

Obstacles to disease control: perceptions of a community

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In the fight against tropical diseases, obstacles in the form of the target population's resistance to the adoption of health promoting behaviours are inevitable. Numerous theories are often postulated to account for the obstacles so as to help overcome them. Rarely however is the target population itself directly asked what it perceives as the obstacles that would be encountered in a disease control programme in its area. Such insight into the perceptions held by the community would prove an invaluable tool in the fight against disease. This paper describes and discusses a rural community's perception of obstacles to the control of the disease schistosomiasis in the Koche area of Mangochi district, Malawi.

Background

In 1994 the University of Malawi College of Medicine carried out schistosomiasis prevalence surveys in the Lungwena area of Mangochi and found a very high prevalence rate of *S haematobium* infection -78% - among primary school children. Following an intensive health education intervention coupled with medication to the school children, the prevalence rate of the infection declined to 47%, but re-infection had occurred within six months as judged seen by the reappearance of schistosome eggs in the urine of those previously treated.

In view of the reported concerns over the increase of schistosomiasis in Mangochi, there was a coming together of involved parties to try to combat the problem. The project was a joint venture between the University of Malawi's Department of Community Health at the College of Medicine; the Malawi Government Ministry of Health & Population in Mangochi district; the Malawi Government Ministry of Parks, Tourism & Wildlife; three hotels in the area and three primary schools: Koche, Makawa and Lwangwa. Health education was to play a central part of the intervention strategy targeted at the three primary schools. The main component of the message would be to encourage children to desist from urinating in the water, so as to interrupt the parasite's life cycle. Our approach was to begin with a social diagnosis by first going out into the community and getting their perceptions about the disease and its impact on their community.

Method

Data were primarily collected through Focus Group Discussions (FGDs). These were employed because they are a quick, effective and inexpensive means of interviewing a homogenous group of people all at one time. They produce rich data on new topics and require little structure on the part of the interviewer. A more detailed analysis of the use of FGDs as a tool can be found in Volume 12 of the MMJ.

Procedure

We conducted eight Focus Group Discussions (FGDs) with chiefs, their counsellors, village representatives, teachers and selected pupils in two primary schools. Each focus group lasted about an hour and comprised approximately ten people. With permission we tape-recorded some of these sessions, transcribed the recordings on to paper and analysed the results by sifting out common themes of the FGDs.

FINDINGS

The FGDs in the schools revealed several perceived obstacles to an effective health education schistosomiasis control programme in the area. These can be categorised into the following groups: a) attitudes towards the disease b) habitual behaviours and (c) issues around medication.

a) Attitudes

The respondents saw the attitudes that community members held towards the disease as the primary obstacle to an effective intervention.

Participants reported that most children do not tell their parents if they have the well-known symptoms of urinary schistosomiasis (dysuria and haematuria). According to respondents there is shame associated with infection. Subsequently this prevents immediate treatment action on the part of parents. Respondents pointed out that children were more open to their friends about their infection.

Another obstacle was the negative attitude parents held towards the schools which we planned to use as the spring board of our intervention. Parents did not see much benefit in sending their children to school; they were sceptical about what the teachers say to them. They look down on the teachers. Only parents who have had some personal exposure to education were perceived to be more receptive to health-related information.

When asked whether parents would listen to their children if they shared what they learned about schistosomiasis at school with them, respondents said some parents would respond negatively by asking the children:

*"When were you born?
What do you think you can teach me?"*

The parents believe children should not teach grown ups, who have greater life experience:

*"We have done it (urinated in the lake) all our lives.
Why the fuss now?"*

If impotence were to be mentioned as being one consequence of the disease, the parents would retort:

*"How come, then, that
we have borne children?"*

Among the respondents, teachers felt that parents held a belief that things taught at school should be confined to the school and the messages should not be brought home.

Koche School teachers further reported that in using

the school as a medium of outreach to the community, past experience had demonstrated certain difficulties. Chief among these was the low attendance of parents at meetings of the school's parent teacher association. There were usually not enough people to form a quorum. Only 15 parents had come to the last meeting out of a student population of over 2,000 pupils. The parents were perceived by the teachers in the FGD to see no benefits in attending the meetings. There are some underlying dynamics between parents and teachers reflected by the fact that the town of Maldeco where Koche is located is a trading area where parents are business minded and are busy making money. Many people were doing quite well financially without having gone to school and therefore see no urgency in sending their children to school or being caught up in the school's affairs. Many pupils felt that the usefulness of school ends with one being able to read and write, about standard 6. Hence most are too busy fishing to even bother to come to the school.

The negative attitude towards message dissemination is not confined to the parents alone. Even young children to whom the message would be directed are also negative. One female participant at Makawa school said some of the children would stubbornly ask:

'Did you give birth to me?

Why are you telling me these things?'

However there was a ray of hope expressed, that if the message was consistent and repeated it would have an effect:

'Children will learn about it like learning to read'.

One young participant gave insight into how she sees the best ways of overcoming these obstacles:

'Initially the children will behave as you tell them only when they see you around. When you are not around, they do what they like. Eventually as you keep hammering home the message, they start acting good on their own'.

b) Habitual behaviour

The second category of perceived obstacles to the effectiveness of a schistosomiasis control intervention centred on habitual behaviour. Because people were so used to urinating in the water, participants believed people could not change. Such behaviour was considered 'normal'. Some feel they already have schistosomiasis therefore they can go ahead and urinate in the lake. If they were to be reprimanded they would then say to their friends:

"If you don't like it then go ahead and leave the water."

Parents and grown ups would act quite threateningly if they were to be reprimanded and told off. They would ask:

'Is the lake yours?'

c) Issues pertaining to medication

Participants said another obstacle to the uptake of an effective health education programme is the perception that many people

were not convinced that receiving just one dosage cured them. Culturally and traditionally medication is given in several dosages or several rituals occur before healing takes place. Praziquantel requires only one dosage and this may tend to make some people sceptical about its effects.

Another obstacle emanating from medication issues is that some participants, especially the teachers, reported that people get shouted at when they get to hospital, and this acts as a deterrent because the hospital staff have developed a poor reputation. They reported that the hospital staff scream at them:

"What took you so long to come here for treatment?!"

Hence people experience the dysuria or haematuria but do not act. Only when the pain of the disease exceeds the fear of being shouted at, do people go to the clinic or hospital.

Discussion

The role community perceptions play in the control of disease cannot be over-emphasised. Such information about perceived obstacles, especially prior to an intervention, provides invaluable information and can provide strategies for that intervention. Such information needs to be ongoing (process evaluation), to ensure optimum feedback that would enable continuous realignment of the objectives of the intervention. Community members are the best informed on the local situation and their ideas as to what the obstacles are should be crucial components of the health intervention. We were forced to redirect our intervention and make it peer-based because of the negative attitudes that parents had towards health related information from their children. We were able to address health service delivery issues at the local clinic as a result of the feedback about the unfriendly staff at the clinic. With regard to our providing medication for mass treatment, we took into consideration the beliefs held by the community that treatment requires an ongoing ritual: we took special care to explain in our health education that praziquantel is effective when only taken in a single dosage. Community perceptions of the barriers to effective control therefore greatly enriched our intervention.

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