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**Qualitative Research in Zaire:
Training of a Social Mobilization Team
in Lubumbashi**

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1. INTRODUCTION

1.1 Background

The HEALTHCOM project is currently planning activities in the Lubumbashi region of Zaire to promote oral rehydration therapy (ORT) for children with diarrheal disease, and to increase participation in the vaccination program (Expanded Program on Immunizations: EPI) for young children. This project, administered by the Academy for Educational Development (AED) and financed by USAID, began working in Lubumbashi, Zaire in August of 1988. The project operates in collaboration with FONAMES (Fondation Médico-Sanitaire) and local Zairian medical authorities. The HEALTHCOM Technical Advisor, Joan Schubert, has been working with medical directors of health zones in Shaba province to generate communication activities that can have an impact on behavior related to ORT and EPI.

In October, 1988, qualitative research related to knowledge and practices about diarrhea and vaccinations was conducted in the city of Lubumbashi. The HEALTHCOM project needed information about both topics to assist the Project Director and colleagues in deciding what kinds of messages would be appropriate, and to help develop a questionnaire for an eventual community survey.

In 1987 UNICEF had assembled a group of people interested in social mobilization for the promotion of vaccinations and diarrhea treatment in Lubumbashi, and Joan Schubert had been in contact with the group. Most of these people were health professionals. Since the goals of this team were very similar to the objectives of the HEALTHCOM project, it was evident that the members of the UNICEF team would be the right persons to participate in a training and practice exercise in qualitative research.

1.2 Objectives of the Training

The training was organized to meet objectives for both the HEALTHCOM project and for the participants themselves.

1.21 The HEALTHCOM project needed information about what women knew about diarrheal illnesses and what were their current choices of treatment for diarrheal disorders. The project also needed information about women's experiences with using SSS and ORS for diarrhea.

1.23 The training was organized in a way that would give the participants the experience of using a method of qualitative research that would allow them to obtain information about questions related to the health and illness of the people with whom they work. The training was also designed to demonstrate to them that there is a structure and logic to knowledge about children's illnesses among women in Lubumbashi.

2. Training Activities

2.1 Training Program: Modified Focus Groups

The model for the training and data collection comes from basic focus group research, a method of qualitative research used increasingly in social marketing. This research method is qualitative in that it seeks to understand what people think, what they want, and how they feel about certain objects or concepts. Instead of considering actions, or objects, what is examined is ways of thinking, ways of reacting, to items in a certain domain.

This method can be adapted to obtain information for a number of purposes, among them:

- to obtain information to better define research questions for a large-scale survey;
- to better formulate questions to be asked in a large scale sample survey;
- for a better overall understanding of how the population talks about certain concepts or products and how they decide what to do;
- to ascertain reactions/responses of people to new products under consideration for introduction into the market.

In such a model of research, the feelings, impressions, and expressed attitudes vis-a-vis ideas, people, or products are emphasized. Groups of eight to 12 people are invited to discuss certain topics led by a moderator. Often people who are socially, economically, and demographically similar are sought in order to have a more or less homogeneous group. A moderator directs a discussion for an hour and a half about several topics chosen in advance. Often groups are assembled whose members are similar except for one factor so that one can judge the relative importance of that factor in explaining the contrasts between the responses of the two groups.

For example, a group could be assembled of women 16-25 years old with children under two years of age and another of women with children of the same age but with women 26-35 years old. If the women were alike in all respects except for the age difference, one is tempted to ascribe differences in their responses to the age difference.

The training was divided into three stages: several days of discussions and practical exercises in a classroom in town, a week of field trips followed by discussions in two health zones,

and two days of summarizing. One would ideally have from three to four weeks for such a training, but unfortunately only two weeks were available. In fact, although materials were developed for addressing both diarrhea and vaccinations, and exercises were completed in the group for both topics, on the field trips there was time for only diarrhea. Our meetings for discussion were held in the library of the Regional Health Inspection building. The first day in the field was in Katuba health zone; all other field trips were to the Ruashi health zone.

2.2 Group Discussions

The training began with presentations of what constitutes qualitative research and the ways it can be used to plan health interventions. Presentations of concepts and principles were brief and always involved group participation. Also presented were the principles of focus group research, a research method first developed by advertising agencies to evaluate reactions to new products they wished to put on the market.

Because the objective of this training was to evaluate the knowledge and experiences of a population about diarrhea and vaccinations, rather than estimating opinions and attitudes toward a new product, we modified our definition of focus group interviews. The classic definition of focus groups presupposes, above all, questions that solicit hypothetical opinions and preferences, an approach that did not fit the needs of this training. Therefore, in our discussions with the groups of women, we asked questions concerning their knowledge and experiences with diarrhea and vaccinations rather than their opinions and sentiments. We asked about kinds of diarrhea, symptoms, options for treatment, and their utilization of SSS and ORS packets.

2.3 Role Playing

In our presentations we emphasized the role of group moderator: the importance of putting the participants at ease, of having everyone talk, of redirecting questions to the speaker when people ask questions of the moderator, of not asking questions with an implied correct answer, etc. We also discussed a method of note-taking: the importance of including what each person said at each moment, noting the tone of the discussion, verbatim noting of responses to key questions, etc.

Such principles cannot be learned without practice, so we moved on to role playing focus groups with the members of our team. For each focus group session the group was divided in two: half to be the focus group per se, and half to take notes of the discussions. Joan Schubert first lead a discussion about AIDS in Lubumbashi so that everyone could see how the process worked. We then continued in that manner, with our training group divided into two and with a team leader who asked questions about diarrhea. After each thirty or forty-five minute discussion in Swahili, we met as one group again to review what had happened.

In this way everyone had the opportunity to take notes on several discussions, everyone was a participant in discussions several times, and many played the role of moderator. The moderators had a written questioning guide to follow which described the subjects to be covered in each session and a list of possible questions to ask. They did not find it easy to cover all of the subjects in the guide, for leading such discussions well takes a great deal of practice. Everyone was quite enthusiastic about this exercise.

We spent only a short time discussing how a summary and analysis would be conducted after field work, because the group did not

yet see clearly the kinds of notes that they were going to take. We simply discussed the steps to follow to make an appropriate summary.

3. FIELD TRIPS

3.1 Context of Discussions

For our field trips the training group was divided into three teams, each team with a moderator and four note-takers. We spent four mornings in Ruashi, visiting a different neighborhood each time. Each team conducted one focus group, which gave us three groups per day. We chose to center the research mostly in Ruashi health zone because that was where HEALTHCOM planned to begin activities, but one afternoon was also spent in Katuba zone in the catchment area of the main Health Center.

We experienced some difficulties getting groups of mothers with small children together as we wished, for it took us time to find the right way to explain what we really wanted. Sometimes we asked medical service personnel and sometimes members of the political structure to invite women to come. We found it extremely important to take the time to explain what we were looking for (characteristics and number of women) to the person who was going to invite the women, since at first those persons had too many women come at the same time. We also learned about the importance of having a place that was quiet where we could talk undisturbed.

3.2 The Development of the Discussions

On each trip we tried to spend an hour with 8-12 mothers of small children in a quiet and private environment. For the most part

the moderators succeeded in having the women talk about all the points of interest. In two or three cases there was one woman in a group who had a special experience in health services and who therefore dominated the conversation. In another group a person with political connections attended the discussion, and the women were hesitant to talk. Finally, in one group most of the women did not speak Swahili, so the discussion took place in Tshiluba.

All discussions took place in Swahili (with the single exception noted above). Usually the moderator sat in a circle with the participants and the three or four note takers sat outside. The moderator recorded the discussions with a tape recorder. The presence of the cassette recorder did not bother the women.

The teams' experience with focus group discussions showed us the great importance of respecting the following conditions in organizing such research:

- a) The moderator must be very familiar with the topics to be discussed before beginning the discussions;
- b) the women must be put at ease before beginning the discussion;
- c) the site of the discussions must be fairly private;
- d) there should not be "experts" or political agents in the group;
- e) the group should be more or less homogeneous (sex, age, education, etc.).

4. Summarizing the discussions

4.1 The method of summarizing the discussions

On the field trip days we met with groups of women in the morning and in the afternoon we examined the results. Each team prepared a summary of the morning's discussion from their notes and the tape recording. We then all met together and each group presented the results of the morning's work with the lessons learned from the exercise. In this way everyone heard about problems encountered and ways of resolving them.

4.2 Group Identity

For each discussion the groups noted a series of elements which characterized the group: address of the locale of the discussion, neighborhood, date, degree of homogeneity of the group, younger or older women, presence of experts, and the group dynamics. Generally such information is used to compare the responses of the groups and to suggest explanations for contrasting points of view. We noticed, for example, that in the poorest neighborhood where the people seemed to have more connections to village life, the women spoke considerably more about traditional medicine than elsewhere.

4.3 Discussion of results

The goal of these discussions was to suggest why we encountered certain problems and how to avoid a repetition of the same circumstances, as well as consider the results per se. We saw, for example, how difficult it is to work well with a large group (15-20) of women. We saw the impact of having an expert present and what happens when people walk by the group during the discussions. We also saw what can happen when older women were

present: the younger women did not speak. Thus, the team learned through experience the importance of following certain conditions in setting up group discussions.

5. Results

5.1 Responses to Diarrheal Disorders

5.1.1 Diagnosis and treatment of diarrhea

The Swahili term for diarrhea is kuhara (a verb), or maladi ya kuhara. At times the women also used a term from French, diale. The other term mentioned often was lukunga, a term from tshiluba that refers to an illness recognized by a sunken fontanelle and eyes, dry skin, and the making of a sound which is a clacking of the tongue (clacking of the tongue is a sign of being thirsty). These are the classic symptoms of dehydration.

Often the women mentioned kilonda ntumbo, an illness associated with diarrhea accompanied by weakness, weight loss, and skin that lightens a bit, all symptoms of kwashiorkor. Some women also spoke about buse, an illness characterized by diarrhea, but it is only diarrhea that occurs in a child who is still nursing. When a woman becomes pregnant while still nursing a child, that can provoke diarrhea. There is also kasumbi, probably also a tshiluba term, which is diarrhea accompanied by a rash or red sores around the anus.

We found these diagnoses especially important because, according to the women, they implied different treatments. The women listed many possible treatments for kuhara, both biomedical (antibiotics, antidiarrheals, SSS) and indigenous (traditional). We noted at least 30 different medications, including rice water,

Vicks, terramycin and enemas. But the women unanimously said that for the other illnesses an indigenous (traditional) treatment was necessary since the nurses could not cure them. A number of times the women explained that the nurses had told them that illnesses such as lukunga, kilonda ntumbo and buse did not exist, and therefore they would not treat them.

Several groups of women gave us recipes from traditional medicine to treat such illnesses as lukunga, kilonda ntumbo and buse. To treat lukunga they use mainly locally made salt with palm oil, often mixed with ashes of different origins. The women put the medicine on the sick person's fontanelle, palate, and elsewhere. We were also given the medicinal ingredients for treating buse and kilonda ntumbo.

5.12 Choice of treatment

Each group of women was asked how they chose the treatment for these illnesses. They responded in two ways, or at two levels. One, for maladi ya kuhara, modern medicines such as SSS or antibiotics are used, while for other illnesses mentioned above, indigenous treatments have to be sought. At times they also use indigenous medicines at home for kuhara.

Two, they said that in general, they decided according to their experience or as they went along, or according to the type of diarrhea, or according to what their ancestors had done. One group also said that they preferred indigenous medicines because they are more effective and less expensive. Another group admitted that the women did not really know what to do and so they tried a bit of everything to see what worked.

5.13 Feeding during Diarrhea

All in all, it seemed that women of Lubumbashi continued to give food and liquids to a child with diarrhea. Many women told us that if the child refused to eat, they prepared a kind of porridge. Only one group (incorrectly) said that feeding should be stopped when a child had diarrhea.

5.2 Experiences with SSS and ORS

5.21 Sources of information

In our discussions with the 12 groups of women in Ruashi, women usually named several different sources of information about SSS and ORS, but health centers and hospitals were cited most often. The women all mentioned the well-baby clinics (kipimo) or the hospital/health center as information sources. Neighbors were mentioned twice, as was radio, and television was mentioned once. One group also cited the local parish as a source of information. According to these general responses, we can say that what the women know now about SSS and ORS comes from medical services. Radio broadcasts and printed materials do not seem to be used often for messages concerning SSS and ORS in Lubumbashi.

Evidence from what women understood about SSS and ORS indicate that some nurses do explain the effects of SSS and ORS to their patients. We asked about what the women understood about SSS and ORS and noted several responses in each group. Of the ten groups for which we had responses, a number of women in eight of the groups said that the solution rehydrated the child, and in six groups someone said the solution restores strength to children who are sick with diarrhea.

5.22 The use of SSS and ORS

We conducted 12 focus group interviews in the Ruashi zone in four days, three groups per day with nine to 18 women per group. In two groups there were only three women who had used SSS at home, and in four groups all the women had used SSS.

This result suggests that in Ruashi zone, the majority of women with small children already tried SSS at least once for diarrhea. We recognize that our sample of women is not representative and that we did not see the poorest or most marginal women. But the responses are sufficiently consistent--almost all have used SSS--that we may speak of a high level of persons having used it one or more times. We also believe that level of use of SSS varies with neighborhood.

5.23 Knowledge of SSS preparation

We found women in each group who provided at least one recipe for preparing SSS. They almost always gave one of three versions of the amount of water: one Simba (beer) bottle, or one Simba bottle plus one soda bottle, or one Guigoz (milk) can. The amount of sugar was also close to the correct amount (3-4 teaspoons). However, the amount of salt varied considerably. Often the amount of salt that the women said they use would, in fact, yield solutions with dangerous levels of salt.

Thus, the principal problem of the recipes women knew was that women put too much salt in the solution. Furthermore, the fact that at least three quantities of water were suggested may be a source of confusion. If health care personnel could agree on a standard volume of water to recommend, it would facilitate the task of health agents in teaching proper preparation of the solution.

5.24 Medical Care at Health Centers

We asked what treatments were given by health centers for children's diarrhea. All the groups mentioned SSS or ORS packets, but we do not know where these women go for medical care. That is, do the majority of the women go to a single health center, or to two or three different ones? Most women also mentioned other medicines (vermifuges, terramycin, charbon, etc) except in two groups. One of these groups said that some time ago medicines were given for diarrhea, but that now only SSS and ORS are given.

6. Conclusions

6.1 Diagnoses and Choice of Treatment

Our focus group interviews demonstrated that Ruashi women recognized a series of five or six illnesses associated with diarrhea: maladi ya kuhara, lukunga, kilonda ntumbo, buse, kasumbi and perhaps others as well. We will have more information concerning these diagnoses from the future ethnomedical study, but we may draw some tentative conclusions already.

Women very often use SSS or take a child to the health center in the case of maladi ya kuhara, but not for the other illnesses. If this is true, the sickest children, those with the greatest need of being rehydrated and closely observed, are not taken to medical services. This is a problem that must be addressed somehow.

There seem to be two ways to address the problem:

- 1) try to convince the public that children who become ill with these sicknesses need to be observed and rehydrated;

- 2) try to convince nurses to accept the reality of the local diagnosis of these illnesses and to rehydrate children while knowing that the indigenous treatments continue.

A publicity campaign that deals only with diarrhea may persuade some women to use SSS for ordinary diarrhea but will scarcely have an impact on treatments of those illnesses which usually are given traditional medicines.

6.2 Experiences with SSS and ORS

The results of this exercise suggest that most of the women have heard of SSS, that they learned about SSS in the Health Center, and that the majority of women have tried it at least once. Some women said that SSS was the only efficacious treatment for diarrhea. We also often heard that SSS rehydrates a child who is sick with diarrhea, which indicates that some nurses have done a good job of educating the public.

The women gave us many different recipes for the preparation of SSS with amounts of water and sugar that were more or less correct. The quantity of salt varied the most. In planning future educational messages, it seems particularly important to promote the use of a quantity of salt that is easy to understand and to measure.

Responses to questions about SSS and ORS indicate that in Ruashi there is already a certain base of knowledge among the women about preparation of SSS and its use. If the level of correct oral rehydration is to be increased, it is not a question of introducing a new product to the public. Rather, two things should be done:

- 1) convince the women that cases of lukunga and similar illnesses should be rehydrated;
- 2) adopt a uniform formula for the preparation of SSS that can be taught everywhere and promoted by everyone.

The results of this research are being used in discussions with medical authorities about the kinds of interventions that might be appropriate in promoting ORT and EPI programs in Lubumbashi. Results are also being used to better adapt the questionnaire for the baseline survey to local conditions in Lubumbashi.

A number of the members of the UNICEF team stated that they would change their way of doing health education after participating in the research and learning what women now know about diarrheal disorders. Many of the team members believe they know how to conduct focus group discussions and want to try them on their own. The training exercise seems to have achieved its objectives for both the HEALTHCOM project and the participants from UNICEF.