Communicating for Health

How disease prevention fails without good communication
Ebun O. Ekonwe, Pat Taylor, Rose Macauley, & Olu Ayodele

Even where resources are plentiful, efforts to achieve full immunization coverage fail if staff and users are misinformed and unmotivated. A highly practical study in Lagos pinpoints some of these failures and suggests ways of overcoming them.

In 1991, Resources for Child Health (REACH) made a preliminary assessment of the Expanded Programme on Immunization (EPI) in Lagos, which is the largest and most cosmopolitan city in Nigeria. This was occasioned by the intention of USAID to start an urban immunization project in one African country. Rather surprisingly, the assessment revealed that for indicators such as drop-out rates and measles coverage the immunization services in Lagos were among the worst in the country.

In view of this and the USAID proposal, REACH decided to start a demonstration immunization project in metropolitan Lagos, with the following seven components:

- decentralized planning;
- immunization service delivery;
- supervision;
- EPI information system;
- communication;
- evaluation/operations research;
- dissemination of findings.

The findings outlined in this paper come from the component on communication, for which a study of beliefs and practices was undertaken to assess support for the immunization services, and discover ways of strengthening it.

The study had two main parts, as follows: focused group discussions with users of the health care services, and in-depth interviews with health care providers at three levels of responsibility.

Setting up the study

Data from the initial survey of 1991 and an assessment based on health facilities showed that many opportunities were missed and much misinformation was passed from the health workers to mothers. Questions were designed to find out why this was happening.

For example, the focused group discussions included questions on such matters as whether sick children should be immunized,
why mothers did not complete their children’s immunization, why mothers were sometimes refused immunization services, how health staff behaved towards mothers, how this affected mothers’ attitudes, and what kind of information was provided through counselling. Participants for these discussions were recruited and categorized according to their children’s immunization status and the family’s economic and employment situation.

The in-depth interview protocols were focused on how health workers felt about their performance and how reliably they were advising mothers. They were designed for the nurses who actually immunized the children, the doctors who supervised them, and the community health extension workers whose job was to mobilize mothers and trace defaulters.

The research team consisted of two social scientists, a clinical psychologist and five field health workers, all with several years’ experience in community survey work. To prepare for this survey they discussed the background and purpose of the urban EPI initiative and the appropriateness of the prepared questions. They also translated the questions into the local language, selected four out of the 15 local government authorities of Lagos to work in, and did a trial run of the group discussion among themselves, deleting and adding questions as they went along. They then recruited participants for the group discussions.

Four of the most densely populated districts in Lagos were selected for the research. From these, 15 groups, each consisting of 15 people, were recruited for the focused discussions. The make-up of each group was as follows.

- With fully immunized child: 3 mothers (1 poor, in commerce; 1 middle class, office worker; 1 poor, home-maker) and 1 father (poor).
- With partially immunized child: 9 mothers (1 middle class, office worker; 1 middle class, in commerce; 1 poor, office worker; 3 poor, in commerce; 3 poor, home-makers) and 2 fathers (1 poor, 1 middle class).

Respondents for the in-depth interviews were selected in almost equal proportions from each of the four localities to make up a sample of 11 medical doctors, 25 nurses and 12 community extension workers. As the survey of coverage had shown that 18% of the fully immunized children had used private health facilities, fee-for-service hospitals providing large numbers of immunizations were included in the study.

The group discussions were conducted by the moderators, supervised by the consultant and tape-recorded. As some of the questions might have adverse implications for facilities and staff, the participants were told at the beginning of each session that neither the moderator nor the note-takers were attached to any health authority. Notes were taken during the discussions and checked against the tapes afterwards. The sessions were then analysed, first by the note-takers, then by the consultant, in terms of what they revealed about how the health services were understood and used, and any major differences between groups.

Most of the in-depth interviews were held in government health facilities, through which the immunization programmes are carried out. Others, especially those with medical doctors, were held in private facilities. The results were analysed by categorizing and tabulating the answers to open-ended questions. Special attention was paid to the reasons given for mothers’ non-completion of their children’s immunization.
Users’ perception of how the health services contribute to incomplete immunization

- Negative staff attitudes
  - scolding mothers for lateness or missed appointments
  - denial of service for similar reasons or lost clinic card
- Long waiting time
  - health workers chat while mothers wait
  - preferential treatment for a few mothers
- Missed opportunities
  - refusal to immunize even mildly sick children
  - refusal to open new vial of vaccine for only one or two children
  - vaccine not available
  - charging for service which is supposed to be free
- Reduced potential contact hours
  - clinics opening late and closing early
  - open clinics not attending to users

Users’ perception of how they themselves contribute to incomplete immunization

- Fear of side-effects
  - fever
  - induration
- Lack of motivation
  - failure of measles vaccine
  - belief in traditional prevention methods
- Misinformation
  - especially the idea that once an appointment is missed a return to the clinic is useless
- Pressures of work
  - mothers too busy
  - deteriorating economic situation
- Mothers’ faults (in fathers’ view)
  - laziness
  - carelessness
  - too preoccupied with making money

Findings

In general, it was easier to find fully immunized children than partially immunized ones. For the latter it was necessary to go further away from the major health facilities, into the less accessible parts of each district, which confirms the belief that coverage by health services goes down as the distance from health facilities goes up.

Focused group discussions

Participants were able to describe the major signs and symptoms of measles and believed that it was an extremely dangerous disease which could lead to death if care was not taken. They believed it could not be definitely prevented but the danger could be reduced by immunization. The participants all agreed that sick children should definitely not be immunized, as this was what they had been told by health workers, who refused to immunize even mildly sick children.

Mothers are informed about their next appointment by health workers, who write the date on their children’s cards. The mothers were all convinced that there would be no point in going to the clinic once that date had passed. They were unable to say how this very widespread belief had gained currency.
The discussions showed that the reasons for failure to complete immunization are to be found both within the health services and among the users. These findings are summarized in the two boxes.

**In-depth interviews**

The main findings of these interviews are set out in Tables 1 to 4.

On the basis of these findings, the following recommendations were made to REACH.

- Increase contact hours between the mother and the health service by:
  - providing immunization services every day;
  - scheduling out-of-clinic hours for immunization, especially at weekends, when

<table>
<thead>
<tr>
<th>Reason</th>
<th>Nurses (%)</th>
<th>Extension workers (%)</th>
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<tbody>
<tr>
<td>Economic (mother has to work all the time)</td>
<td>26.1</td>
<td>45</td>
</tr>
<tr>
<td>Mother travelling</td>
<td>23.9</td>
<td>5</td>
</tr>
<tr>
<td>Ignorance/carelessness/laziness</td>
<td>21.7</td>
<td>15</td>
</tr>
<tr>
<td>Illness of child</td>
<td>8.7</td>
<td>15</td>
</tr>
<tr>
<td>Side-effects</td>
<td>4.4</td>
<td>20</td>
</tr>
<tr>
<td>Prefers native method/no faith in immunization</td>
<td>4.4</td>
<td>0</td>
</tr>
<tr>
<td>Staff attitudes</td>
<td>2.1</td>
<td>0</td>
</tr>
<tr>
<td>Other *</td>
<td>8.7</td>
<td>0</td>
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* These include marital problems, high cost in the fee-for-service facilities, and long waiting time.

<table>
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<tr>
<th>Suggestions</th>
<th>Nurses (%)</th>
<th>Extension workers (%)</th>
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<tbody>
<tr>
<td>Set up market-place immunization centres</td>
<td>17.6</td>
<td>21.6</td>
</tr>
<tr>
<td>Increase mobilization</td>
<td>17.6</td>
<td>21.4</td>
</tr>
<tr>
<td>Provide more material</td>
<td>23.5</td>
<td>0</td>
</tr>
<tr>
<td>Door-to-door immunization</td>
<td>11.8</td>
<td>21.4</td>
</tr>
<tr>
<td>Provide greater publicity</td>
<td>11.8</td>
<td>7.1</td>
</tr>
<tr>
<td>Improve economic situation</td>
<td>0</td>
<td>21.4</td>
</tr>
<tr>
<td>Simplify health message</td>
<td>0</td>
<td>7.1</td>
</tr>
<tr>
<td>Others</td>
<td>17.6</td>
<td>0</td>
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A workshop was organized recently to pass on these findings and recommendations to all the EPI workers in Lagos State. Each district has now worked out its own plan for implementing the recommendations.

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**Oral health projects — deadline 31 January 1995**

The Year of Oral Health (YORH) Consortium, comprising the International Association for Dental Research, the International Federation of Dental Hygienists, the International Association of Dental Students, the International Federation of Dental Education Associations, and WHO, is pleased to announce the existence of a YORH fund which has been created to support the promotion of oral health worldwide. Two types of projects may be funded:

- projects of multinational impact;
- specific projects to promote oral health in developing countries.

In both cases, project-funding requests should clearly state aims, objectives and methods, and provide measurable goals. They should aim at improving or promoting oral health, or research on oral health.

A standard form for application may be obtained from:
Professor Denis O'Mullane, Oral Health Services Research Centre, University Dental School, Wilton, Cork, Ireland; telephone (353) 21-545100; fax (353) 21-343561. Applications must be submitted before 31 January 1995.