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Mothers voice their opinion on immunization services

A survey of the Expanded Programme on Immunization (EPI) in eastern Zimbabwe showed a low valid immunization coverage by one year of age. While health personnel originally thought traditional and religious beliefs were to blame, the survey indicated the problem lay in the poor quality of EPI services. Focus group discussions with mothers confirmed this. Mothers were well informed, highly motivated and had many suggestions on how services could be improved, but were rarely given the opportunity to discuss them with health workers.

A survey of coverage by the Expanded Programme on Immunization (EPI) in Chimanimani District of eastern Zimbabwe in November 1991 (1) showed that the crude coverage rate was high (86.8%) and that only 0.9% of the children had received no vaccines at all. Most children (96.7%) had an immunization card. Access/utilization of services, as measured by the crude DPT-1 (first immunization with diphtheria-pertussis-tetanus vaccines) coverage rate, was excellent (98.1%), but the valid coverage rate by one year of age was only 51.4%.

Prior to the survey, the district health team had assumed that the major obstacles to full immunization coverage were ignorance, religious beliefs, long distances to immunization points and the resulting lack of motivation of the mothers. A measles outbreak in 1986 was partly blamed on a religious group that allegedly does not allow its members to have their children immunized (2).

Analysis of the survey data showed that the low valid coverage was mainly due to the poor quality of EPI services, particularly invalid doses and missed opportunities for immunization, and that problems related to the users of the services (the mothers) played only a minor role.

A further study was proposed in order to test the hypothesis that user-related problems were not a major contributing factor to low immunization coverage and to find out how mothers responded to the closure of almost one third of the immunization outreach points in the district.

**Study population**

Chimanimani District is located in Zimbabwe’s eastern province of Manicaland.
Population estimates for 1990 vary between 96,958 and 114,662. Commercial estates make up half the total area of 3353 square kilometres. Communal land and resettlement schemes make up the rest. The terrain in the east is mountainous and rugged, making access to some health centres difficult, especially in the rainy season.

Immunization services had been offered daily at 15 static facilities and once a month at 65 outreach points since 1983. In 1990 and 1991, 21 outreach points had to be closed due to a cutback in mileage allocation, though since then the number of static facilities offering daily EPI services has been increased to 22. Nevertheless, some mothers now have to walk as far as 12 km to have their children immunized.

Focus group sessions are group discussions on a predetermined topic, guided by open, non-leading questions. They are not a substitute for quantitative research, but a parallel source of relevant information that can help interpret the results of quantitative surveys.

In this study, focus group discussions were held with mothers to find out more about their attitudes towards immunization, their interaction with the nurses giving vaccines and their reaction to the closure of outreach points. Discussions were focused by six leading questions:

- What do you think about immunization?
- What are the good effects and bad effects of immunization?
- Have you heard about mothers who fail to bring their children for immunization and, if so, what reasons do they have?
- Is it a problem for you to bring your child for immunization?
- Did you find any problems with the nurses when you brought your child for immunization?
- If the Ministry of Health is no longer able (or: imagine the Ministry of Health is no longer able) to send the immunization team to your village on a monthly basis, how can we make sure that all children still receive immunization?

Seven discussions, each lasting from 25 to 45 minutes, were conducted between February and May 1992, four of them in places where outreach points had been closed (Chitinha, Bvumbura, Zimunda, Chiramba). Forty-three mothers (five to eight per session), with at least one child under the age of five years, took part. The mothers were recruited with the help of local teachers or village community workers and one session was held with waiting mothers at the hospital in Chimanimani.

A senior community health worker (not in uniform) who was trained as a focus group facilitator conducted the discussions in the vernacular and later translated the transcripts of the recordings.

**Mothers’ views on immunization**

All mothers who participated in the focus groups seemed to value immunizations (they called them “good” or “helpful”) and supported their views with their own experiences and observations. However, not all participants were aware against which diseases their children would be protected. Measles was mentioned most often, and many participants had observed a decrease in mortality from measles since the start of EPI. Some noted that once a child has been immunized, it is rare for it to contract measles. Others thought that children could still contract the disease but that it would be in a mild form. Participants in all sessions mentioned that immunized children would “grow up strong.”
Low valid coverage was mainly due to the poor quality of EPI services, and problems related to the users of the services played only a minor role.

— “We used to have problems with measles. Children used to die, but these days it’s very rare.” (Chitinha)
— “If there is a disease like measles, those who are not immunized will get the disease, but my children will not get it.” (Chimanimani)

— “When the child is immunized and it catches measles, it will not be as bad. The child won’t stay indoors. The attack might even pass without you as the mother noticing it.” (Zimunda)

Many participants observed that their children ran a temperature after vaccination. Some were able to give reassurance and advice on the nature of this side-effect. Others worried that if their child missed out a vaccine dose it would receive two doses a month later, which they felt might increase the severity of side-effects. Only one participant believed that possible side-effects could be a reason for other mothers not to bring their children for immunization.

— “When a child is injected, she will cry for a few moments, and then she will be protected for life.” (Ruwedza)
— “After the injection, the child will have a hot body. So at times you feel it’s not good to have the child immunized. Especially if you have skipped one month and the child has to get two injections. That night you won’t sleep.”

This was answered by another mother:
— “Ah! But that happens, and the nurses even tell you that your child might have a temperature. All you need to do is to buy some paracetamol and give it to your child.” (Chitinha)

The focus group participants did not consider traditional beliefs a major obstacle to immunization.
— “These days we bring the children for immunization. In the past, we used to take them to n'angas (traditional healers), but it was not helpful.” (Vimba)

— “Those who use herbs also bring their children for immunization.” (Ruwedza)

Some participants mentioned that laziness and lack of knowledge were potential factors in non-attendance, but this was disputed by others as not very relevant. Long distances are a problem, especially for grandmothers who take care of young children.

— “It is very far to the clinic. There is no bus, and most of us here are old women looking after their grandchildren.” (Chiramba)

Since a number of outreach points had to be closed, some mothers have to walk as far as 12 km to have their children immunized. The participants described how they weighed the felt benefits of monthly visits against the disadvantages. Most decided to bring their children only when they were due for vaccination, but no longer for monthly growth monitoring. This is reflected in a 25% decrease in routine weighings from 1989 to 1991, the year after the closure of outreach points.

— “With growth monitoring, you can skip one month, but not with the injections.” (Bvumbura)

— “It is a big problem, especially when you have two children to take. You cannot put one on your back and take the other one by the hand, the distance is too much. So we now just take them when they are due for an injection, and not for weighing.” (Zimunda, similar statement in Bvumbura)

— “It is very hard for us to walk there, but we have no choice. The child is ours, so we have to take the child for immunization. It is not the government’s child.” (Chitinha)

In Bvumbura and Chiramba, the discussions circled around a reopening of the outreach centre all the time:

— “All we want to ask for is the reopening of this centre.” (Bvumbura)

— “When we saw you coming with this car, we thought you had come to tell us the date when you are going to start immunizing here again.” (Chiramba)

Are mothers respected?

The focus group participants generally reported they were on good terms with the nurses who offer immunization services. Potential sources of conflict arise when a mother loses her child health card, comes late to a clinic, or is told a vaccine is out of stock.

— “We are still on good terms with the staff. We have no complaints.” (Vimba)

— “If you tell the nurses that you have lost the card, they will say you are very careless. They will shout at you.” (Bvumbura, similar statements in Chitinha and Chimanimani)

— “It will take you at least 2 to 3 hours to get to the clinic, and by that time the nurses will say they have finished immunizing. So you will come home with the children not immunized.” (Chitinha, also Chiramba)

Health education at outreach points traditionally comprises lecturing the mothers on personal hygiene and immunizations, and examining their knowledge on the correct ages for vaccinations and the intervals between vaccine doses. The participants appreciated helpful advice, but considered some of the messages to be inappropriate.

— “At times, the nurses will try to teach us something, but you find some mothers
will take it as an insult. For example, when they say you should keep your children smart, some take it as if the nurse is indicating that we are dirty people.” (Bvumbura)

The focus group participants had numerous ideas and suggestions (besides the reopening of centres) on how to tailor health services to their needs. Apparently, they are rarely asked for their views.

— During outreach, medicines for minor illnesses should be supplied (Chitinha, Zimunda, Chimanimani, Chiramba, Ruwedza)
— A trained staff member should join the outreach team to offer antenatal care (Zimunda, Ruwedza) and family planning guidance (Chimanimani)
— Instead of admitting underweight children to hospital for feeding, mothers should receive food handouts at outreach points (Chitinha, Chiramba)

One participant explained why she thought the nurses at a certain clinic were doing their job well:

“— They ask us to give our opinion.”
(Zimunda)

Shortcomings

The focus group participants at times tried to impress the facilitating nurse by giving what they knew were considered to be the “right answers”, and by giving unelicited comments on “wrong” behaviour (“That is not the right thing to do”). They tried to avoid conflicts. At the beginning of an interview, they often denied problems with the nurses, or knowledge on why some mothers fail to bring their children for immunization. Group consensus was the rule. Almost all statements were made in the “we” form, and contradictions were restricted to correcting factual errors. On the other hand, participants clearly knew what they wanted and were well able to air their wishes and complaints once the ice was broken. The positive effect of starting a communication process between the mothers and the providers of health services well outweighed the bias introduced by having a nurse as facilitator.

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Mothers are neither ignorant nor unmotivated when it comes to the immunization of their children. They know and understand the benefits of immunization. They are willing to walk even long distances to have their children immunized, provided the quality of services is adequate and treatment by health personnel is decent. Traditional and religious beliefs are no longer major factors in failure of immunization. Care should be taken not to attribute the low immunization coverage to laziness and ignorance of the mothers when the main contributing factor is poor quality of services. In health education sessions, mothers should be given an opportunity to discuss their problems and make suggestions. By listening to the mothers’ suggestions, the health care providers can learn how to make their services more attractive.

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References