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Qualitative methods for assessing the acceptability of immunisation in Somalia

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• Introduction

In 1989, Save the Children Fund and the Ministry of Health in Somalia conducted a study to identify the factors influencing acceptance of immunisation. Focus group discussions, key informant interviews and observation were employed to assess the following:

- Knowledge of immunisation;
- Attitudes towards characteristics of immunisation: safety, effectiveness, accessibility and cost;
- Perceptions of the EPI (Expanded Programme on Immunisation) diseases: susceptibility, seriousness and cause, treatment and prevention;
- Perceptions of prevention;
- Attitudes toward methods of immunisation promotion;
- Sources of advice on health matters; and,
- Attitudes toward the health services and other health providers.

The research team consisted of the research co-ordinator (Save the Children) and two Somali researchers. During the fieldwork phase, the team lived with families in two communities for a total of 12 weeks.

Methods and respondents

Focus groups: Mothers aged 15-30
Mothers aged 31-45
Mothers over 45
Mother and Child Health (MCH) staff
Traditional Birth Attendants (TBAs)

Key informant interviews were held with:

- people with official connection to immunisation activities - party and government officials, health staff, community health workers, TBAs; and,

- community members normally consulted for health advice - midwives, sheiks, traditional healers, older women.

Observations were made in MCH clinics and immunisation sites of traditional healers' working. sessions.

Summary of main findings

- Perceptions of the EPI diseases influenced mothers' attitudes toward immunisation. Where the disease was believed to be serious, a child's susceptibility high and the cause unrelated to spiritual phenomena (measles and whooping cough), motivation for seeking out immunisation was greater. Favourable attitudes toward measles and whooping cough immunisation were enhanced through mothers experiencing a visible reduction of these diseases in the community following immunisation campaigns.

  Alternatively, mothers generally felt immunisation could not be effective against diseases which were believed to be caused by spiritual phenomena (polio and neonatal tetanus) and dsease where reduction was not evident.

- The messages used to promote immunisation were also found to hinder acceptance. Many of these messages did not reflect mothers' perceptions of certain

Source: RRA Notes (1992), Issue 16, pp.22–26, IIED London

diseases and failed to inform, educate or motivate. For example, mothers distinguished between neonatal tetanus and tetanus as diseases with different causes and names. Health messages failed to make the connection between tetanus toxoid immunisation and prevention of neonatal tetanus because health messages employed an incorrect term for neonatal tetanus.

Messages about polio immunisation were also misunderstood due to poor understanding of community perceptions of polio. The name given to polio, *dabeyl*, means wind or spirit and relates to the perceived cause of the disease. In addition to polio, the term *dabeyl* is used to describe a number of conditions of like origin such as epilepsy, miscarriage and madness. Using the term dabeyl for immunisation education confused mothers as to the purpose of polio immunisation. Hence, few mothers believed that immunisation could prevent polio.

- In relation to perceived safety of immunisation, mothers feared side effects in children and spread rumours that tetanus immunisation would cause infertility. These negative attitudes were exacerbated by the methods of promotion employed in the programme. Campaigns which emphasised rapid increases in coverage through authoritarian measures incited resentment and fear. Information and health education suffered due to lack of time spent informing and involving beneficiaries. The use of Party cadres to ensure compliance with the programme also linked immunisation with political goals rather than community needs.

- Mothers reported that they normally seek health advice from relatives, friends and traditional and religious healers. Neither government officials nor the MCH were trusted as a source of health advice, therefore immunisation messages were ineffective.

  Lack of trust in health services resulted from the poor quality of health care available. Immunisation was often the only service offered in many health centres. Lack of perceived benefit from attending the MCH coupled with constraints on mothers' time hindered immunisation completion.

• Lessons learned

For health planning

Throughout the implementation of the EPI, no effort was made to assess community needs or attitudes toward immunization. This study provided evidence of the need for this type of information and the importance of involving beneficiaries in programme planning and implementation. From the community's standpoint, they had participated in the immunization programme as the `object' rather than the subject of development efforts. According to beneficiaries, this approach proved highly ineffective for two reasons:

- As in many countries, immunisation was introduced in Somalia through mass campaigns bent on raising coverage quickly. This approach continued beyond the campaigns through biannual immunisation days and a birth registration campaign and always involved intense promotion and sometimes forced compliance.

  Throughout the period of rapid expansion of immunisation services, planners neglected to involve and educate the community. Health messages were often misunderstood because community perceptions of immunisation and disease were not considered in design. Trusted health advisors were rarely involved in spreading information about immunisation or designing the approach to the community. Rather, health messages were delivered through Party officials or MCH staff, who, because of their authoritarian approach or the poor quality of their health services, were not respected or believed and failed to inspire confidence in the programme.

- At the time of introduction of immunisation, Somalia's basic health infrastructure was near collapse. Nevertheless, the EPI focused exclusively on reaching immunisation coverage targets and paid little attention to strengthening the

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faltering MCH services. Respondents revealed that motivation for regular attendance at the MCH was indeed dependent on the presence of other health service. Delivering immunisation alone would not ensure sustained demand. Mothers perceived that the immunization programme aimed to benefit the health and government staff, who received payments for increasing coverage.

For further research

- In the Somali context, many of the reasons for poor immunization acceptance were complex and politically sensitive. Qualitative methods proved very effective for identifying and explaining these factors of acceptance. Had the research not employed informal and open methods of communication, it is unlikely that certain attitudes would have been reported. Nor would the research have revealed the importance of certain factors of acceptance such as disease perceptions and the authoritarian measures used to raise coverage.

- Mothers in focus group discussion were divided into three groups which reflected their level of experience and authority in relation to child-raising. Young mothers (aged 15-30) with fewer than 4 children were grouped together, as were mothers (aged 31-45) with 4 or more children. A third type of group consisted of 'grandmothers' or women who had completed their child-bearing and served as experienced and often powerful advisors on child health issues. These divisions ensured that women were among their peers in terms of levels of experience and authority and responded freely in discussions.

- Gathering information in Somalia was a sensitive activity. Due to the political culture of the previous regime, officials were often suspicious of 'surveys' especially those which involved foreigners. The qualitative approach, which allowed time to live in a community and establish relationships with officials as well as community members, greatly facilitated data gathering.

- Because the study was partly exploratory, the flexibility of the approach allowed for identification of new research topics and questions and revision of inappropriate concepts.

- Use of three methods - focus groups, key informant interviews and observation - allowed for cross-checking and validation of themes throughout the data gathering and analysis.

- The quality of this research was largely dependent on the strength of the researchers we employed. However, this does not preclude involving relatively inexperienced people. Neither of the two researchers in the programme was familiar with qualitative methods prior to the research. While many hours were spent sensitizing researchers to a qualitative approach and training them in data gathering methods, their interest in the topic ensured successful implementation.

- In addition to 'rapidly assessing' factors of immunization acceptance, this programme also aimed to develop a capacity for conducting qualitative research within the Ministry of Health (MOH) in Somalia. Hence, it was necessary to involve researchers in every stage of development and execution of the research. This participatory/learning approach was welcomed by the MOH and ensured necessary support from Ministry authorities. However, the 'in-house training aspects of the programme' greatly extended the time frame of the study.

• Additional comments

The focus group meetings with the mothers were conducted during the afternoons. We had 2-3 hour discussions with them on mats over a flask of hot tea.

We were able to piece together an historical picture of how communities had experienced EPI over the past 6-7 years. For instance we learnt that women could see that measles had been cut dramatically by the EPI campaign. But women made no connection between neo-natal tetanus and EPI. *"Why should it help?"* they asked. Neo-natal tetanus is known in Somali as

Source: RRA Notes (1992), Issue 16, pp.22–26, IIED London

"*seven days of stalking*", essentially a spiritual ailment only to be protected by an amulet from a sheik. The health education they had received had only taught them that EPI protected against tetanus, not against neo-natal tetanus. Likewise polio, known as the *wind of the djinn*, could, they said, only be prevented by a sheik. EPI could not help them.

Many EPI messages were not making sense, because the wrong name was being used for diseases or women believed that children do not suffer from the disease. TB, for instance, according to these women, was not a child's illness.

The Government had already run several mass campaigns, such as literacy, Arabic language teaching, anti-tribalism and so on. So this was seen as just another government self-promotion drive. They dubbed it the year of forced immunisation, where they had to attend.

The first round coverage was quite high. But during the second and third rounds, women fled to the bush, fearing that their children were going to die. They just did not believe the health messages because of the forced approach to the issue.

When we talked with the women about health services, they said, "*Why don't you talk to the people to whom we go for health care*?" But when we thought this was the MCH, the women replied *"No! The MCH offers nothing but EPI"*.

With regard to future EPI health education, the women talked about the measles vaccine as if it were like putting a house round their child. We thought that EPI in general might in future be presented as a house of protection. It might also be presented positively as an amulet, in co-operation with influential sheiks who are widely regarded in Somali society.

In conclusion, the women whom we had talked to said that they had learnt a lot from our discussions. We were at first worried when they said this, because we had been trying to learn from them and not impose our views on the discussion. But they then explained that they had not been taught, but that they had learnt a lot for themselves from the discussion experience. Next, this approach is not familiar to health staff, who treats patients as objects rather than subjects. We are missing out here and need to use these methods in regular working practice. Thirdly, there is often a complete failure to include fathers and other men in these maternal health programmes. Men should be included in such matters. Finally, it is essential to make the first round of an EPI campaign a very positive experience, to encourage women to return for the further rounds.

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NOTE

The full report of this work, *A Study of Immunisation Acceptability in Somalia* 1990, is available from Anne La Fond at the above address.

Source: RRA Notes (1992), Issue 16, pp.22–26, IIED London