises at the clinic. Some respondents in CRR and URR also mention the provision of breakfast and lunch (milk and “cherreh”) for the RCH team.

5.1.3 FGD with pregnant women

Issue 1: Explore pregnant women’s knowledge of services (care package) provided to children under the age of five years and pregnant women at the RCH clinic
Pregnant women demonstrated high level of awareness about care packages provided at RCH clinic. About 75% are able to mention at least 3 to 4 care packages provided to children under 5 years and pregnant women at the RCH clinic. The packages mostly stated by majority of them include weighing, immunization, palpation, scanning and checking blood pressure for pregnant women. A limited number also mentioned services such as counseling draft and blood test for HIV and AIDS. Birth registration; food supplementation; payment of incentives and ITN distribution are also mention.

Issue 2: Find out if pregnant women know the importance of RCH services including immunization. Let them explain;
Pregnant women in all regions have demonstrated some knowledge of the importance of RCH services including immunization. The most commonly mentioned importance of RCH services is framed around the health and well-being of the child. These include; to make the child healthy; to prevent diseases; pregnant women get care. In some regions, they made mention of easy access to birth registration.

Issue 3: Explore pregnant women’s level of Knowledge of diseases against which children less than 5 years of age and pregnant women are vaccinated in the country ;( Ask them to explain)
The knowledge of pregnant women on diseases children under 5 years are vaccinated against in the country is not very impressive. In individual focus groups, only few groups were able to state more than three VPD, however, they also mentioned many other diseases that are not vaccine preventable in the country. Polio and measles were mentioned in all the groups in all regions. One or two other VPD such as Meningitis, Pneumonia, diarrhea and TB are also mentioned in various groups in the different regions. The most common non-VPD mentioned in all groups and in all regions, is malaria. HIV and AIDS, hypertension, diabetes are also stated in some groups.

Issue 4: In the Gambia a significant proportion of parents/ families fail to take their children less than 5 years regularly to “RCH clinic” for immunization or other aspects of the IWC package; do they have any idea as to why
The most common reasons as to why some parents/families in Gambia do fail to take their children regularly for RCH as stated by the discussant include too much household chores on mothers; limited knowledge on the importance of attending RCH clinic; long distance to the RCH site; limited men support to women, carelessness on the side of some mothers. The poor attitude of some staff and long waiting time at the RCH clinic were also mentioned in some of the focus groups.

Established: June 1997  Motto: Striving to improve lives and living conditions of people
In few of the groups, the issue of children born out of wedlock is not regularly taking to RCH as their mothers mostly feel shy or ashamed.

**Issue 5: It has been observed that many pregnant women register lately for antenatal and RCH services; do you know the reasons for this problem?**
The late antenatal booking observed is blamed on many reasons according to the pregnant women. Among the most common reasons that is indicated by overwhelming majority are: shyness of exposing their pregnancy; socio-cultural beliefs; unwanted pregnancy or pregnancy very close and have nobody to care for the index child. Few respondents also blamed on the staff attitude which they described as rude. Some men failing to support and encourage their spouse to attend RCH though mention by very few respondents in a limited number of FGDs, but important to point it out as it has been blamed by other respondents too.

**Issue 6: In the Gambia it is evident that there is low coverage of TT in your opinion why do you think some pregnant women do not take Tetanus Toxoid (TT) injection?**
A good number of discussants blame the low TT coverage on negligence and laziness on the part of pregnant women. However, they were also quick to say they do take the injection when told to do so. Some other reasons given include pregnant women fears/scared the needle. Some people blamed that they feel dizzy and feel fatigue any time they took the injection.

**Issue 7: In your opinion, whose primary role/responsibility in the household is it to take children under 5 to the ‘RCH clinic’ regularly for immunization and other child health services?**
Most of the respondents said that it’s the primary role of the mother to take the child regularly to the clinic for immunization and other child health services. However, a good number also argued that taking children regularly for immunization should be the collective responsibility of both the mother and the father. Some of those who said “is the primary role of the mother, implicate their tradition that dictates the roles and as such caring of children including taking them to the clinic falls under traditional role of the mothers. Most of those who said it is a collective responsibility also belief that the man and the woman should help each other including taking the child regularly for immunization.

**Issue 8: Has any of the pregnant women among you ever discussed the health of children under 5 with their husband; please elaborate**
Majority of pregnant women who took part in the FGDs indicates that they don’t discuss the health of their children under 5 with their husbands, but only when they are sick. A quarter of the respondents’ stated that they do discuss the health of their children with their husbands. Few pregnant mothers also said they do discuss but only when going to the RCH clinic or when they returned from RCH clinic and their discussion is usually based on weight of the child and information received from the RCH.

**Issue 9: Has any of them been ever stopped or prevented from taking their child under five years of age to the RCH CLINIC; if there is any, let them discuss the reason/s**
Almost all pregnant women in all the regions state that they have never been prevented or stopped from taking their child under five years of age to the RCH clinic. A few of the mothers instated stated that they are pressured to take their child to the clinic.
In a very peculiar incident, a pregnant woman reported that she has seen a man who stopped or prevent the wife from attending RCH clinic. She states that the woman was stopped because the husband said he is expecting visitors, so the wife should stay and cook for the visitors.

**Issue 10: Can you explain the immunization schedule and how often do you take your child to RCH CLINIC to become completely immunized.**

This question appears to be one of the most critical issues in the survey and pregnant women demonstrated inadequate knowledge of the immunization schedule. Generally, they are not able to correctly state the immunization schedule, although they mentioned sporadically at 1, 2, 3 and 4 months intervals. On average, nationally, no pregnant women were able to correctly state the number of times a child should be taking to RCH to become fully immunized. The response to this question is generally poor among all the different respondents.

**Issues 11: What are the best ways of informing people about RCH services including immunization in this community?**

The regions are divided on this issue. However, Village health workers and CBCs are the mostly commonly mentioned best ways of informing people about RCH including immunization in all regions except in western 1 and two. In western 2 health region, RCH site is stated as the best way, while in Western 1 region which is predominantly urban sitting identify community sensitization and house to house as best ways of informing people about RCH services including immunization in their community.

**Issues 12: What do you think are the barriers to immunization in this community?**

Many different barriers to immunization in the community are stated by pregnant women in the different regions. The most common barriers stated are: domestic chores; socio-cultural events like wedding ceremony, funeral; inadequate knowledge of the importance of RCH. Few pregnant women also mentioned long distance and long waiting hours at the clinic as barriers to immunization in their communities. Similarly, some pregnant women also mentioned side effects of vaccinations and health workers late coming to RCH clinic.

**Issues 13: In addition to the issues discussed, do you have any other issues pertaining to RCH including immunization? Things they think can improve RCH services including immunization in their communities**

In most of the FGDs this issue has not been elaborated. In some of the groups, they indicated that all relevant issues have been discussed. However, in some of the groups they elaborated on the importance of early antenatal booking and regular RCH attendance. One of the groups highlight that use of loudhailers will help in reminding people of RCH days.

5.1.4 FGD with Village Heads

**Issue 1: Knowledge of services (care package) provided at the RCH clinic; (Ask them to explain)**

The knowledge of village heads on care package/services provided at RCH clinic was generally low. For the majority of the village heads, RCH is a period for seeking treatment for the child, as handful of them refer to it as “bori ta”, meaning getting medicine. The most common services that are mentioned widely are weighing and seeking treatment.

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Many village heads claimed they know children receive different services at RCH including different vaccines, they do not know what these services and vaccines are as stated by a respondent “I know that children are vaccinated at the RCH clinic during the first 6 months of life but I don’t know the name of the vaccines given to them”. Some of the village heads mentioned prevention services that are not within the RCH package for example “Children are prevented from diseases like AIDS”. However, services provided to pregnant and lactating mothers are not mentioned by any of the Village heads. Services such as bed net distribution to children and pregnant women and plumpy nuts for children are also mentioned in 3 regions.

**Issue 2: Find out if the village heads know the importance of RCH services including immunization. Let them explain;**

Findings from the FGD among the village heads indicate that knowledge on the importance of RCH is not very impressive. Majority of them who claim to know the importance only mentioned that it helps prevent children from sickness. Few village heads also mentioned the good that children receive is good for their health.

**Issue 3: Views as to whose primary role/responsibility in the household is it to take children under 5 to the RCH clinic regularly for immunization and other child health services;**

The majority of the participants mentioned that taking the children to clinic is the responsibility of the mother. Few household heads had a different view as to whose primary role is to take the children to RCH regularly. Their argument is that caring of children should be seen as a collective responsibility and not only the mothers as stated by others. The majority who said it’s the mother’s responsibility; state that in our culture it’s the responsibility of the women to take care of the children.

**Issue 4: Find out if any of the village heads has ever accompanied their spouse to the RCH clinic for their child 0-24 months old to be immunized or benefit from the other RCH services; solicit explanations any how;**

Overwhelming majority of the village heads said they never accompanied their spouse to the RCH clinic for their children 0 – 24 months to be immunized or benefit from other RCH services. Majority of those who said they have never accompanied their spouse state that they don’t know that they can do that. A very few among the discussants state that they have ever accompanied their spouse to the RCH clinic on few occasions. Most of these people said they provide transportation such as donkey-cart, motorcycle etc. There is no regional difference in terms of village heads accompanying spouse.

**Issue 5: Discuss the level of Knowledge of diseases against which children less than 5 years of age are vaccinated in the country;**

Village heads knowledge of diseases against which children less than 5 years of age are vaccinated in the country is scanty. Majority of them were able to mention at least one VPD. The most commonly mentioned diseases by village heads are Polio, measles and diarrhea. A lot of other diseases are mentioned which are not vaccinated against in the Gambia, these include Malaria, HIV and AIDS. Some other VPD are mentioned by few of the village heads in the different focus groups and these include yellow fever, Pneumonia, Tuberculosis. Malaria is mentioned in all the FGDs.
Most of the diseases that are mentioned are the traditional vaccines however new vaccines introduced in the system are not mentioned.

**Issue 6: Find out if in the past 12 months any of the village heads have at all discussed the health of their children under the age of 5 who are not sick with other community members; (Let them deliberate)**

A limited number of village heads said they ever discussed the health of children in the past 12 months with other community members. Most of the village heads who said they ever discussed the health of children with other community members mentioned meetings with village support groups in their communities who talked on different health issues about children’s health. The most common issues that are discussed as stated by the village heads are exclusive breastfeeding and hand washing. Majority of village heads who state that they ever discussed the health of children with other community members are in the rural areas (NB, URR, CRR, and LRR).

**Issue 7: Tell the village heads that in The Gambia (including their community) a significant proportion of parents/families fail to take their children less than 5 years regularly taken to the RCH clinic for immunization or other RCH services; do they have any idea as to why**

Many reasons were put forward by village heads as to why parents/families fail to take their children less than 5 years regularly to RCH clinic for immunization or other RCH services. The three most common reasons that cut across all regions include: domestic activities of women; limited knowledge of the importance of RCH among mothers and distance to RCH sites. Few village heads also mentioned lack of mobility for mothers.

**Issue 8: Has any participant ever stopped or prevented their spouse or any other family member from taking their child under five years of age to the RCH clinic; if there is any, let them discuss the reason/s**

This is one of the most positive responses not only because none of them said he has seen any spouse or other family member stopping or preventing taking children to RCH clinic, but because all of them emphasized that RCH is important and that no child should be prevented from attending RCH.

**Issue 9: Find out whether the village heads feel they have a role to play in ensuring that children less than 5 years old in their community are taken regularly (monthly) to the RCH for immunization and other services; if they feel they have a role to play, let them explain their perceived role**

In all regions, discussants feel they have a role to play in ensuring children less than 5 years old in their community are taken regularly to RCH for immunization and other services. Different roles were mentioned but the most outstanding is: to advice and engage household heads to ensure that women regularly take their children to RCH. Some few discussants state that they should ensure that men provide transport and or transport fares to their spouse and ensure they attend RCH regularly.

**Issue 10: Find out the ways they get information in relation to immunization. Discuss**

The sources of information related to immunization vary from urban to rural. In the rural regions, the most commonly information sources stated by discussants are village health workers (CHW), community birth attendance, community health nurses (CHN).
In the urban areas, the commonly mentioned sources of information are radio and TV. Few village heads also mentioned VSGs as source of information; however, their emphasis is on RCH not immunization specifically.

**Issue 11: Find out whether they support the RCH sites in their community. Discuss**  
Most of the village heads state that they support the RCH sites in their communities. The most common forms of support provided by village heads include: conducting cleaning exercises at the RCH site and providing breakfast for the RCH staff. Few village heads in the rural areas mentioned refurbishment and painting of the RCH building as support offered to the site. Similarly, many of the supports reported are in the rural areas.

**Issue 12: Let them tell you things they think can improve RCH services including immunization in their communities? Discuss**  
The most common suggestions put forward by majority of village heads that they think can improve RCH services including immunization in their communities are: Expansion of RCH site to communities where there is none, this according to them will improve access; support women with transport that can take them to the RCH( an interesting comment was made by a women in URR, Jimara who are argued that “horse cart is provided in many villages to carry children to school, if such is provided for women to go to RCH will really help”; sensitization of women on the importance of attending RCH. Few discussants mentioned (CRR) supply of CSB to mothers will motivate them to come to the RCH.

**5.1.5 FGD with women leaders**

**Issue 1: Find out if the women leaders know the importance of RCH services including immunization. Let them explain.**  
Women leaders compared to other FGD participants demonstrate good understanding of the importance of RCH services including immunization, although they could not talk in detail of such importance. They made mentioned that attending RCH helps improve the health of pregnant women and their unborn babies; That it helps in preventing diseases in children such as polio, diphtheria, malaria etc.

**Issue 2: Views as to whose primary role/responsibility is it in the household to take children under 5 years to the RCH clinic.**  
The views as to whose primary role/responsibility is to take children to RCH clinic in the household is very positive compared to husbands. A good number of them viewed that such role or responsibility should be a collective one. Such view from women leaders could have stem from their experience as mothers and care givers. The few women leaders who had different views, state that such role has ever been performed by the mother and even in our cultural norms is the mother’s responsibility.

**Issue 3: knowledge of services (care package) provided to children under the age of five years at the RCH clinic in the community;**  
Generally, knowledge on care package or services provided at RCH clinic is very high among women leaders throughout the country. Majority of the women leaders were able to mention two to
three care packages provided to children under 5 years and pregnant women at the RCH clinics. The most commonly mentioned services were weighing; immunization; health talk; IPT, bed net distribution and antenatal care.

Issue 4: Knowledge of diseases against which children 0-24 months of age are vaccinated in the country;
Like all other discussants, women leaders’ knowledge of diseases against which children 0 – 24 months of age are vaccinated in the country is not very impressive. Although they were able to itemize some, but they also mentioned many that are not VPDs. The most common VPDs mentioned are Polio, measles and diarrhea. A few of them mentioned pneumonia and meningitis. Malaria and HIV and AIDS are consistently mentioned as VPD even by women who had so much interaction with the RCH.

Issue 5: For the past 12 months if any of the women leader have discussed the health of children less than 5 years who are not sick with other women; let them deliberate
Most women leaders reported that they do discuss the health of children less than 5 years who are not sick with other women. However, most of the women who reported that they do discuss with other women are in the rural areas. According to them the issues they do discuss include; exclusive breastfeeding, proper hand washing and importance of RCH. Some of the women leaders who said they do not discuss with other women health of children blamed it on the nature of their daily activities such as petty trading.

Issue 6: Tell the women leaders that in The Gambia (including their community) a significant proportion of parents/families fail to take their children 0-24 months regularly to the RCH clinic for immunization, do they have any idea as to why?
The reasons why a significant number of parents/families fail to take their children 0 – 24 months regularly to RCH clinic for immunization according to women leaders is similar to what pregnant women, adolescents and village heads had stated. The reasons include; domestic chores; limited knowledge of the importance of RCH services, laziness and negligence of mothers; distance to RCH site. The issue of mothers been involved in petty trading as a means of living was highlighted in the urban areas. Although only mentioned in few FGDs, staff attitude is also incriminated as a contributory factor for some parent not attending RCH clinics. Such staff attitude should be addressed.

Issue 7: Have you ever witnessed/heard any husband stopping or preventing their spouse or any other family member from taking their children under five years of age to the RCH clinic; if there is any, let them discuss the reason/s
All the discussant in all regions state that they never witnessed or heard any husband stopping or preventing their spouse or any other family member from taking their children under 5 years to the RCH clinic. This is consistent with what has been reported so far. Some women leader reported that they are encouraged by their husbands to go and attend RCH clinic and in some instances, they provide transport or transport cost.
Issue 8: Find out whether the women leaders have a role to play in ensuring that children 0-24 months old in their community are taken regularly (monthly) to the RCH for immunization and other services; let them explain their perceived role.

Majority of women leaders’ state that they have a role to play in ensuring that children 0 – 24 months old in their communities are taking regularly to RCH clinic for immunization. Their perceived role includes; encouraging young mothers to attend RCH clinic monthly; conduct community meetings and discuss about importance of attending RCH clinic; referring women for RCH service.

Issue 9: Open discussion on RCH including immunization that is not discussed above. Things they think can improve RCH services including immunization in their communities

This issue was not well attempted, however in few of the FGDs some of the issues raised include; Health workers to sensitize people more on the importance of RCH services; RCH staff to go to the RCH site early and conducting Saturday clinics for working mothers.

5.3 Findings from the Participatory Rural Appraisal

In the conduct of the PRA the teams used tools and techniques that were generally recommended to generate information required to address the objective of the assessment and these were the following:

5.3.1 Community Resource Map

In the community resource mapping, the following assets and resources were identified in the sampled communities which contribute to their livelihood. The availability or in availability of these resources and assets can affects participation in health care and other development activities. For instance, in the rural areas, portable drinking water, health posts, milling machines, and seed stores where identified as key community resources whilst in the urban areas like in EBO Town, electricity, day care centres, markets and health centres were identified as key community resources. These assets and resources enhance living conditions of communities. Therefore, service providers need to be cognizant of the resource implications of communities in the design of their programs.

5.3.2 Daily Activity Calendar

The findings from all the sites on the daily activities of men and women revealed that women work longer hours, have more activities to do than their male spouses through multi-tasking which also affect the degree of leisure time they need. The triple roles of women in reproduction, production and community work seriously affects the participation of women in development work, particularly on health issues such as completing the immunization cycle of their children. It was found out that though women in both urban and rural areas have busy work schedule, those in the urban are impacted more as their daily economic activity is all round whilst those in the rural areas are less busy during the dry season. In situations where men give less support to women to ensure the completion of immunization, the coverage will continue to drop and the issues of stereotyping requires attention during project and program planning.
5.3.3 Venn Diagram and Institutional Analysis Framework

The Venn diagrams were used to identify internal and external institutions operating in the communities and their linkages. This study identified critical institutions that could be useful in partnership activities relative to immunization and implementation of health and development activities.

At the lower level, Village Development Committees (VDCs), Village Support Groups (VSGs), Community Child protection Committees (CCPCs), Day Care Centers Committees (DCCC), Women and Youth Groups, School Committees and Traditional Communicators could be instrumental for sensitization, advocacy and generic project implementation.

External Institutions that have a stake in contributing to immunization coverage and exist or have structures in the communities and identified in the study include the following: Unicef, SOS, Medical Research Council (MRC), Ministry of Health and Social Welfare (MoHSW), Community Development, National Nutrition Agency, Child Fund, Ministry of Basic and Secondary Education and The Agency for Rural Development (TARUD) Gambia Family Planning Association (GFPA), National Council for Civic Education (NCCE) Wulli and Sandu Development Association (WASDA) National Youth Council (NYC) and Nova Scotia Gambia Association (NSGA).

5.3.4 Focus Group Discussion

As part of the PRA, FGD was conducted in fourteen sites with a cross section of community members, such as VDCs, VSGs, mothers, fathers and other members of the community to have a better insight of the issues being discussed. Some useful information on participant’s knowledge, attitude and practice towards the uptake of RCH services including immunization was generated.

Findings of the PRA are discussed below:

Issues: Types of services provided to particularly under five children during RCH clinic

Participant identified the following: Weighing of children, Periodic injection (Immunization), provision of vitamin A and deworming tablets, nutritional supplements, treatment of pregnant women with injection (TT) and children as services provided during RCH clinics. These services were mentioned in all the communities where PRA was conducted. In addition to these services, health talks by RCH staff were also mentioned in 14% of the communities.

Issue 2: Schedules of immunization for children of 0-24 months,

The general understanding was that there is a monthly RCH visit. However, the different vaccine schedule (immunization) is not fully known by the participants. Out of the fourteen communities assessed, 50% of them could not clearly explain the national immunization schedules.

Issues 3: Factors that motivate women with children of 0-24 months to visit the RCH clinic

These includes the following as stated by the participants

- Bed net, food ration (Dugula),
- Their families do support them by doing their daily household chores for them while they visit the health post,
- Husbands give money to buys foods whilst at the RCH Clinic,
• Availability of transport fares,
• Remind each other the day for next RCH clinic
• Free RCH services
• Health talks
• Mothers and communities implementing the Maternal and Child Health and Nutrition Results Project benefits from financial incentive upon facilitating a skilled delivery at a health facility.

**Issue 4:** The benefit of immunizing children, the responses from the participant were that immunization-

• Prevents the infants from diseases such as polio worms, yellow fever, measles, and other diseases
• Give lifelong immunity for certain disease

**Issue 5:** The strategies to be adopted for children access these benefits uninterrupted; the participant gave various options as thus:

• “Nurse” (RCH clinic) schedule conflict with their schooling especially those above 3 years, in that case if it can be held at the school level
• If the Ministry of Health and Social Welfare (MoHSW) can sign Memorandum of Understanding (MoU) with GRTS to sensitize the public the important of completing immunization cycle
• Attitude of some health officers discourage women but if experienced officers could be attached to the young officers will help a lot to improve on their attitude and work ethics
• Weekend clinic for formal sector workers

**Issue 6:** Whose role or responsibility of ensuring the continuity of immunization

The responses were that it should be a collective responsibility of the couples but women particularly as they are the mothers. This is because they are close to the children and know their conditions better. Other stakeholders were also mentioned such as care givers, VDCs, VSGs and family members.

**Issue 7:** Main reasons why a significant proportion of parents/families failing to take their children 0-59 months regularly to the RCH clinic:

The following reasons were given.

• Inadequate support to the women toward the welfare of the child by the husbands
• Inadequate birth spacing causing them to have too many children to carry at a time
• Distance from the health post as it makes some lazy to visit the clinic
• Congested clinic service points in many urban centres.
• Laziness/Negligence
• Clinic schedule coincide with school time for nursery school
• Employment of mother
• Time consuming (7-13.00)
• Conflict with business time
• The workload on women in general hinders their regular visiting to clinics for immunization (household chores too much)
• Inadequate awareness on the importance of the services to their children
- Social activities within the neighbouring communities,
- Many mothers are illiterates and thus don’t understand the schedules

**Issue 8: What should be done to improve immunization uptake?**

According to the participants, much needs to be done to improve the situation. Among the recommended ones are the following.

- Increase people awareness on the importance of the RCH services
- Decongest the RCH centre by opening new ones
- Community- sub ward, village development and ward development committees should be involved in the sensitization of communities on the importance of complete immunization with sample of scenarios the differences between immunized child and one without immunization.
- At household level the couples should try and space their births
- Create outreach centre in strategic locations to enhance access for mothers with many children.
- To make immunization a law
- To consider creating RCH days on a weekend to cater for the working parent and the children attending ECD and nursery school

### 5.3 5 Problem ranking and analysis

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>CAUSES</th>
<th>EFFECTS</th>
<th>Proposed Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop in child Immunization coverage</td>
<td>Low knowledge of immunization schedules, and types of antigens given to children during RCH clinics</td>
<td>Irregular attendance of RCH clinics</td>
<td>RCH team should strengthen caregivers’ knowledge and understanding on the schedule, types and the benefits of antigens given to their children.</td>
</tr>
<tr>
<td></td>
<td>High domestic chores on women vis-à-vis overcrowding at RCH clinics</td>
<td>Irregular attendance of RCH clinics</td>
<td>Other family members should be sensitized to support mothers with children 0 – 5 years as they take their kids to RCH clinics</td>
</tr>
<tr>
<td></td>
<td>Poor financial status of some caregivers (inability to afford transport fares and food for the kids)</td>
<td>Frequent default in attending RCH clinics</td>
<td>Husbands and village institutions such as VDCs should be fully sensitized to support women to take their children to RCH clinics regularly</td>
</tr>
<tr>
<td></td>
<td>Laziness amongst some caregivers (especially young mothers) in attending RCH clinics regularly</td>
<td>Irregular attendance of RCH clinic</td>
<td>Strengthening behavioral change communication among mothers especially among young mothers.</td>
</tr>
<tr>
<td></td>
<td>Poor road conditions especially during rainy seasons in hard to reach areas</td>
<td>Low RCH clinics attendance</td>
<td>Government construct more outreach RCH clinics to improve access</td>
</tr>
</tbody>
</table>
Established: June 1997  Motto: Striving to improve lives and living conditions of people

| Attitude of some health officers discourage women from going to clinics in some cases | Low RCH clinics attendance | Close monitoring of health staff attitude during clinic day by their supervisors |

### 5.4 Findings from the in-depth interview

A total of 307 interviews were conducted among the six different group namely pregnant women, breast feeding mothers, women leaders, adolescent and youths, district authorities and village health workers. Further characteristics of the survey participants are below:

#### General profile of respondents

A total of 307 respondents comprising District Authorities, Village heads, Community health workers, Women leaders, Pregnant women and Breast feeding mothers were interviewed in the survey. District authorities accounted for 46 (15.0%), Community health workers 53(17.3%) and the remaining groups accounted for 52 (16.9%) each.

The number of interviews conducted in the health region varies as follows: WCR1 (13.7%), WCR 2 (17.6%), LRR (10.4%), CRR (19.2%), URR (16.16%), NBWR (12.04%), and NBER (10.1%)

According to the survey data majority of the respondent (30.8%) mentioned the RCH clinic as their main sources of getting information on immunization. A combination of information sources which include radio, TV, RCH clinic, CBC were mentioned by 28.2% of the respondents. Another 8.4% mentioned village health workers as their sources of information on RCH. Only 8.8% of the respondents mentioned Radio/TV as their source of information on RCH services. Among those who mentioned the RCH clinic as their main source of information majority were women leaders (35.7%) and pregnant women (19%).

#### i. District Authorities’ KABP on RCH services including immunization

**Issue: Reason for taking child to RCH**

About 15.2% of the District Authorities interviewed country wide mentioned that weighing and immunization are the main reasons for taking children to the RCH, 17.4% mentioned care for illness, 4.3%, mentioned immunization with only 2.2% saying they don’t know. However, majority (60.9%) mentioned multiple services such as care of illness, immunization, weighing, VAS as reason why children are taken to the RCH clinic Out of the 15.2% who mentioned weighing and immunization, 57.1% were from West Coast Region 2.

**Issue: Factors that prevent taking children to RCH regularly by caregivers**

Majority (65.2%) mentioned multiple reasons such as not recognizing the importance of RCH, socio economic status, culture, tradition etc as main barriers preventing children from been taken to RCH clinic regularly.
However, 8.7% of did mention that parents or caregivers don’t recognizing the importance of RCH clinic whilst another 8.7% also mentioned socioeconomic status as factor hindering parents or caregivers from taking their children regularly to RCH clinic.

**Issue: Primary responsibility to take children to RCH clinic regularly**

Half of the respondents (50%) said that it is the mothers’ responsibility, 30.4% beliefs is the responsibility of the couples whilst only 2.2% believing that it is a collective responsibility of the family members.

Nationally majority of the District Authorities (47.8%) stated Culture, tradition, economic & lack of knowledge as barriers to new born receiving the first dose within 24hours. Another 30.4% mentioned lack of knowledge about the birth dose. Majority (31.8%) of those who stated culture, tradition, economy and lack of knowledge were in CRR whilst 21.4% of those who stated lack of knowledge about the birth dose were from WCR 2.

**Issue: Support provided by district authorities**

More than half of the respondents (65.2%) of district authorities have ever provided support to the RCH clinic. Support provided by them to RCH clinic was highest in CRR (33%),,, LRR(17%),, NBER (13%) and URR(13%) ( . The form of support usually is either breakfast for the RCH teams, helping to organize the RCH site, refurbishment etc.

**ii. Village Heads’ KABP on RCH services including immunization**
Out of 52 respondents nationwide 38 (73%) cited immunization as the main reason for taking children to the RCH clinics. Among those who mentioned immunization, majority 18% were from WCR 2.

An overwhelming majority (84.6%) as showed in the graph stated that it is the mother’s responsibility/role to take the children to the RCH clinics. Although not significant, few in URR and NBER have mentioned that it is everybody’s responsibility. Interestingly of those who stated that it is also the responsibility of the father to take the children to the RCH clinics, 50% were from WCR 2.

iii. Community Health Workers KABP on RCH services including immunization
Nationwide 82.7% of the Community health workers, who took part in the survey, said they have been trained or at least have some form of training. The highest of those trained were in WCR 1 (18%). However 17.3% nationwide are still formally untrained. This is an indication that there still exist few workers in our health delivery system mostly in rural areas who need to be trained to enhance efficient and effective service delivery.

Fever was cited by majority of the community health workers (69%) as the most common adverse effects following immunization.
Nationally limited knowledge (40%) and cultural beliefs/practices (42%) were mentioned as key barriers for mothers not coming for the first dose of immunization within the 24hrs. It is observe from the graph that cultural belief is peculiar in all the regions. There is the generally belief that newly delivered mothers should not go out until after the 7th day.

Majority (58%) of the respondents countrywide said they do observed parents continuation to go for RCH services after the fourth visit, however 33% expressed opposite observations.

iv. Women Leaders KABP on RCH services including immunization
About 28.8% of the respondents mentioned that a child should receive first dose of vaccine within first month of life. Only 17.3% mentioned at birth withing 24 hours and of this number 33.3% were from URR and 11.1% from WCR 1 and WCR 2 each. Another 13.5% said they dont know when a child should recieve first dose of immunization. Knowlegde is identify as an issues about the importance and timing of the first dose.

Nationwide, only 8% could named up 5 VPDs as disease against which children are immunized. Majority 29% and 27% could only correctly named 1 VPD and 3 VPDs respectively. Regional variations is observed as indicated in the graph above.
v. Pregnant Women KABP on RCH services including immunization
From the total respondents, of who took part in the survey 86.5% were found registered for ANC services at the time of the survey with the highest been in CRR and URR 20% each. However of those who were not found registered, majority 57.1% were resident in WCR 1.

Among the respondents, 48.1% mentioned not wanting to expose their pregnancy early as reason for late ANC registration. These phenomena is peculiar in all regions but highly manifested in the rural areas such as NBER. Other reasons such as shyness, scared of injections etc. were also mentioned.

Among the responses, 26.9% mentioned several factors such as not knowing schedules, carelessness, unfriendly approach of RCH staff, shyness etc. However 21.2% said they don’t know the factors whilst another 7% said not knowing schedule of visits as reason for defaulting. Of those who mentioned not knowing scheduled of visit, 50% were from WCR1.
Issue: When to take first doses of TT

Among the 52 PW, who responded to this question, 38.5% mentioned that first dose is taken at first contact whilst 15.4% mentioned they don’t know when the first dose is to be taken. Out of the 15.4% who said they don’t know when the first dose is to be taken, 37.5% were from WCR 1 and URR.

Out of the 52 respondents nationwide, 24 (46.2%) mentioned limited knowledge/information about TT immunization schedule. However 26.9% said they don’t know the barriers to completion of five doses of TT immunization. Only 3.8% mentioned cultural reason as barrier to the completion of the five doses of TT. Regions with highest number of respondents who cited limited knowledge / information as barriers to having all the five doses were WCR1, URR NBRs.

vi. Breast Feeding Mothers KABP on RCH services including immunization
Majority of the respondents about 48.1% cited immunization and weighing as the only services provided at the RCH clinics whilst another 42.3% mentioned multiple RCH services such as treatment, palpation, weighing, immunization, issuance of bed nets, vitamin A supplementation, deworming as other essential services provided. Majority of the respondents who mentioned specifically immunization were highest in CRR.

Nationally, 26.9% of the respondents were able to cite multiple VPDs such as polio, measles, and yellow fever as disease against which children are immunized. However 9.6% mentioned non VPDs such as malaria and HIV/AIDS whilst a significant number (23.1%) said they don’t know the different diseases. Those who said they don’t know was highest in WCR1 (33.3%) whilst those who were able to mentioned multiple VPDs (21.4%) was highest in CRR and URR.
Nationally only 25% of the respondents mentioned that the child is due to receive first dose of vaccine soon after birth within 24 hours. Majority of those who mentioned at birth within first 24 hours, were from the regions of WCR2 (23.1%), CRR (23.1%), URR (23.1%) and NBER (23.1%).

**Respondent’s knowledge on the diseases children are immunized against at the different ages and intervals**
Among the 52 respondents country wide, 38 (73.1%) said they don’t know or could not state correctly the diseases which children are immunized against and their different age intervals. Out of the 73.1% who do not know or could not state correctly the diseases which children are immunized against were 55.2% were from WCR 1 (18.4%), WCR 2 (18.4%) and CRR (18.4%) respectively. Only 5.8% of the total respondents were able to name correctly the diseases children are immunized at birth and they were from the LRR, CRR and NBER.

**Health facilities where respondents take their children for RCH services by region**
Among those responded to this question 51.9% access RCH services at Public health facilities outreach sites. Majority of these are in the rural regions which is an indication of more outreach sites in rural regions.

Out of the 36.5% (19 respondents) who reported defaulting in taking their children for immunization, 5 (26.3%) were from WCR 1 and 4(21.1%) from WCR 2. Of those who defaulted, 36.8% was because of the mother travelling.
RESPONDENT'S OPINION ON SOME KEY STATEMENTS

Participants were asked to indicate whether they agree or disagree with the following statements:

- **That the benefits of taking children less than 5 years old to the RCH clinic regularly (monthly) in strict compliance with the immunization schedule outweigh the burden (time, energy, money, putting other commitments on hold)**

With respect to the above statement, all the Breastfeeding mothers, Women Leaders, District Authorities and Pregnant Women agreed but with few exceptions of the Village Heads and Community Health Workers 3.8% and 1.4% respectively not agreeing. Generally, the respondents expressed a good and positive opinion towards taking their children to the RCH clinic for RCH services including immunization services, as more than 95% in all the different categories of respondents indicated their preference to taking their children for RCH services than encounter the burden.

- **Making sure that the children less than 5 years is taken to the RCH clinic regularly for immunization is the collective responsibility of parents not the mother alone**

Participants were asked to indicate as to whether they agree or disagree with the statement above, and 94.2% of the Breastfeeding mothers said they agree with the statement. 91% of the Women Leaders, 96% of Village Heads, 98% of District Authorities and 95% of the Community Health Workers all said they agree to the statement. The views as to taking children to RCH clinic as a collective responsibility of parents and not the mother alone is very positive, as more than 95% of the different respondents categories viewed that such role or responsibility should be a collective one.

- **For a child to be considered fully immunized against some vaccine preventable disease, e.g. poliomyelitis, he/she must receive several doses and not one dose**

Respondents’ feeling to the above statement was impressive as 91% Breastfeeding Mothers, 96.8% Pregnant Women, 90.1% Village Heads, 97.8% District Authorities and 98.1% Community Health Workers agreeing to the statement. This opinion shows that majority knows that several doses of vaccine shots are required to be fully immunized. In addition to been fully immunized, they also recognize the fact that vaccine help to prevent diseases, boost immunity and as well as promote healthy growth of a child.
6. Discussion of findings

KNOWLEDGE, ATTITUDE, BEHAVIOR/PRACTICE OF ADOLESCENTS

Knowledge: All the adolescents in the health regions who took part are aware that children under 5 years in the Gambia are taken to the RCH clinic where they received some services. However, few are with the view that the services offered at the RCH clinic is mainly for newborns. Their knowledge of the care packages provided at the RCH clinic to children under 5 years is not impressive compared to other groups like mothers or women leaders. The most common services that they knew about are weighing and treating of sick children. Their knowledge of vaccine preventable diseases are equally very low as in most instances they are not able to state more than 3 VPDS in a focus group. This limited knowledge about services offered and VPD can be blamed on the limited interaction adolescents have with the RCH. The most common VPDs mentioned almost by all groups were Polio, diarrhea and measles. It could be observed that the few VPDs they know about are old vaccines except for diarrhea which was introduced not long ago. It is interesting to note that they made mentioned of several other diseases that are not vaccine preventable such as malaria, HIV and AIDS.

Attitude: A very positive attitude demonstrated by adolescents is the fact that they will encourage their husbands/wives to take their children under 5 years to RCH clinic once they start having children. They relate this to the benefits of RCH for the child. This is very impressive and should be encouraging and nurtured as very soon these people will take the mantle of motherhood and fatherhood. However, even though they demonstrated positive attitude about taking children to RCH clinic, but on who is responsible of making decision raises some eyebrows. Majority of them still uphold the view that such decisions should be made by the father. Such arguments are based on cultural norms. The fact that the father may not always be at home, such stands can affect the regularity of RCH attendance

Behavior/practice: Adolescents responded positively to the view that the benefits of taking children 0 – 24 months of age to the RCH clinic for immunization every month outweigh any burden that may be faced in attending clinic. They relate this to the fact that health supersedes everything. Most of them agree that they have a role to play in ensuring that children 0 – 24 months of age are regularly taking to RCH and when they become parents in the future will take their children to the RCH clinics. Their perceived roles include; taking the child to the clinic when the mother is busy; take care of domestic chores for the mother to have time to go to the RCH clinic. These are very critical role which contribute or serve as barriers to RCH attendance mentioned by almost all the different FGD groups. On the reasons, why parents/families fail to take their children regularly for Immunization, they stated several reasons such as; long distance to the RCH site; close pregnancy intervals; household chores; limited awareness of the importance of RCH services including immunization schedule. They therefore suggest the following to improve immunization services in the Gambia; increase awareness of importance of immunization; health workers going meet people in their communities and other family members to support mothers. These are very impressive views and in tandem with the view of other discussants.
KNOWLEDGE, ATTITUDE, BEHAVIOR/PRACTICE OF HUSBANDS

Knowledge: Husbands’ knowledge of services provided to children under the age of 5 at RCH clinic is not as impressive as that of pregnant and women leaders. Their knowledge of care packages is limited to weighing and “pengoo” (immunization). Although, they are aware that immunization is offered at the RCH clinic, but they demonstrated limited knowledge of the diseases against which children are vaccinated against, the vaccination schedule and number of times the child should be taking to RCH to be fully immunized. The VPD they know of are mainly Polio and Measles. They however mentioned a catalog of other diseases that are not VPD and malaria standout clearly among these diseases. This limited knowledge among husbands should really be a cause of concern for immunization service providers, as husbands are decision makers. Therefore, adequate strategies should be put in place targeting them to increase their awareness on services that are provided at RCH as well as diseases that children are vaccinated against in the country.

Attitude: There were divergent views among the husbands as to whose primary role/responsibility in the household is to make decisions concerning whether, when and how often children less than 5 years should be taking to the RCH clinic regularly for immunization and other services. Majority viewed that decision making in the household is the responsibility of the husband. However, a couple more opined that such responsibility should be a collective one. Interestingly, some few husbands advanced that it should be the mothers to decide as they are the once who care for the child including taking them to RCH clinic.

On whose role is to take the child to the RCH regularly, discussants are divided over this issue too. However, majority opined that it should be a collective responsibility, which is really very encouraging but the few who thought otherwise, belief that in our society this responsibility has being women’s role. Failure of some parents/families failing to take their children regularly to RCH clinic for immunization was attributed to several factors such as, social events, domestic chores, carelessness, travel, rains just to name a few. Although these could be reasons, however, some husbands blamed such failure on the women squarely which is a very negative attitude. This could explain how disconnected husbands are from RCH and thus the need to ensure their active involvement including taking the child to the RCH when the mother is busy on other domestic chores.

Behavior/practice: Nationally, there is negative attitude among husbands towards going to the RCH to acquaint themselves with services that their children are offered. The very few who has ever visited the RCH clinic mostly did when they have to accompany the sick transporting them using donkey cart or car. Most of these husbands are in the rural areas. Similarly, an insignificant number of fathers said they ever took their child to the RCH clinic for immunization. The bulk of these husbands are in the urban area. The husbands blamed the nature of their jobs and some few who said they don’t know that men can take their children to RCH clinic.

Although, the IWC card contains useful information about the child’s immunization schedule and update, as well as the road to health chart, however, overwhelming majority of husbands do not look at this card to acquaint themselves with the information there-in. Most of those who ever held the IWC card in this survey are in URR. Most of them state that they look at the card to see the weight of the child. The majority of husbands blame that they cannot either read the information on the cards or they cannot interpret the information on the card.
These responses are clear indication of the limited involvement of husbands in RCH services. It is prudent therefore to actively involve husbands as duty bears of children. There active involvement through education and engagement can motivate them to take lead roles in RCH services which can translate to regular and consistent uptake of services. Therefore, there should be a more robust community engagement by targeting key stakeholder like the husbands in the community.

Although, there is limited husband involvement in RCH, it is very impressive that rarely does husbands or their family members stopped or prevent their spouse from attending RCH clinic. Equally, it is positive that husbands feel they have a role to play in ensuring that their children less than 5 years old are taking regularly to the RCH. Their perceived roles according to them include; providing means of transportation or transport fares and reminding mothers every month. These are no doubt importance roles, but roles like taking the child to the RCH clinic when the mother is busy, accompanying spouse to the clinic are critical role of a husband but rarely practice. Community support to RCH is important for sustainability and ownership, a sizeable number of husbands in the rural areas do support RCH clinic in various ways such as participating in building or refurbishment, cleaning exercises and provision of breakfast (milk and “cherreh”). These positive attitudes are a reflection of willingness that can be harnessed to improve immunization uptake in the country. Husbands in the urban areas should be targeted for their active involvement and support to the RCH in their respective communities or settings.

KNOWLEDGE, ATTITUDE, BEHAVIOR/PRACTICE OF DISTRICT AUTHORITIES

Knowledge: District Authorities being key decision makers at local level have an influential role in the success or failure of any intervention whether regional or national. The DA’s knowledge on RCH services including immunization is considered high as 60.9% of them country wide mentioned multiple services such as care of illness, immunization, weighing, VAS as reason why children are taken to the RCH clinic. It was only 2.2% who said they don’t know the reason why children are taken to the RCH clinic. However, 57.1% indicated weighing and immunization as they sole services offered at the RCH clinic. This is indicative that in instances where a child is not due for immunization usually between the ages of 4 to 9 months, DAs will not be active in ensuring that children are taking to the clinics for other services. This is as a result of their belief that weighing and immunizations are the major services that a child should receive at the clinic. Significantly 30.% of the Das lack knowledge about the birth doze and therefore compromise their participation in ensuring the newly born babies receive their first dose within 24 hours.

Limited knowledge of District Authorities on the different services offered at the RCH and the interval at which children are supposed to get such services is a clear manifestation of their low involvement by the responsible programs routinely but rather on adhoc basis. Their involvement is only limited to when there are mass events such campaigns.

Attitude: Half of the 46 DA’s country wide (50%) belief that it is the mothers’ responsibility to take the children to the clinic but 30.4% beliefs is the responsibility of the couples whilst only 2.2% believing that it is a collective responsibility of the family members. All of them agreed that the benefits of immunization outweigh the burden and therefore it is important that care givers be given the necessary support take their children to complete the immunization on time.
Nationally majority of the District Authorities (47.8%) belief that Culture, tradition, economic & lack of knowledge are barriers to new born receiving the first dose within 24hours. Another 30.4% are with the opinion that lack of knowledge about the birth dose as barriers to new born receiving the fist doej within 24 hours. Majority (31.8%) of those who stated culture, tradition, economy and lack of knowledge were in CRR whilst the majority (21.4%) who stated lack of knowledge about the birth dose as barrier was from WCR 2.

**Behavior/practice:** More than half of the respondents (65.2%) of district authorities have ever provided support to the RCH clinic. Support provided by them to RCH clinic was highest in CRR (33%), LRR(17%), NBER (13%) and URR(13%). The form of support usually is either providing breakfast for the RCH teams, supporting in identification and allocation of site RCH post, refurbishment etc.

**KNOWLEDGE, ATTITUDE, BEHAVIOR/PRACTICE OF VILLAGE HEADS**

**Knowledge:** Village heads generally demonstrated limited knowledge of the importance of RCH services including immunization in both qualitative and quantitative assessment. The most importance issue they generally mentioned in the FGDs was that it prevents children from sickness. When they were probed on the services provided at RCH, they mentioned weighing, immunization and seeking treatment which they refer to as “Bori ta”. For the in-depth interviews 73% cited immunization as the main reason for taking children to the RCH clinics and out of those who mentioned immunization, majority 18% were from WCR 2. Other services such as bed net distribution and food ration were mainly stated by rural health regions. Services offered to pregnant women and lactating mothers were not mentioned. Village heads knowledge is also limited to very few VPDs which they were able to mention such as Polio, measles and diarrhea. Surprisingly, malaria and HIV and AIDS were mentioned in almost all FGDs, PRAs and in-depth interviews.

This limited knowledge of Village heads about the importance of RCH services provided at RCH and the VPDs indicates their limited involvement in RCH services. As traditional leaders, they can influence the uptake of RCH services including immunization in their communities if they are aware and actively involved in RCH. Programs and interventions geared towards improving RCH services should target them to gain their active participation and support.

**Attitude:** Village heads’ views as to whose primary role/responsibility in the household is to take children under 5 to the RCH clinic regularly for immunization is not different from that of husbands. Majority 84.6% viewed that it is the mother’s responsibility to take the child regularly to the RCH clinic but the only reason they put forward is that culturally caring of children is mother’s responsibility. However, some viewed that it should be a collective responsibility which is very impressive. It is very positive that all village heads feel that they have a role to play in ensuring that children under 5 years are regularly taking to RCH clinic. Some of their perceived roles include; giving advice to household heads to ensure women regularly take their children to RCH, ensuring that men provide means of transportation to their spouse to attend RCH clinic regularly. These perceived roles are impressive; however consistent engagement of both village heads and community members will be a good receipt to achieve this.
Behavior/practice: The practice of accompanying spouse to the RCH clinic for their children 0–24 months to be immunized or benefit from other RCH services is less impressive among village heads who took part in this survey. The few who had accompanied their spouses to RCH clinics was by transporting them with donkey-carts or car. Discussing health of children at community level by duty bearers, is an indication of concern for the health and well-being of children, however this is not commonly done. An overwhelming majority of village heads state that they did not discuss the health of children with other community members in the past 12 months. Those who said they did discussed mainly exclusive breastfeeding and hand washing and that the meetings were sermon by the village support group (VSG) and these are mainly in rural areas. It is indeed very positive that many village heads state that they do support RCH site in their community. Their support includes conducting cleaning exercise, providing breakfast to RCH team as well as refurbishment and painting of the structure.

KNOWLEDGE, ATTITUDE, BEHAVIOR/PRACTICE OF COMMUNITY HEALTH WORKERS

Knowledge: Knowledge on the importance of RCH clinics and the services offered at the RCH sites is very high among the community health workers. This could be attributed to the fact that they are health workers and are exposed to the things. Their knowledge on the VPDs is also very high and was able to mention vaccine schedules for both pregnant women and children. Knowledge on RCH services including immunization services was obtain through radio as the main source and health workers as the secondary source. They have also indicated that the most common adverse effect following immunization was fever. Although other effects such as pain, abscess etc. occurs, fever is the most common. This however does not lead to default in immunization services. Majority of them indicated that they have received some form of training as either a village health workers, community birth companions etc. across all the regions.

Their knowledge on when a child should receive the first dose of vaccine was also very high, as majority of them mentioned that it should be taken at birth (within 24hrs). Community health workers responded positively to whose role or responsibility is it in the household to take children to RCH even when they are not sick. They mentioned that it should be the collective responsibility of all household members. They opined that domestic chores serve as the most common barriers to RCH attendance. On the reasons, why parents/families fail to take their children regularly for Immunization, they indicated many different reasons such as; long distance to the RCH site; close pregnancy intervals; household chores; limited awareness of the importance of RCH services including immunization schedule.

On the issue of parents continuing clinic visits even after the fourth visit, majority of the respondents in all the regions claimed that they continued visiting clinics.

Attitude: Community Health Workers attitude towards RCH including immunization services is very encouraging and many of them do support service delivery at community level. They do give counseling services and always willing to accompany pregnant women or new born to the clinics.

Behavior/practice: On the issue of discussing reproductive and child health with their community members, majority of them indicated that they do conduct discussions with their
KNOWLEDGE, ATTITUDE, BEHAVIOR/PRACTICE OF WOMEN LEADERS

Knowledge: Generally, women leaders demonstrated high level of awareness of the importance of RCH services. This is expected due to their past interaction with RCH service. They however, stated two importance of RCH services; it improves the health of pregnant women and their unborn babies and that it helps in preventing diseases in children such as polio, diphtheria and Malaria. However, their knowledge of VPD is less impressive. Most women leaders could not mention more than 3 vaccine preventable diseases which is disappointing. On the other hand, their knowledge on the care package provided at RCH is generally impressive compared to many other discussant groups. They state services such as weighing, immunization, health talk, IPT, antenatal care. In some rural regions, they also mention food and bed net distribution. Although women leaders demonstrated higher level of awareness compared to other groups who took part in the surveys, there is still more rooms for improvement especially in the areas of vaccine preventable diseases which are problematic for all other groups. As revealed by the quantitative survey only 28.8% of the respondent who mentioned that a child should receive first dose of vaccine within first month of life. Nationwide, only 8% could name up to 5 VPDs as disease against which children are immunized. Majority 29% and 27% could only correctly name 1 VPD and 3 VPDs respectively. Regional variations is observed as indicated in the graph above. Health talk at the RCH and during community engagements emphasis should be made on VPD so that communities will know which diseases or conditions are vaccinated against in the Gambia. Knowing these diseases can motivate them more to ensuring that their children receives them by regularly attending the RCH clinic.

Attitude: The attitudes of women leaders towards RCH were generally positive. Their views as to whose primary role is to take children under 5 to RCH in the household is impressive as nearly all of them agree that it is a collective responsibility. This is very important, as one of the reason families fail to attend RCH regularly according to all the respondent groups is the level of household chores on mothers. Therefore, recognizing taking the child as a collective responsibility will allow for other family members to step in when the mother is busy on other household chores. Although few women leaders viewed that such responsibility has ever being mother’s role which is consistent with existing cultural and societal norms. As in all other discussant groups, women leaders also state that they have never witnesses/heard any husband stopping or preventing or any other family member from taking children to RCH clinic. This shows that RCH service is recognized by the community and therefore if they are adequately engaged can increase their participation leading to ownership and sustainability.

Behavior/practice: Women leaders’ behavior/practice towards the discussion of the health of children with other women is both positive and negative. A sizeable number of them especially those in the rural regions reported discussing with other women as most of them are part of VSGs. Their discussions mainly center on exclusive breastfeeding; proper hand washing and importance of attending RCH clinic. This difference between rural and urban could be the effects of other intervention programs such as the 4+4 key household practices and the MCHNRSP which were extensively implemented in rural regions.
A replica of such interventions in the communities focusing on immunization can greatly improve awareness and improve positive behavior towards immunization.

On why a significant number of parents/families fail to take their children regularly to the RCH clinic for immunization, household chores were frequently mentioned in both rural and urban regions. Other reasons include distance to RCH site and limited knowledge of the importance of RCH services. In the urban regions women involvement in petty trading also came up as a contributory factor. The issue of staff attitude was also mentioned especially in urban regions as a reason for the failure of clinic attendance among mothers. This is however, very negative and needs to be addressed by authorities concern with severe disciplinary measures. As leaders in their respective communities, women leaders perceived roles include encouraging young mothers to attend RCH clinic monthly; conduct community meetings and discuss about importance of attending RCH clinic and referring women to RCH clinic. These perceived roles can contribute immensely to the improvement of regular RCH attendance. For these to happen, women leaders should be adequately engaged to improve their knowledge of RCH including immunization.

KNOWLEDGE, ATTITUDE, BEHAVIOR/PRACTICE OF PREGNANT WOMEN

Knowledge: As beneficiaries of RCH services or due to their frequent contact with such service providers, pregnant women are expected to demonstrate high level of awareness about care packages provided to children under 5 and pregnant women at the RCH clinic. This has been amply demonstrated by them compared to men and adolescent. All the key services offered in almost all RCH clinics were mentioned, there were other services such as scanning also frequently mentioned but most by those in western 1 and 2 health regions. On the other hand food supply, incentives and ITN distribution were mostly mentioned by rural regions. They equally demonstrate knowledge of the importance of RCH services including immunization, although such importance is generally framed around the health and well-being of the child. Although, pregnant women knew children are vaccinated against disease, but their knowledge of such diseases is not as impressive as only few were able to mention more than 3 VPD. Malaria, which is a non-VPD, came up in both the qualitative and quantitative survey.

Pregnant women awareness of services provided at RCH clinic is very positive, but their inadequate knowledge of vaccine preventable diseases should be a cause for concern. This reflects the inadequacy in the health education or lack of it between health care providers and pregnant women. Many of them have been visiting the RCH clinic for many years and it is still problematic for them to state correctly the VPDs. It is essential that communication support material on these diseases be developed and use by health care workers during health talks at RCH clinics, as well as at community level. Pregnant women have the most frequent contact with RCH services and as such are expected to master most of the issues including the immunization schedule. On the contrary, like other groups, they are not able to correctly state the immunization schedule and the number of times a child should be taking to the RCH to be fully vaccinated. Furthermore the number of doses a PW required to be fully immunized and when to get the dose is a cause for concern. For instance only 38.5% mentioned that first dose is taken at first contact whilst 15.4% mention ed they don’t know when the first dose is to be taken. The knowledge of Pregnant women on TT immunization is still a cause for concern as a proportion of them (15.4%) do not know the TT schedule. Out of the 15.4%, about 37.5% are in the Greater Banjul Area of WCR 1.
It is important to note that it may be little difficult to master the immunization schedule correctly, it is however important that such important subjects are discussed with caregivers at the RCH clinic. A mastery of the immunization schedule can greatly reduce miss opportunities.

**Attitude:** Pregnant women demonstrated high level of understanding of factors that influence significant proportion of parents/families not to take their children less than 5 years regularly to the RCH. They enumerated several reasons must of which points to social and cultural underpinnings in the community. Household chores tops the rank of reason put forward by pregnant women, addressing this will require adequate engagement of families so that they all understand the importance of attending RCH clinic and thus help mothers on these particular days so that they can have time to attend. Other reason such as not knowing schedules, carelessness, unfriendly approach of RCH staff, shyness etc are contributing factors to default. The issue of poor staff attitude should be a concern and the Ministry of Health should address this as a matter of urgency. The other issues mentioned such as carelessness, limited men support requires interactive engagement to change such attitudes.

Late antenatal booking which continue to be a perennial problem is blamed on several reasons all of which are amendable through consistent interactive dialog and engagement of key community members such as husbands, women and other key family members. Such community engagement can also help address some other issues blamed for late registration such as shyness to expose pregnancy too early and unwanted pregnancy and also address the issues of low TT coverage which is blamed on negligence and or fear of the needle.

**Behavior and Practice:** Engaged on whose primary role/responsibility is it to take children under 5 to RCH clinic, a good number said it should be a collective responsibility which indeed is very positive. However, some others belief that it has been women’s responsibility and this is attributed to gender roles in the society. A very positive argument put forward by some pregnant women is that men and women should help each other in caring of their children including taking them to monthly RCH clinic. This is a very constructive argument that can be use by frontline health workers in their interaction with communities and families. It can also encourage discussion among couples about the health of their children, which majority of discussants said they don’t do. It is very positive that none of them have ever been stop or prevented from taking their child under 5 years to the RCH clinic. Only one case of such behavior is reported nationally and that is an indication that is a rear happening. Regarding early registration during pregnancy 86.5% of those interviewed were found to have registered during the survey. However late ANC booking was recorded in WCR where 57.1% were not registered. Among the respondents, 48.1% mentioned not wanting to expose their pregnancy early as reason for late ANC registration. These phenomena is peculiar in all regions but highly manifested in the rural areas such as NBER. Other reasons such as shyness, scared of injections etc. were also mentioned.

**KNOWLEDGE, ATTITUDE, BEHAVIOR /PRACTICE OF BREAST FEEDING MOTHERS**

**Knowledge:** Breast feeding mother who in most cases take their children to the RCH clinics services plays a key role in access services. Their knowledge on the types of services is of paramount importance to the success of the EPI coverage. Among the BFM interviewed countrywide, 48.1% cited immunization and weighing as the only services provided whilst another
42.3% mentioned multiple services such as treatment, palpation, weighing, immunization, issuance of bed nets, vitamin A supplementation, deworming as other essential services provided at the RCH clinic. Majority of the respondents who mentioned specifically immunization were highest in CRR. Among the diseases against which children are immunized, about 26.9% of the respondents mentioned polio, measles, yellow fever and diarrhea. This findings suggest that women are more familiar with the traditional vaccines than the recently introduce ones. However it is interesting to note that about 9.6% mentioned non EPI VPDs such as malaria and HIV/AIDS whilst a significant number (23.1%) said they don’t know the different diseases. Those who said they don’t know was highest in WCR1 (33.3%) whilst those who were able to mentioned multiple VPDs (21.4%) was highest in CRR and URR.

On birth dose only 25% nationally mentioned that the child is due to receive first dose of vaccine soon after birth within 24 hours with majority coming from the regions of WCR1 (23.1%), CRR (23.1%), URR (23.1%) and NBER (23.1%). In relation to diseases and intervals of vaccination 73.1% said they don’t know or could not state correctly the diseases which children are immunized against and their different age intervals. The highest of this group were from WCR 1, WCR 2 and CRR 18.4% each. Only 5.8% of the respondents were able to name correctly the diseases children are immunized at birth and they were from the LRR, CRR and NBER.

Limited knowledge about the immunization particularly the birth dose, recently introduce vaccines and their schedules and disease against which children are immunized is critical and could compromise timely completion of immunization thus leading to drop in coverage. Furthermore given that majority of the women access RCH services at outreach sites, it becomes evident where there exist few outreach sites; the tendency of children not getting immunization on schedule becomes higher.

**Attitude:** Nationally 51.9% access RCH services at Public health facilities outreach sites. This is impressive as it indicates a positive toward RCH attendance though it could have been higher. Among those who access RCH services at outreach sites, the highest was recorded in WCR2 and NBER 25.9% each and the lowest was in WCR 1 3.7%. A total of 36.5% indicated they have defaulted in taking their children to the RCH clinic regularly. Out of the 36.5% who defaulted 26.3% were from WCR 1, and 21.1% from WCR 2. About 36.8% of the reasons for default were due to the mothers travelled outside their areas of resident or went to attend other social events. Overall the attitude of going to attend RCH in the Gambia is impressive more so in the rural regions compared to the urban areas. As revealed by the survey it is observed that regions with more urban setting such as WCR 1 & 2 recorded a high defaulted rate link mainly to the mother not having the time to attend the clinic due to other competing events

**Behavior/Practice:** Most of the mother felt that it is their primary role/responsibility s it to take children fewer than 5 to RCH clinic for the simple reason that it is them who are in constant contact with the child and knows when he/she is sick or not. However, some others belief that it has been women’s responsibility and this is attributed to gender roles in the society. About 21.2% felt it should be the couples whilst another 11.5% felt it should be everybody responsibility. A very positive argument put forward by the breast feeding mothers is that men and women should help each other in caring of their children including taking them to monthly RCH clinic. This is a very constructive argument that can be use by frontline health workers in their interaction with
communities and families. Given crucial role mothers play in the family welfare and care for the child, their behavior/practice can influence the outcome of a program. The health most especially the EPI program needs to involve them through adequate sensitization and training on the importance of VPDs for the health and wellbeing of the child.
7. Conclusion and recommendations

Conclusions

This KABP study revealed interesting findings on the utilization of RCH services including immunization across different stakeholder groups in the country. Generally, knowledge/awareness among the different discussants or interviewees on issues been asked during the survey is not very impressive. Knowledge on importance of RCH services was low across the different groups who took part in the survey. This low awareness can affect the value attached to RCH services including immunization leading to low coverage. To improve and maintain high utilization of RCH services, parents and other caregiver should be aware of the importance of these services. This can motivate them to priorities it over social and cultural events such as wedding and naming ceremonies which in the survey has been reported as some of the reasons for defaulting.

Equally, many respondents knew that at RCH children are immunized, however, little do they know which diseases they are vaccinated against. The most commonly mentioned vaccines were polio, yellow fever and measles which traditionally have been used since the commencement of the RCH and immunization activities in The Gambia. Not much of the recently introduce vaccines in the past five years has been mention whilst non-vaccine preventable diseases like malaria and HIV/AIDS were frequently mentioned. Knowing these diseases can really motivate parents and other caregivers to ensure that their children are vaccinated to be prevented from those illnesses. For parents and caregivers to know these diseases, it’s important that they form part of the issues covered in the communication support materials that are recommended to be developed. They should also be included in message booklets that can be used in schools.

The awareness among respondents on the immunization schedule was very low even among pregnant and breastfeeding mothers who should be very conversant with issues relating to RCH services due to their interaction. The immunization schedule is very important and their every parent or caregiver with a child 0 - 24 months of age should master. Limited knowledge of the schedule has an implication on clinic attendance which influences immunization coverage.

It could be noted that health behavior and practices revealed by the survey among all the respondent groups are driven by socio-cultural gender roles. As such many still harbor the belief that taking the child to the RCH to be the responsibility of the woman. Whereas women are overwhelmed with household chores, they still have to take the child to the RCH clinic or else in must instance the child will attend the clinic. Household chores are incriminated as reasons for defaulting; therefore dialogue at the level of the household is crucial to relief the mother from some of the household chore so that she can have time to take the child to the clinic. Whereas the mother cannot go, someone else in the household example older siblings or husband should take the child to the clinic. Issues relating to staff attitude were highlighted by different respondents. This should be a course of concern as it may in one way or the other impact on delivery of services.
**Recommendations**

To improve knowledge, attitude, behavior and practices around the uptake of RCH services including immunization, the following recommendations are made based on the findings:

- The finding of the survey revealed that there is limited community engagement in promoting demand for RCH services including immunization. This resulted to low awareness among caregivers and community leaders on the significance of obtaining RCH services. In view of this there should be a paradigm shift from RCH based IEC to aggressive community engagement through the use of decentralized community base structures such as MDFTs, VDCs VSGs, TCs, mothers club; For effective community engagement to take place, VSGs, TCs and mothers clubs should be effectively trained on community engagement and communication skills.
- Timely and accurate information dissemination on the importance of immunization services and compliance to the schedule visits requires a multi-faceted approach. The active involvement and participation of all stakeholders at household, community and facility level should be coordinated and encouraged by increasing sensitization, vigorous use of community radios, use of social and behavior change communication materials.
- Communication support material covering different facets of immunization services such as names of vaccines, diseases they prevent and immunization schedule must be developed and produced. These communication support materials should be in the form of pictorial flip charts, posters, message booklets, radio spots and leaflets;
- Development of communication support materials should be followed by adequate orientation of selected groups and structures in the community on the support materials. These groups and structures in the community will engage community members on the issues on the support communication materials;
- Men involvement in RCH can contribute in addressing low uptake of immunization services as decision makers in the household. Therefore, they should be targeted in communication interventions to increase their awareness on the importance of RCH including immunization;
- Generally, adolescents and youths demonstrated limited knowledge and practices on most aspects of the survey. These are expected to become mothers and fathers in near feature; they should be targeted in the communication interventions to increase their awareness of the importance of RCH including immunization. Such intervention can best be delivered through the school system;
- RCH sites provide a useful avenue to talk to mothers about the vaccines given to children, the immunization schedule, the importance of the different services provided. Material on these should be developed and public health officers and other RCH team members should ensure they discuss with the mothers on those key issues. However the capacities of the health workers who are expected to deliver the necessary health talks need to be developed especially in the area of interpersonal communication.

- There is also need to increase RCH sites especially in the urban areas so as to decongest the existing sites.
As Knowledge on the vaccination schedule and the diseases children are vaccinated against is very low among all the respondents in the survey there is need for continuous mass sensitization of the general public.