COMBATTING ANTIVACCINATION RUMOURS: LESSONS LEARNED FROM CASE STUDIES **IN EAST AFRICA** EASTERN AND SOUTHERN AFRICA REGIONAL OFFICE UNITED NATIONS CHILDRENS FUND NAIROBI, KENYA

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Foreword

The Genesis of Antivaccination Rumours

The Expanded Programme on Immunisation (EPI), set up in 1974, has been one of the largest and best documented public health programmes in history. The present report seeks to fill a gap on the EPI bookshelf by documenting an underreported phenomenon in developing countries, namely, the rise of antivaccination campaigns mounted against vaccination.

The vaccination programmes of recent decades have, to a certain extent, been the victims of their success. As morbidity and mortality have declined, so, too, has the African public's perception of the importance of some vaccine preventable diseases (measles is a notable exception). Fears of side effects and rumours of long term repercussions of vaccination, never entirely absent, have surfaced as vaccination programmes have matured and approached their goals of polio eradication and tetanus elimination.

The near disappearance of some EPI target diseases, especially polio and, in some countries, tetanus, has raised the quite natural question "Why vaccinate?" This question has arisen just as political and religious forces opposed to government have a new tool, in the Internet, to provide support to their allegations against vaccination. The large and growing scientific literature on vaccine side effects has become a blunt instrument for attacking all vaccines, without due attention to the question which all parents need to answer: do the benefits of this vaccination for my child exceed the risks? There are, of course, articulate defences of vaccination against its detractors. In the international field, the best known of these is the World Health Organization (WHO) homepage, www.who.int/vaccines-diseases/safety/infobank/ttox.shtml")

Why is it important to document rumours?

Given the importance of vaccination, and the possible threat from antivaccination campaigns, surprisingly little has been written on the subject from developing countries. The subject has been widely reported from industrialised countries, especially the sometimes devastating campaigns against pertussis vaccination. A recent report by the U.S. monthly *Consumer Reports*, examining anti-vaccination attitudes and arguments in the US context, notes that questions about vaccine safety "can be detrimental to the general public, as those with concerns may choose not to have their children vaccinated." The report cites findings of a Colorado study that concluded that unimmunised children

¹ E J Gangarosa, A M Galazka, C R Wolfe, L M Phillips, R E Gangarosa, E Miller, R T Chen, "Impact of anti-vaccine movements on pertussis control: the untold story," *The Lancet* 1998; 351: 356-61

are 22 times more likely to contract measles and six times more likely to contract pertussis than those vaccinated. In developing countries, where case fatality rates may be higher, the effects of antivaccination campaigns carry risks even more serious than in the industrialised countries. ²

• Documenting rumour campaigns

The present report contains case studies from Kenya, Uganda, and Tanzania done by a consultant for the UN Childrens Fund, UNICEF. Each case study involved an in-depth study of the campaigns and included interviews with key players said to have spread rumours. The studies sought to determine the basis for their views and whether they were, or can be, brought over to the EPI position by persuasion. Interviews and focus groups included mothers, fathers, health workers and officials, religious leaders, the media, and elected officials.

• Combating rumours

This report also reviews responses of national and local governments, WHO, UNICEF, and other agencies and officials to see whether these responses were effective in combating or stopping the rumours. Additionally, this report seeks to determine whether there is a direct correlation between rumours and drops in vaccination rates. If so, what can we learn for future campaigns? What is working? What is not?

Developing tools to use in future campaigns

Finally, this report looks at lessons learned from the experience of these three countries. From the lessons of these campaigns, can a set of tools be prepared to share with other national programmes to support future vaccination campaigns and routine immunisation?

The country studies show the need for tailor made responses. With that much said, there are generic lessons learned from these studies which are of more than country specific interest

LESSONS LEARNED

The following table shows how rumour campaigns have developed in different ways in western countries and in the three countries studied in the present study.

² "Vaccines: An Issue of Trust" 01/08/01 Consumer Reports Online (www.consumerreports.org)

E	AST AFRICAN COUNTRI	ES
	WESTERN COUNTRIES	EAST AFRICA
TARGET OF ANTIVACCINATION CAMPAIGNS	ROUTINE VACCINATIONS	SIAs
VACCINES MOST OFTEN TARGETED	PERTUSSIS AND MEASLES/MUMPS/RU BELLA	TETANUS TOXOID AND ORAL POLIO VACCINES
CORE ARGUMENTS AGAINST VACCINATION	MEDICAL AND PHILOSOPHICAL ARGUMENTS	RELIGIOUS AND POLITICAL ARGUMENTS
HIV/AIDS ARGUMENTS	NOT IMPORTANT	IMPORTANT IN SOME COUNTRIES
FAMILY PLANNING ARGUMENTS	NOT AN ISSUE	IMPORTANT IN SOME COUNTRIES
"WESTERN PLOT" ARGUMENTS	NONEXISTENT	COMMON
MILITARY VACCINES	IMPORTANT FOR ANTHRAX	NOT IMPORTANT

While every rumour campaign has its specificities, the following generic responses are often indicated.

BEFORE THE SCHEDULED ACTIVITIES

- Prepare packages on frequently asked questions for all health workers, especially before vaccination campaigns or introduction of new vaccines.
- Involve ethnic, religious and political minorities in information activities.
- Schedule EPI campaigns outside the timeframe for family planning or AIDS awareness campaigns.
- Associate tetanus toxoid in the public mind with successful pregnancies.
- Give TT in prenatal clinics, not family planning clinics.
- Keep TV, radio and other media on board.

WHEN THE STORM BREAKS

- Disseminate a single set of messages through the same channels as those used by the rumourmongers. Everyone from the dispensary attendant to the Minister of Health needs a copy of the key messages, with no confusion about the official line.
- Do not raise the rumourmongers' profile by identifying and denouncing them. Our job is informing the public about vaccines, not denouncing our opponents.
- Monitor vaccinations in areas reached by rumours. Do not overreact where there is no decline in vaccinations. Quantify impacts. Do your vaccination tally sheets tell a different story from what you anticipated? Do not respond to a decline in vaccinations which does not, in the event, materialize.
- Meet with your opponents as well as your friends.
- Combat ignorance with knowledge, not with coercion.

Uganda

Summary Points

- The vaccination decline predated the antivaccination FM radio blitz.
- Shifts in NIDs dates to the malaria high season led to popular association of child deaths with the NIDs season. Temporal association became a causal association in the minds of many.
- Official responses, though correct, were long in coming.
- FM attacks, though articulate, were not shown to be effective.
- The government has not ruled out a sledgehammer response.
- Confusion continues over different official answers to the media blitz.

The anti-vaccination campaign in Uganda began at the time of the 1997 rainy season, coinciding with the National Immunisation Days (NIDs) of that year. Mothers observed high mortality, probably from malaria, in their vaccinated children in the south-western districts. Mothers and fathers then went to a popular FM radio station for possible explanations of the deaths. Thus, the FM station was the ultimate link in the chain of events starting with the logical decision to synchronise polio NIDs in East Africa. Two factors have made the official response less effective than it would have been: the failure of the authorities to respond early to the public anxieties about the excess mortality perceived during the vaccination campaign, and the sometimes inconsistent responses of officialdom to media questions about vaccination.

Remarkably, there is much evidence to show that declines in Uganda's immunisation programme predated the FM radio scares, and that these scares, though widely discussed, had little if any quantifiable impact on the polio campaigns.

"People may have refused – not because of the rumours – but because of the way they got the messages. They lacked education."

- Mr. Erastus N. Kihumba, Deputy Provincial Public Health Officer, Central Province, Kenya

Uganda

Country Background

Located on the equator, Uganda is bordered by Sudan, Kenya, Tanzania, Rwanda and Zaire. Nearly 90 percent of Uganda's population lives in rural areas. The country's largest population centres are in rural areas.

In the early 1990's, Uganda began decentralising government services to give more decision-making power to local jurisdictions. This political process has involved creating new districts, which now number 56, an increase from 39 in 1997. According to the Local Chairman V (LC V) interviewed in Ntungamo District, the "power, resources, and responsibility have moved from the centre to rural areas."

MAP OF UGANDA SHOWING 56 DISTRICTS -2001

[OMITTED FROM WEB VERSION]

Source: Uganda National Expanded Programme on Immunisation

The vaccination programme in Uganda started in 1963 with polio and smallpox in 1968. The reign of Idi Amin, 1971 to 1979, led to massive cuts in basic health services. By 1980, BCG coverage, 70 percent before his seizure of power, had dropped to one per cent. After his demise, a vast effort to relaunch vaccinations was cosponsored by the new government, with NGO and UN assistance. The Uganda Expanded Programme on Immunisation (UNEPI) began in 1983, with support from UNICEF, Save the Children Fund, and the WHO. Immunisation made slow progress until 1986, by which time most areas of the country had become secure. In 1988, Uganda voted for polio eradication. The country has not seen a case of polio since 1996.

In 1988 Uganda supported the World Health Assembly's resolution to eradicate polio by 2000. In 1995, Uganda began planning for its first NIDs in 1996. In its 1996 report on its first National Immunisation Days, UNEPI reported that it had achieved about 75 to 80 percent coverage in routine immunisation in most remote areas of the country. However, the following table, given in a press briefing to kick off the 2001 SNIDs, shows coverage for polio coverage in 1996 to have been more than 95 percent and shows coverage in the mass campaigns since1996.³

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¹ National Immunisation Days 1996 Final Report. 1996. Ministry of Health. Uganda.

² National Immunisation Days 1996 Final Report. 1996. Ministry of Health. Uganda.

³ A Brief to the Press by Hon. Minister of Health. Figures provided by UNEPI.

Results of National Polio Campaigns, 1996 – 2000, and Absence of Impact from FM Radio Antivaccination Campaigns

	Year	Round	Number of	Estimated
			Children	Percentage
			Immunised <5	Coverage
	1996	1	3,831,957	96
		2	3,785,443	95
	1997	1	3,719,912	92
		2	3,821,849	94
	1998	1	3,964,030	97.7
		2	4,337,872	106.9
FM BLITZ BEGINS	1999	1	4,567,403	107.2
BEFORE ROUND 1 ►		2	4,814,520	113
SUBNATIONAL DAYS	2000	1	1,753,879	91.5
ONLY IN 2000	SNIDs	2	1,943,916	101.4

Note: After the start of the media blitz, NIDS vaccinations rose from 4.4 to 4.6 million.

Source: Uganda National EPI

Constraints to the mass polio immunisation campaign were noted in a 1996 report. They included problems with refrigeration and vaccine storage (cold chain), late and insufficient funding, rumours, and limited time. Other constraints included the following:

- □ The planning process for NIDs was centralised with minimal district input, resulting in omission of some crucial activities in certain districts.
- □ Planning coincided with national presidential and parliamentary elections, making it difficult to involve districts and lower levels early enough.
- □ Both central and district levels lacked experience in planning for NIDs.
- Time was limited.

All these subsidiary factors were later to feed into the official reaction to the rumour campaign. Structures hard pressed to deal with the predictable challenges of planning and managing mass campaigns were hard pressed to deal with the wild card of antivaccination rumours.

Programme communication was done, but not always to a high standard. As in other countries, there was an emphasis on mass media and printed materials, and little effort was made in the early stages of the NIDs to target health workers themselves, who were thought to be loyal supporters of the government initiative. The 1996 NIDS report notes

Anti-Vaccination Rumour Campaigns in Eastern Africa - UNICEF

that social mobilisation was targeted at all levels of the population, and mass media were used effectively to promote NIDs, especially through a variety of radio programmes. Government run Radio Uganda and Capital Radio were used extensively. In addition to mass media, many print materials were produced, but these later proved inadequate because they were in English, a language not read by most Ugandans.

To counter negative rumour campaigns, health officials used current affairs and other popular radio programmes, including live call-in programmes, for answering questions and doubts expressed by the public and putting down rumours. The 1996 report does not specify who was spreading rumours against polio vaccination.

The 1997 report on NIDs states that health workers did not participate in the planning of 1996 NIDs. As a result, most of them did not support NIDs. According to this report, some health workers had doubts and misgivings and openly campaigned against NIDs. In some areas of the country, they tried to discourage clients from immunising their children, and the health workers themselves did not take their children for immunisation.⁴

In 1997, as in 1996, UNEPI conducted intense community mobilisation. At the same time, deliberate attention was given to health workers. Senior medical officers and other health workers from Mulago Hospital, as well as other government and NGO hospitals, were involved in planning for 1997 NIDs. A number of sensitisation meetings targeted health workers at all levels and a booklet titled "National Immunisation Days in Uganda – A Guide for Health Workers" was prepared and distributed.⁵

The scheduled dates for NIDs were changed from December and January (1996-97) to August and September in 1997. It was this change in timing, well indicated on programme grounds, which led to the coincidence in time of the vaccination campaign and the malaria season, which peaks in August. One official questioned about the scheduling change said that he thought the change was implemented when the East Africa countries – Kenya, Tanzania, and Uganda – co-ordinated their NIDs efforts.

In the first round of NIDs in 1997 eight districts of the central and eastern regions showed low coverage, covering under 75 percent of the targeted children. The 1997 report says that lowered coverage might be the result of:

- □ Rumours and misconceptions As in the 1996 NIDs, some individuals and media organisations (not identified by name) spread rumours that OPV was contaminated with HIV.
- □ Poor mobilisation Social mobilisation activities were started very late in most districts due to late disbursement of funds.

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⁴ National Immunisation Days 1997 Final Report. 1997. Ministry of Health. Uganda.

⁵ National Immunisation Days 1997 Final Report. 1997. Ministry of Health. Uganda.

□ Lack of adequate knowledge - Explanations about the objectives of NIDs and the reasons for immunising children who had completed the schedule (antigens in routine immunisation) were not given.⁶

Like other countries, Uganda told its parents to complete their children's vaccinations in infancy, then to come back for polio campaign vaccinations until the age of 59 months. Such double sets of messages, in support of a sound scientific policy, are bound to cause popular confusion when the public is also exposed to unfounded rumours about the alleged pathogenicity of a vaccine which protects against a disease that few parents have seen in recent years.

By 1997, officialdom began to react. Between the first and second rounds of NIDs in that year, teams were dispatched to districts with lower coverage to hold sensitisation meetings for local leaders, opinion leaders, health workers and mobilisers. At these meetings, information about NIDs was presented and openly discussed. According to the 1997 report, these meetings and an intensified media campaign on radio and television helped to dispel rumours and improve coverage in the second round.⁷

By 1998, officials were concerned with the continuing decline in routine immunisation, a trend that dated from 1994, before the NIDs, and was largely related to changes in funding and administration of vaccination services. As a result, the Ministry of Health (Ministry of Health) commissioned a KAP study, published in 1998, to investigate the causes of the perceived decline in routine immunisation coverage. The Executive Summary to the KAP study notes that "most players in the programme seem to agree that there is a decline in immunisation coverage nationally although this is not backed by detailed data because it is scanty." The KAP study quotes a senior officer from UNICEF: "There seems to be no data at hand to substantiate decline." The KAP study does not say why data were not available.

Sometimes our priorities are not the priorities of the community.

-- Mr. Paul Kagwa, Assistant Commissioner, Health Promotion and Education, Ministry of Health

⁶ National Immunisation Days 1997 Final Report. 1997. Ministry of Health. Uganda.

⁷ National Immunisation Days 1997 Final Report. 1997. Ministry of Health. Uganda.

⁸ KAP Study Report on Immunisation Services in Uganda. 1998. Health Management Consult Uganda funded by UNICEF. P. 15.

Rumours by Radio against OPV

Rumours started in 1996 in the Buganda area around Kampala when NIDs were first implemented. They came from two sources, according to several officials who were interviewed for this report. In 1996 Mulindwa Muwonge, who operated Central Broadcasting Service (CBS) Radio, a private FM station in Kampala, questioned why the polio NIDs were implemented. Why at that particular time? He purportedly said that the OPV contained anti-fertility drugs to end the race. His actions had a big influence in lowering coverage in Mpigi District.

At the same time, Muwonge's message was reinforced by a group called the Bazukulu or "Grandchildren of Buganda," a radical group of Buganda youths. They said that the polio vaccine was a plot coming from the West to kill off the race. In addition to these stories, the HIV rumour was still circulating. Since some OPV formulations are red, the children were said to be receiving blood contaminated with HIV.

Ugandan health officials responded to Muwonge by meeting with him, briefing him about the polio campaign, and answering his questions. He stopped broadcasting the rumours as a result. The Ministry of Health talked to the Minister of Health for the Buganda Kingdom at that time and asked him to use his influence with the university students. He held meetings to sensitize the students. After 1997 to 1998 there were no further problems with rumours in the Buganda area. Central Broadcasting Service aired interactive programmes with questions and answers.

During the 1990s the Uganda government allowed for private ownership of FM stations under its policy of media liberalisation. Health officials from UNEPI, the Ministry of Health, UNICEF, and the WHO believe that it was during this period that one radio operator who began broadcasting in mid-1999 contributed to declines in routine immunisation and poor coverage for NIDs in the southwestern regions of Uganda.

People had a quarrel with the Ministry of Health before I started talking.

-- Kihura Nkuba Head of Service Greater Afrikan Radio Mbarara

While officials believe that one owner affected NIDs negatively, coverage results have always been above 90 percent in each year NIDs were held. In addition, all medical personnel interviewed concede that routine immunisation declines began around 1994. This was long before Greater Afrikan Radio FM 98.3 began broadcasting from Mbarara town in western Uganda, covering an area of about 50 miles, inclusive of six districts.

The station, according to the proprietor, currently has a listenership of about five million people, covering most of Uganda except for the northern and far eastern districts.

The problem is that he plays on the minds of the uninformed.

-- Hon. Robert B.K. Ssebunnya, Minister of Health, Buganda Kingdom District Governor 9200, Rotary (in reference to Kihura Nkuba)

Dr. Mark Grabowsky, a former WHO medical officer now in Washington, DC gave his retrospective on the rumour campaign that was promoted on Uganda FM radio. He says that "rumours happen and that the radio station responded to market forces. People were listening for more." Dr. Iyorlumun Uhaa, a UNICEF Senior Project Officer, seemed to agree with Dr. Grabowsky: "Radio fills a niche we didn't have. It gives information."

Several factors reported in the 1996 and 1997 documents on NIDs may have contributed to some of the rumours, such as expired drugs and the attitudes of health workers themselves. Moreover, NIDs and the HIV vaccine campaign kicked off on the same day. Many perceived HIV/AIDS as a Western plot and that the West had originated HIV.

In 1997, a number of children reportedly died in the southwestern region of Uganda following vaccinations during NIDs. The exact number of deaths is not known. Officials everywhere in Uganda explained that the rainy season in Uganda coincides with NIDs. Malaria epidemics have been reported during September to December since 1998 in the southwestern area. Although officials said that the deaths were from malaria and not OPV, people became more sceptical, especially about the mass campaigns. Some officials recalled, too, that when the BCG antigen was administered in 1989 some children suffered adverse effects.

It was in this context of rumours that Nkamuhayo Rwacumika or, as he is popularly known, Kihura Nkuba, began broadcasting in early 1999. He said that he kept his views on immunisation to himself until May 1999, when he went to the village of Bwizibwera in Mbarara District to give a lecture. Here he says he learned from people that many children had died following mass polio immunisations in 1997. According to Kihura Nkuba one of the preachers said, "I buried children and my cassock got old." According to an uncorroborated account by Kihura Nkuba, one of the parents, who had four children die after OPV, was forced at gunpoint to get her last child immunised,. Many people

began hiding, rather than take their children to NIDs. Kihura Nkuba said that people reported that officials went house to house and jailed people who refused to have children immunised.

When Kihura Nkuba heard these accounts from people in Bwizibwera, he began reading about OPV and vaccinations on the Internet and from many books on scientific and alternative medicine subjects. He has by now amassed an extensive library of technical and scientific information on vaccines and vaccinations.

In response to the people's questions, Kihura Nkuba also contacted the CDC and researched vaccines and vaccine safety on the CDC Website. He was particularly concerned about the use of the Sabin polio vaccine, OPV, because it contains the live but weakened poliovirus. In an interview, he said that his main concern was that OPV was being used in the mass polio campaign without regard to the HIV status of recipients. Kihura Nkuba had read the CDC guidelines. These stated that OPV should not be given to individuals with compromised immune systems. Further, he pointed out that the manufacturer's literature accompanying the vaccine vials recommends that OPV not be given to anyone with immunodeficiency, or who has a family history of AIDS.

He continues to be concerned that health workers giving OPV have never taken into account the health status of the children. Kihura Nkuba also stated in his interview that callers to his radio station told him that some of the OPV vials were expired.

Kihura Nkuba says that he does not tell people not to go for vaccinations. He does not speak against vaccinations. And he doesn't say, "Don't get your children vaccinated, or they will die." He tells his audience that they should have the right to choose for their children. His goal is to give them enough information to make informed choices and to ask questions. He said that when people questioned officials about adverse reactions or events, the attitude of the Ministry of Health was that people are too simple and uneducated to understand what they are told. To date he says he has only talked about OPV and that he has never discussed other vaccines or routine immunisations on his programme.

Kihura Nkuba and others interviewed in the villages also questioned: why polio? People in the villages have never seen a case of polio. Everyone interviewed pointed out that malaria is what kills people in Uganda. Why have "they" prioritised polio over the disease that kills us?

Greater Afrikan Radio has been "quite popular and the owner characterised himself as the voice of the people against a regime that was the pawn of Western interests. Every taxi driver could cite his claims," noted Dr. Grabowsky.

Since 1999, when Kihura Nkuba began raising public doubts about OPV, the Ministry of Health has resisted his broadcasts. Kihura Nkuba says that the people had a quarrel with

the Ministry of Health before he started talking. The Ministry of Health says people were enthusiastic about NIDs until Kihura Nkuba started broadcasting. According to the figures for national coverage, Kihura Nkuba has had no effect on the NIDs. Dr. Grabowsky also thought the impact of the rumour campaign was possibly overrated.

The evidence is overwhelming that the rumours broadcast on FM radio made little impact because the majority of mothers chose to get their children vaccinated during the NIDs.

Regardless, officials would like nothing better than to shut down the station or for Kihura Nkuba to simply go away. In reaction to his broadcast in 1999, the Ministry of Health brought doctors to debate with him. They met over lunch and thought that the result of the meeting would be for Kihura Nkuba to desist, but three days later, he started up again. The government also attempted to refute his positions on the air with debates, but this effort was unsuccessful because the moderator, Kihura Nkuba, had a better command of the facts than government officials had. According to Dr. Grabowsky's account, the government also attempted to "buy off" Kihura Nkuba by placing pro-NIDs advertisements on the air, but these were undermined by the station's commentaries.

At a Bushenyi District officials' meeting in September 2001, officials were still at a loss as to how to silence Kihura Nkuba. They conceded that trying to convince him to be quiet is a waste of time, and that the "problem" of Kihura Nkuba must be dealt with on a national level. The government is planning to take action through legislation. According to the Ministry of Health, a law requiring immunisation is in effect, but the punishment for not following the law is weak. The Hon. Mike Mikula, Minister of State for Health, expressed the following view, in a closed-door session prior to an open hearing for the district: "If parents cannot be arrested for not complying, then they should be taken to court and punished."

At that meeting the Ministry of Health proposed to launch a protracted campaign. The Ministry of Health said that the Ministry had failed to explain "negative" (adverse events) to the people. He said that leaders would use the same medium – radio – and that the Ministry of Health and Kihura Nkuba would issue a joint statement answering questions. The Ministry of Health would help with advertising to counter rumours. In addition, the Ministry of Health would go to the grass roots and address their questions. They would involve the churches and schools. The churches are "100 percent behind us." In schools parents would be met and addressed through the PTAs. Mr. Mikula also noted that the Ministry of Health believes that Kihura Nkuba has used them for a scapegoat. "If he does not bend, then we shall legislate."

Later that day Bushenyi District held a public meeting attended by over 100 people. Following reports from officials, the chairman took comments from the floor about why that district had the lowest coverage in the first round of SNIDs in 2001. (This district is

one targeted for SNIDs for the border districts.) Here is a summary of reasons or opinions people gave for low coverage:

- ☐ Inadequate financing not enough funds for social mobilisation to move around the district.
- □ Inability to explain to people why Kihura Nkuba is wrong because he brings research; Ministry of Health is not responding with opposing views.
- Local leaders are not adequately supporting immunisation.
- People who did not take their children were not punished.
- □ Leaders did not take their own children.
- □ Rumours that OPV contained HIV.
- Rumours that OPV contain anti-fertility drugs.
- People say they are tired of the exercise (NIDs).
- □ People are suspicious. Why NIDs again?
- Sensitisation is poor radio is sending negative messages but no one explains that radio is wrong.
- □ Adverse events in 1998.
- Messages given during social mobilisation are not consistent. Speakers say different things.
- □ Too much freedom for people they can refuse. Biggest response was in remote areas of the country where the government came out strongly and forced people.
- Non-standardised data incorrect projection figures for number to be immunised.
- □ Superstitions and suspicions no one had seen a case of polio.
- Rumour that the government is using the vaccine against those that don't agree.
- Questions about why supplemental (booster) immunisations for polio only?
- □ Before NIDs mothers took children for routine immunisation. Why is this (NIDs) necessary?
- Doctors are not punished for not immunising their children.
- □ Government is making it political.
- People giving OPV are not trained, and parents question their skills.

Along with these concerns, the radio station and Kihura Nkuba were mentioned many times by the people in attendance. Officials put forth a plan of action to counter rumours and educate people about immunisation, starting at the community level. They would develop scientific, focused messages and disseminate information through all channels available to them, including radio. They would develop radio programmes and begin using film vans again with the goal to make Bushenyi a model district in polio eradication.

The Ministry of Health said it wanted Kihura Nkuba to meet and discuss areas of disagreement so that the Ministry of Health and Kihura Nkuba could develop a team approach. At this district-wide meeting the Ministry of Health noted in response to

Kihura Nkuba's broadcasts that it was Ministry of Health policy not to immunise those known to be HIV-infected. According to Kihura Nkuba in a later interview, this was the first time the Ministry of Health stated this policy publicly. Nkuba seemed to feel this was a small vindication of what he had already been saying on the radio.

Near the close of this meeting, Kihura Nkuba was invited to come and speak. He said that he was happy that "the Ministry of Health and I are engaged in a dialogue for the betterment of our people's health." The Ministry of Health agreed that a post-vaccination survey would be conducted in the region to determine whether there was credence to the belief that many people expressed: health of children goes downhill after OPV. The Ministry of Health and Kihura Nkuba declared a "cease-fire."

In an interview several days later when asked what he wanted to see happen, Kihura Nkuba said that he would like these questions addressed:

Why spend all those resources on polio when it kills few or no people? If IPV is a safer vaccine, why use OPV? Malaria is the number one killer of children. Most people cannot afford treatment, so why devote limited resources to polio? If global organisations and governments want to help Uganda, why not have them put resources into diseases that kill? Wouldn't paralysis be preferable to death? If polio vaccination is so good, why do you have to force us? If polio is actually caused from faeces, if I improve sanitation/hygiene, how could I come into contact with polio? If OPV is safe and we know its ingredients, why don't we manufacture OPV in this country? If we made the vaccine in Uganda, would we force people in other countries to take it and put them in jail if they didn't? Before we started vaccinations, we didn't see a lot of polio and we had our own methods (herbs) to vaccinate. Why can't we emphasise this method? When we vaccinate, the children die. We do not see you. You come to vaccinate and leave. We remain with the children.

Kihura Nkuba's questions and concerns, which he says are the questions and concerns of mothers and fathers, are confirmed by the mothers and fathers interviewed. Letters that the listening audience sent to Kihura Nkuba during that period of time and until the present continue to raise the same questions. Parents are especially concerned about the safety of OPV and why it is being given to their children in Africa when it is banned in America? And why are their children dying?

In addition to answers to these questions, Kihura Nkuba said that the Ministry of Health needs to do the following:

□ Change from OPV to IPV.

- Allow children some time between birth and when they receive vaccination.
- Conduct a study to see what is killing children. (Ministry of Health has already agreed to this.)
- ☐ Make exceptions to vaccinations: e.g. do not vaccinate in cases of HIV, malaria, infections, vomiting, and fever.
- Concede ground to give parents full information and the right to choose. He stated here that force will cause campaigns to collapse. Parents need information about reactions and post-vaccination support. Officials defeat their own purpose: if a child dies, the entire village will not go. Fully informed parents have an incentive to go.
- ☐ Improve radio advertising through thoughtful concepts and by giving information. Promote immunisation all year not just in July. The Ministry of Health does not have a public relations or research department. Ministry of Health could reduce its budget by giving information. Kihura Nkuba would be willing to help design health messages.
- Implement an independent consumer protection and advocacy organisation (similar to the U.S. Food and Drug Administration) that can be trusted by the people.

He says that he is prepared to work with the government, but the Ministry of Health does not come and ask what he is saying. He views Greater Afrikan Radio as a media organisation that researches the material it presents on air. He feels that he has the ear of the people. He said in an interview that "the government expects to speak and people just go and do it..." Nkuba is, in his own lights, a firm believer in empowerment through knowledge and information.

He said that he had discussed the possibility of developing and implementing an alternative information centre through the radio station with Michel Sidibe, the UNICEF country representative. Although Kihura Nkuba wrote a proposal for such a centre in March 2000, as requested, he claims never to have received a response from UNICEF.

Later in the week, following the Bushenyi District meeting, another example of confusing messages appeared in the newspapers. The Ministry of Health generated the confusion.

The Saturday, September 8, 2001 edition of *The Monitor* newspaper quoted Minister of State for Health Mike Mukula as saying: "Don't immunise children with HIV." Then on Sunday, September 09, 2001 the *Sunday Vision* said the opposite: "Immunise HIV kids – Mukula." In the latter article Mukula dismissed press reports that he had advised against immunisation for HIV positive children.

In a National Coordinating Committee Meeting to Prepare for the Second Round of SNIDs in Kampala on September 11, 2001 (See Annex), Kihura Nkuba was still the

topic of a great deal of discussion when officials met to assess the first round of polio SNIDs. Several participants talked about taking Kihura Nkuba to court and the possibility of closing down the station.

While many thought that Kihura Nkuba's broadcasting is still having a negative effect on SNIDs, a number of participants noted that instead of reacting to Kihura Nkuba, they sensitised people in the district causing coverage to improve last year in the second round. Others noted that they needed to look at the administration of Bushenyi District because leadership is lacking. Leaders show no interest in the exercise of NIDs: *i.e.* more vaccine was wasted there; they did not have enough health workers; the cold chain technician is not a former health worker; and mobilisation was inadequate.

The WHO Information Officer, in a later interview, agreed that in 2000, Bushenyi had only 54 percent coverage in the first round of NIDs. He agreed, too, that when intense mobilisation was done at the sub county and parish levels, coverage increased to 94 percent in the second round. He said that Kihura Nkuba is not the whole issue. People asked simple, logical questions which they wanted answered. When their questions were answered, they got their children vaccinated.

The Ntungamo District Chairman, Local Council V, Mr. John Karazarwe, said that when the radio rumours came, resistance to vaccinations developed. "When people listen to the radio or television, they think it's the word from the government, even if it's private." He said that at first everyone believed Kihura Nkuba's messages because they came at the time when many children were dying from malaria and AIDS.

In response to the resistance to polio immunisations, the LC V Chairman said that Ntungamo District formed an anti-malaria task force. They noted that NIDs coincided with the emergence of mosquitoes in August. That was why the mothers and fathers thought children were dying from polio vaccinations. They did not take their children to hospitals or clinics to find out that the illness and death were from malaria. Some said that vaccine looked like blood and their children were getting AIDS in the mouth. Some simply thought that the vaccine was unnecessary. Since there was widespread ignorance about the polio vaccinations, people withdrew. Everyone, including educated people, stopped taking their children. Even the police had to be arrested because they would not take their children.

Chairman Karazarwe said that in the de-centralisation taking place in Uganda, he got substantial funds that he could decide how to use in his district. He said that he chose to ignore the radio broadcasts and began implementing health improvements that have helped to improve coverage in routine immunisation and coverage in SNIDs. Here are some of the steps he took:

- Upgraded health units from nine to 25 (the district does not have a hospital). Encouraged every parish to have a health centre.
- Trained and required health workers to do outreach.

- □ Began treatment for malaria sensitised and trained health workers about treatment.
- □ Used AfriCare and other institutions to assist with improving water sources.
- Improved food security by encouraging development of back yard gardens, teaching about nutrition and its relation to improved immunity to resist diseases.
- ☐ Improved communication and access for mothers.

Ntungamo District moved away from confrontation, took the resources that would have been diverted through confronting and arguing with Kihura Nkuba, and put those resources into district services combined with increased education. The LC V Chairman sees this as empowering mothers.

He believes that when you fight Kihura Nkuba that "you show you're afraid." His strategy has been to remove the grounds for Kihura Nkuba's strength – his influence with the people. "If you go to radio, at the end of the day, you confuse the masses." You must disarm him by using a different message.

His (Kihura Nkuba's) broadcasts caused EPI and NIDs to drop (but) there were other variables or problems. His broadcasts just accelerated (the decline).

--Dr. Kaguna, District Director of Health Services, Mbarara District

The challenge, says Chairman Karazarwe, is to be careful not to disappoint people. He says he must make sure to give the services people travel long distances to get. As the level of awareness in the district has gone up, people have started coming to the health units. Thus, demands on local government, especially for drugs, have increased. If people become disappointed, they will drop out.

In addition, the Ntungamo Assistant District Director of Health Services said that Kihura Nkuba said mothers did not get information about possible adverse events following vaccination, such as fevers. "But we tell mothers what to do. If fever persists it might be malaria."

How do you make decisions when you have conflicting information?

I wait and see.

-- Mr Erikadi Mworozi father and resident Rwizihwera LC

Effect of Rumours on Routine EPI

NIDs coverage in Uganda has been successful, and most of the districts were positive about NIDs. But some of the people interviewed for the 1998 KAP study expressed concerns that NIDs affected routine immunisation because mothers were tending to wait for NIDs and forgetting routine immunisation. "The first round of NIDs affected immunisation. People thought they had finished all immunisation." ⁹

There is not a lot of buzz around routine immunisation. Routine coverage is low everywhere, due more to cultural attitudes than "vaccinations are a plot to weaken children."

-- Dr. Mark Grabowsky, former WHO medical officer

Although there was uncertainty among participants in FGDs at the sub-county level about whether routine immunisation was declining, many were uninformed.

Others interviewed for the KAP study offered the following reasons as possibilities for the decline in routine immunisation:

- □ Family planning has reduced the number of children born (therefore the projected number of children to be vaccinated has dropped)
- □ AIDS has caused a decline in the number of mothers and children.
- □ Long distances make it difficult for mothers to come; they are tired. 10
- □ Morale is poor among health workers.
- □ The masses lack understanding about routine immunisation.
- □ There is mistrust of health workers.
- ☐ There are rumours and fears about mass polio immunisation.
- □ Expired drugs breed mistrust of the health services in general.

Most striking from the KAP study, however, among those interviewed – including women and men with children three to 20 months old, youth, opinion leaders and others – is the lack of understanding about the differences between routine immunisation and the mass polio campaigns. The study notes that opinion leaders could have easily advised parents that there was no need for subsequent immunisations after the NIDs. 11

Anti-Vaccination Rumour Campaigns in Fastern Africa - UNICEF

⁹ KAP Study Report on Immunisation Services in Uganda. 1998. Health Management Consult Uganda funded by UNICEF. P. 15.

¹⁰ KAP Study Report on Immunisation Services in Uganda. 1998. Health Management Consult Uganda funded by UNICEF. P. 27-29.

¹¹ KAP Study Report on Immunisation Services in Uganda. 1998. Health Management Consult Uganda funded by UNICEF. P. 85.

For the purpose of this study on rumours, figures for four routine antigens in the districts thought to be most influenced by Greater Afrikan Radio are given in the following tables. These figures were taken from data provided by UNEPI.

Vaccine Coverage, by Antigen and Year, Bushenyi District

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BCG	78	96	97	92	100	131	100	122	102	82	67	60
DPT 3	56	69	70	81	97	97	99	99	88	62	54	49
Polio 3	56	71	70	79	96	89	100	97	87	65	53	48
Mea- sles	57	69	64	71	93	95	100	95	84	63	49	56

Source: UNEPI

The decline in routine immunisation in Bushenyi District appears to have started in 1997.

Mbarara District Coverage Percentages

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BCG	98	85	93	86	95	104	100	107	104	78	84	74
DPT 3	88	66	73	71	76	79	67	80	80	54	61	51
Polio 3	87	67	73	70	81	69	84	81	84	56	62	51
Mea- sles	80	60	63	66	76	82	87	76	87	57	59	62

Source: UNEPI

The decline in routine immunisation in Mbarara District appears to have started in 1998.

Ntungamo District Coverage Percentages

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BCG					68	100	100	113	100	66	74	70
DPT 3					66	78	81	99	84	50	57	53
Polio 3					68	76	93	96	82	50	56	50
Mea- sles					30	75	92	83	86	47	57	55

Note: Ntungamo District was created in 1993.

Source: UNEPI

The decline in routine immunisation appears to have started in Ntungamo District in 1998.

In each of these three districts, the decline in routine immunisation started before Kihura Nkuba began broadcasting in 1999. Generally speaking, it appears that the decline occurred following the change in time of year NIDs were conducted and that particular year, 1997, was also the year when many children died during the malaria epidemic.

It has been reported that EPI was low before NIDs. It seems that a number of factors account for poor routine coverage. Kihura Nkuba's broadcasts have most likely had some negative impact when combined with already existing fears created by the deaths

from malaria right after children received OPV in 1997. But most important, mothers and fathers never got the information they needed following those deaths.

In addition, Dr. Grabowsky pointed out that while much effort is given to raising coverage, the "other side" controls the message because there is not informed consent and mothers are not prepared to handle adverse effects. In other words, the lack of information for parents creates fertile ground for the opposition to create rumours and confusion. One of the fathers interviewed said that if he gets conflicting information, he takes a wait and see attitude.

People need information. They want a lot of information. They don't want simple information.

--- Kihura Nkuba, Head of Service, Greater Afrikan Radio, Mbarara

Mr. Paul Kagwa, in an interview at the Ministry of Health, concluded that NIDs have helped officials to understand what is going on in villages and the importance of communication. Now, he says, is an opportunity to broaden alliances, form relationships with the media, and raise awareness.

But what is the most effective way to fight rumours, or, better, what is the most effective tool for stopping rumours from getting started? Give the people the right information, give the people all of the information, and trust the people to make the best choices for their children.

The best method for getting good coverage is social mobilisation -- ongoing. Don't ever stop.

Health workers are the best source of health information.

-- Ms Justina Musiime, mother, Rwetonjo Village

What is the best way to counteract rumours? Give the people the right information. Use the radio stations, such as Radio West.

-- Dr. Kaguna, District Director of Health Services, Mbarara District

Anti-Vaccina

Kenya

Kenya

Summary Points

- Geographical focus in Central Province, the heartland of the political opposition
- Religious opposition from Catholic bishop of Nyeri, not under control of his superiors
- Temporal coincidence of polio NIDs and national AIDS campaign, an unfortunate timing in retrospect
- No perceptible effect on routine EPI, and no reintroduction of wild poliovirus
- House to house vaccination seems to have blunted the impact of the rumours.

In Kenya, anti-NIDs campaigns started in the final stage of the country's successful campaign against polio, and after polio had faded from the headlines. They were focused in Central Province, the heartland of the political opposition, and especially in Nyeri, where a militant bishop, unsupported by his superiors, led a campaign from the pulpit against the polio NIDs. Other factors also intervened. In retrospect, the rumours might have had less impact on coverage if the NIDs and the national AIDS campaign had been launched consecutively, and not at the same time. One notable feature of the Kenyan campaigns is that they had no perceptible effect on the routine EPI. In Kenya, as elsewhere, vaccination campaigns have provided a more attractive target for critics than has the routine vaccination programme.

The Kenyan anti-vaccination campaigns, though successful in lowering NIDs performance, did not lead to reintroduction of polio. Central Province of Kenya has high routine coverage, and it does not border on polio endemic areas. After the initial shock of 1996, the government and agencies responded with public information campaigns which blunted the edge of the attacks. By the year 2001, a prominent opposition politician was willing to appear in public with government and UNICEF staff, administering OPV on camera on the grounds of a Catholic church.

Background

The Ministry of Health launched Kenya's Expanded Programme on Immunisation (KEPI) in 1980. The main purpose of KEPI has been to assure that all children are immunised against six childhood diseases before their first birthday: tuberculosis (BCG), given at birth; diphtheria; pertussis; tetanus; poliomyelitis; and measles. The six antigen programme will add hepatitis B and *Haemophilus influenzae* B vaccines in 2002.

KEPI is also committed to the global Polio Eradication Initiative and has been conducting National Immunisation Days since 1996. From 1996 to the present period, over 20 million children less than five years were given polio vaccines. According to health officials and statistical data, coverage for both rounds of NIDs stood around 81 percent except in 1999 and 2000, when it rose above 90 percent.

Geographical Kenya

[map omitted from Web version]

As eradication programmes enter their final phase, the target diseases become less and less common, and their importance declines in the eye of the press and the public. Doubts about vaccines and vaccination, previously disregarded when the diseases were common, rise to the surface, and programme communication becomes more common.

"Mothers and others didn't understand about repeat immunisation. They needed time to be convinced...but social mobilisation was inadequate to do this."

- Ms Martha Muriithi , District Public Health Nurse at District Medical Health Offices housed at Provincial General Hospital, Nyeri, Central Province

Programme communication is widely recognised as an important component of immunisation programmes. It gets lip service in all documents about immunisation and campaigns, and every individual interviewed said the same thing. However, in practice, communication does not always get the respect, priority and funding that it deserves. This report documents the tendencies to implement communication activities in a haphazard and unfocussed way, implementing social mobilisation activities too late to be effective, and the failure to communicate the purpose of repeated NIDs to opinion, religious, and other grassroots leaders and mothers/caretakers.

"The rumours are deep-rooted. They were hearsay. They had no basis, but they created uncertainty. Therefore, the mothers don't take their children. They wanted the government to guarantee that they're safe. The priests and opinion leaders passed along their doubts."

 Ms. Edith Githii, Deputy Hospital Matron, Mathari Consulata Mission Hospital, Nyeri, Central Province

Historical Situation Analysis of NIDs

Before examining rumours during NIDs and looking at their impact on immunisation rates, an analysis of Kenya as a nation and the Central Province is needed. This will show national trends for the five years NIDs were conducted throughout the country, along with routine vaccinations.

1996 Records and reports on National Immunisation Days for polio start with 1996 when the first NIDs were conducted. In these reports, mention of rumours or questions is very frequent.²

² *National Immunisation Days Report- 1996.* November 1996. Kenya Expanded Programmeme on Immunisation. Nairobi. Pp. 22 – 26.

Rumours related to Polio Eradication Campaign to a significant extent influenced the poor performance in coverage of some of the provinces. The rumours emanated from various groups were relating to PEI and extra polio vaccine doses. These rumours created fear among some communities. The rumour was that the new lot of vaccines was infected with HIV, while others said that it was meant to cause infertility at a later age in those vaccinated as preschoolers. Others said that it was meant to exterminate certain communities.

The rumours may have risen due to probably inadequate information disseminated in the message content. (emphasis added) This is demonstrated by the questions that came from the communities, such as:

- 1. Why so much emphasis on polio disease and not any other?
- 2. Why should I take my child for extra-dose if he has completed the immunisation?
- 3. Is the extra-dose harmful?
- 4. Is there an outbreak of Polio?
- 5. Why is the colour of the vaccine different from the normal one used?

- National Immunisation Days Report- 1996

In the first NIDs in 1996, Central Province was recorded as having the lowest coverage in Kenya. Central Province recorded an overall coverage of 60.3 percent during the first round and 51.2 percent in the second round. Within Central Province, Nyeri district coverage was 40 percent, far below the average for the province as a whole. According to the same report, these were unexpected results considering the fact that the province has always reported high OPV coverage in the past, as verified by immunisation coverage surveys and routine immunisation data.

1997 In the 1997 *National Immunisation Days Report for Kenya*, KEPI states that false rumours related to the polio campaign had a negative effect on NIDs coverage in certain parts of the country. Fears were aroused because of controversies about the safety of the vaccines and whether they were laced with contraceptives and HIV. Another fear was that overdoses might occur from extra doses. People felt that there were more important public health problems, such as malaria and typhoid; thus, polio spending could not be justified. ³

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³ *National Immunisation Days Report- 1997*. November 1997. Kenya Expanded Programmeme on Immunisation. Nairobi. Pp. 28 – 31.

In 1997, as the following table shows, the Central Province had the biggest drop in coverage in both rounds compared to 1996 -- a 15 percent drop in round one and about a five percent drop in Round Two.

NIDs OPV coverage by Province, Kenya, 1997

Province	Percentage Coverage	Percentage Coverage
1997	First Round	Second Round
Nairobi	82.33	101.32
Central	46.98	46.96
Coast	87.34	84.91
Eastern	72.58	76.83
North Eastern	56.37	58.97
Nyanza	81.40	90.10
Rift Valley	91.31	92.20
Western	84.02	85.28
National: Kenya	78.80	82.30

Source: National Immunisation Days Report-1997

In the 1998 NIDs, all provinces registered 70 to 90 percent in OPV coverage with the exception of Central Province, which was below 70 percent. Yet while Central Province NIDs were lowest in the country, routine immunisation was highest, with 70 percent fully immunised. (DPT3 coverage was at 97.2 percent.) ⁴

1999 – 2000 Results for 1999 NIDs were almost identical to those in 1998 for the Central Province but with an increase in those fully immunised at 84.8 percent. (DPT3 coverage was again 97.2 percent – the highest in the country). At the same time, Central Province coverage in the NIDs for polio was still the lowest in the country. ⁵

The following table shows the routine immunisation rates for Kenya.

⁴ *National Immunisation Days Report- 1998*. November 1998. Kenya Expanded Programmeme on Immunisation. Nairobi. Page 4.

⁵ *National Immunisation Days Report- 1999*. January 2000. Kenya Expanded Programmeme on Immunisation. Nairobi. Page 7.

Kenya Expanded Programme on Immunisation – Infant Coverage, as Percentage, 1999

Province	BCG	DPT	DPT	DPT	Polio	Polio	Polio	Polio	Measles
		1	2	3		1	2	3	
Nairobi	97.7	95.5	90.9	75.0	84.1	97.7	88.6	86.4	93.2
Central	100.0	100.0	98.6	97.2	82.4	97.8	95.6	94.9	91.3
Coast	94.8	97.9	89.5	81.3	73.3	98.4	94.2	85.3	91.6
Eastern	97.9	97.4	93.6	86.2	77.4	96.3	93.7	98.8	86.6
Nyanza	92.9	92.1	81.6	66.2	53.3	91.2	79.8	66.4	61.9
Rift Valley	96.3	96.5	92.2	83.9	56.2	96.2	95.1	84.4	83.7
Western	94.4	94.4	89.2	72.2	54.9	94.4	89.2	72.0	65.8
Kenya	95.9	95.8	90.0	79.2	64.3	95.4	90.4	80.8	79.2

Source: Kenya Demographic and Health Survey

According to the 2000 *Report on National Immunisation Days*, Central Province, which had lagged behind in NIDs since 1996, finally caught up with the rest of the provinces. Many of the interviews conducted in Nyeri in the Central Province concurred that NID participation improved where house-to-house immunisations were done.

Most striking, the 2000 report again documents that some of the low NIDs OPV coverage areas are also areas with a background of high routine immunisation coverage. In fact, Central Province boasts the highest routine coverage in Kenya.

What accounts for low coverage in Central Province during NIDs compared to its high routine coverage? This report will answer that question as it focuses on the Nyeri District, the centre of many rumours.

^{*}North Eastern Province is not included.

Nyeri Profile⁶

Nyeri district is one of the seven districts in Central Province, covering an area of 3,284 square kilometers. Nyeri itself has seven divisions: Mukurweini, Mathira, Kieni East, Kieni West, Tetu Municipality, and Othaya. Physical features of the district are Mount Kenya to the east and Aberdare Ranges to the West.

The people of Nyeri appear to be very religious, predominantly literate and aware of the health needs of their children, particularly immunisations. This is evident in the continuing high level of routine immunisations, the highest in Kenya. It is also evident to any visitor to Nyeri that family planning has been widely accepted. Advertisements for condoms are everywhere: "Let's talk," the slogan of Trust condoms, is apparent on buildings and kiosks even in the smallest villages.

Immunisation services in Nyeri district are provided at 59 service delivery points. Forty-four of the facilities are operated by the government of Kenya, eight are private, and seven are church run. Four outreach clinics are conducted monthly for communities not able to access health facilities. The majority of the facilities give vaccinations on a daily basis.

The following table shows crude routine coverage statistics from the 2000 Immunisation Coverage Survey – Nyeri District. These statistics are based on information recorded on immunisation cards or information given by the mother if the card was not available. The survey confirms high routine coverage for Nyeri.

In this survey, immunisation card retention rate was 80.1 percent, an indicator of how mothers regard the importance of child vaccinations. The survey analyses immunisation coverage by card alone and by verbal history.

INFANT IMMUNISATION COVERAGE RESULTS

	CARD	ONLY	CARD AND HISTORY			
	Number	%	Number	% Coverage		
BCG	171	81.0	203	96.2		
BCG Scar			191	90.5		
DPT 1	172	81.5	203	96.3		
DPT 2	171	81.0	202	96.2		
DPT 3	167	79.1	201	95.3		
OPV 0	166	78.6	203	96.2		

⁶ Information in this section taken from: Immunisation Coverage Survey, Nyeri District: Results 2000. 2001. Ministry of Health, Kenya by Kenya Expanded Programmeme on Immunisation.

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OPV 1	172	81.5	203	96.2
OPV 2	171	81.0	202	95.7
OPV 3	163	77.2	196	92.9
Measles	163	77.2	200	94.8
Full immunised			203	96.2
Immunised before			200	94.7
one year				

Source: Immunisation Coverage Survey, Nyeri District: Results 2000

In this same study, a comparison between routine immunisation and survey coverage shows a close correlation and similar results between the two methods of evaluating immunisation coverage. In both methods, immunisation coverage was above 80 percent for most antigens in both 1998 and 1999.

This survey also gives a strong indication as to why mothers chose not to participate in NIDs in Nyeri district.

REASONS FOR NO OPV DOSE DURING NATIONAL IMMUNISATION DAYS

	No. (36)	%
Child fully immunised	11	31
Religious influence	6	17
Negative rumour	3	8
Discouraged by health workers	0	0
Not aware	8	22
Others	13	36

Source: Immunisation Coverage Survey, Nyeri District: Results 2000

As shown in the table above, the main reason for mothers' not taking their children to NIDs to get OPV is that their children were already fully immunised. Religious influence accounted for 17 percent of those not participating in NIDs, while negative rumours concerning the vaccine accounted for eight percent of those not responding to NIDs. Thirty-six percent of those not responding to NIDs could not be specified as to reason. Of those reporting rumours as the reason for not participating, the rumour most often cited was that the vaccines were laced with contraceptives.

KEPI and UNICEF have commissioned a number of studies over the past five years to determine why participation in NIDs has been so low in Central Province compared to other Provinces, and why routine immunisation is the highest in the country -- a contradiction noted in some of those studies.

For several years, officials outside Central Province have assumed that rumours kept mothers away from NIDs. In fact, while many rumours were circulating, closer

examination reveals that many other trends and factors may have converged to subvert participation in NIDs.

How Rumours Started

Rumours may be religious, political or ethnic in origin. In a meeting of KEPI staff, some suggested that the rumours may have been spread by health workers or others who did not understand the purpose of NIDs, or because of jealousy, or feeling left out. Some health workers were trained during social mobilisation activities while others were not. Whether it was priests, health workers, mothers, or chiefs, rumours continued to flourish in Central Province because no one could answer the questions raised by the mothers. All their sources of information didn't know the answers.

Rumours in Central Province have circulated from 1996 to the present. They vary in character, but the major ones are about OPV being laced with contraceptives or HIV. These rumours seem to have impacted the 1997 campaign most, but rumours themselves have not necessarily played a central role in low turnout for NIDs. It is rumours along with other factors which may account for the poor results in Central Province.

The first Kenya NIDs in 1996 took place in the context of a political atmosphere that bred fear and distrust. The current government and its ruling party, in the view of people in Nyeri, had neglected the Central Province because it is home to the political opposition. President Moi and his Kenya African National Union Party have governed Kenya since independence.

- "...Whatever comes from the government is rejected. Mothers won't risk because they heard rumours and they have fears. The church gave announcements, but we did not know how to counter the rumours. We expected people to go. We didn't know about the (low) turnout. No one campaigned against NIDs. It was just rumours on the ground that escalated."
- Reverend Kathuni, Presbyterian Church of East Africa, Nyeri, Central Province

A study in 1997 reported that the involvement of the Office of the President (Provincial Administration) in mobilisation and use of the Chiefs' camps as immunisation centres reinforced negative publicity against NIDs, since the provincial administration was perceived to be a tool of the ruling party. ⁷ The report went on to say that the administration's involvement in NIDs may have sent the wrong signal and helped fuel negative allegations from sections of the Catholic Church and some opposition politicians.

People had not been adequately sensitised to the global eradication of polio. Some health workers, most of the mothers and caregivers, and all of the opinion and religious leaders did not understand the purpose of NIDs. After all, mothers in Central Province were doing a good job of getting routine immunisations for their children. Now why all of the free, extra doses? Kenya had not had a case of polio since 1984; as far as everyone was concerned, polio was not a problem in Kenya.

Health workers had told mothers for several years before the NIDs that their children needed only four OPV doses to be fully immunised. Based on that knowledge, questions came up. Wouldn't the extra doses be toxic to their children? Couldn't their children be overdosed? And if the government was going to spend all this money on polio, why wasn't another disease chosen since their children were already immunised against polio? Why should polio be a priority, given all the health problems they faced? Why this campaign when we are immunised already? Who has seen a case of polio?

In addition to a political situation fraught with suspicion, national elections were scheduled for 1997. Political divisions were entrenched and deepening. People questioned whether the ruling party was attempting to root out the opposition by the use of vaccines that are toxic, or laced with contraceptives or HIV/AIDS. People in Central Province were fearful of anything "free" from the government.

The Central Province is the seat of the opposition to the ruling party; the leader of the National Democratic Party lives in Othaya District in Central Province. Since the Kenya government had never given the people of Central Province anything, so the reasoning went, why was the government giving out polio vaccine? Was there a sinister plot behind the free gift?

Once rumours and the growing fears got rolling, they were hard to stop. They continue to circulate on a limited scale today. No one could help the mothers. When mothers went to their religious leaders or some of the health workers, they could not get factual answers to dispel their fears or refute the rumours because of inadequate preparation against the

⁷ National Immunisation Days (NIDs) Consultancy Final Report. 1997. UNICEF. Nairobi.

rumour campaign. Social mobilisation and training were limited and late due to inadequacy of financial and human resources.

There has been a widespread belief that the Catholic Church actively campaigned against NIDs by dispensing erroneous information in 1996 and 1997. However, while some priests influenced people to boycott the NIDs, it was not for religious reasons. The priests felt that they had a moral obligation to speak out against issues that threatened the community. ⁸

In this atmosphere of fear, several other things happened that may have consciously or subconsciously contributed to the uneasiness and the rumours of people in Central Province. NIDs were launched at the same time as the national HIV/AIDS campaign. Perhaps these two health issues became linked in some minds and may have accounted for the rumour that OPV was laced with HIV.

"The Church is the voice of the people. Mothers were afraid. Some refused. It was hard for educated mothers to get them to go."

- Jennifer, mother of children aged 4 years and 8 years, and Public Health Technician, Othaya Township, Central Province

People also had a fear of devil worship. The Commission on Devil Worship, chaired by Bishop Nicodemus Kirima of the Roman Catholic Diocese of Nyeri, had just concluded its work. Some rumours were related to devil worship, including the color of OPV (red) and the snake on the WHO logo. Fears came up about the safety of children, especially opening their mouths, which caused caregivers to associate the move with the "removal of tongue," a practice said to be associated with devil worship. House marking during the 2000 NIDs was rejected in some areas because of its association in the popular mind with devil worship.

While official statistics confirm low turnout, might the figures be based on erroneous estimates of the number of children under five in Central Province? That is the suggestion of the former Provincial Medical Officer, Dr. Mwangi, in an interview in his medical offices.

⁸ National Immunisation Days (NIDs) Consultancy Final Report. 1997. UNICEF. Nairobi.

The Stories

In 1996 Bishop Nicodemus Kirima spoke from the pulpit against polio vaccination NIDs. The Kenya Ministry of Health and Douglas Klaucke, WHO Regional Epidemiologist, met with Archbishop Ndingi Mwana'a Nzeki, Bishop Njue, Bishop Koris, and the communication officer for the Catholic Church, several other top church officials, and their medical doctor in a six hour discussion. This meeting was called in an attempt to stop Church opposition to NIDs.

The Catholic Church leaders and officials believed that OPV was laced with contraceptives. They cited TT and contraceptive studies. The meeting was further complicated when the WHO medical officer stated, contrary to fact, that WHO did not support contraceptive research.

"What did the church tell them? Sometimes we don't know what is the right answer to give. In Central Province the government neglected the province, so therefore the people do not want to accept services. And they were not told why this? The people didn't go (to NIDs) because they were afraid."

- Fr. Njoroge, Roman Catholic Church, Karatina Township, Central Province

During the discussion it became clear that the bishop was not against polio campaigns *per se*, but saw them as a prelude to other campaigns, especially ones that would involve injections that could then be laced. This anti-vaccination campaign was based in the Diocese of Nyeri, and without support from the national bishops' conference, much less the Vatican. The campaign, however, did have an international dimension as vaccination opponents got their misinformation from the Internet.

As a result of the meeting, the church officials agreed to be quiet about OPV but they would not agree to support OPV. However, they did not follow up by communicating this pledge in their pastoral letters to all parishes.

"Fears may or may not be justified, but fears prevent them from going (to NIDs)."

- Mr. John K. Munyi, Deputy Town Clerk, Nyeri, Central Province

Tanzania

Tanzania

- Well documented link between Philippines rumours and Tanzania
- Opposition to TT centreed around a single mission hospital in mainland Tanzania, with some antivaccination activity on Tanzania's offshore islands
- Lab testing required to disprove the alleged association between TT and contraception
- Medical missionary now won over to WHO/government position

In the United Republic of Tanzania, anti-vaccination rumours against tetanus toxoid (TT) emanated from a Catholic mission hospital in the southern part of the country whose medical director read about anti-TT rumours through a Philippine NGO. She took the rumours to a regional meeting in 1994 where she raised questions about whether tetanus vaccine was laced with human chorionic gonadotrophin (hCG). She opposed vaccinating women of child bearing age until she had an independent laboratory attest to the purity of TT vaccine being used in Tanzania. She now supports vaccination of children and of women of child bearing age.

[Insert map Tanzania]

Overview of EPI and NIDs

Tanzania's Ministry of Health launched the Expanded Programme on Immunisation in 1975. EPI made a substantial increase in immunisation coverage in the 1980's. By 1988, coverage was more than 80 percent, two years ahead of the 1990 global target for reaching 80 percent coverage.

Vaccination coverage rose from 50 percent in 1984 to 80 percent in 1989, but started to fall in the early 1990's. The proportion of children fully immunised by 12 months of age fell from 72 percent in 1989 to under 60 percent in 1991, 1992, 1993, and 1996. The post-1990 fluctuations were more closely linked to patterns of donor support than to rumours or to social factors.

Tanzania has been working toward the goal of polio eradication since 1988, when the World Health Assembly chose the target year of 2000 for global eradication. With the support of WHO and other international organisations and agencies, Tanzania

implemented its first rounds of National Immunisation Days in 1996. NIDs were synchronised with those of Kenya, Zambia, and Uganda. The technical report on NIDs and EPI, quoted in the following box, calls attention to a major constraint in social mobilisation.

A few days before the first round there emerged a group of people, led by the Prolife Activist Group, who created fear in people so that in a few villages no child was taken for vaccination during the second round. Fortunately, the impact of this counter-NIDs propaganda was minimal due to the fact that all religious faiths in the country were already supporting NIDs. ²

The report does not give any other information regarding the rumour, including where it was being spread and exactly which communities were affected. It does note, however, in the Lessons Learnt section that "religious leaders are a potential for community mobilisation and their timely involvement is crucial." Strategic planning for the following year included efforts to engage mass media to reach the community and disseminate correct promotional messages to support the campaign and not create fear.³

Reports on the 1998 NIDs note other rumours about OPV, including many doses of OPV will cause side effects, OPV would cause sterility, and OPV was associated with the malaria epidemic in the Muleba District. Additional social mobilisation activities were supported with funding from UNICEF, especially during the time between the first and second rounds of NIDs, to counter the rumours.⁴

In 1998 the Tanzania Ministry of Health reported that national levels of polio coverage reached 97 percent for the first round of NIDs and 100 percent for the second round with an overall average above 90 percent. The report attributes low coverage in some (unspecified) districts to the rumours. The last reported cases of polio occurred in 1993.

An annual Tanzania EPI evaluation meeting in April 2000 highlighted some of the milestones of the past 25 years, including continued strong national political support and some improvements in technology. Yet Tanzania faces many health challenges,

² First National Immunisation Days in Tanzania 10-11 August and 14-15 September, 1996: Process, Results and Lessons Learnt Technical Report. March 1997. Compiled by Khadija Msambichaka and Peter Kilima for the Ministry of Health. Dar es Salaam. P.6.

³ First National Immunisation Days in Tanzania 10-11 August and 14-15 September, 1996: Process, Results and Lessons Learnt Technical Report. March 1997. Compiled by Khadija Msambichaka and Peter Kilima for the Ministry of Health. Dar es Salaam. P.17.

⁴ *Technical Report: Tanzania National Immunisation Days 1998.* 1998. Compiled by Caroline Akim and Peter Kilima for the Ministry of Health. Dar es Salaam.

particularly a fluctuating immunisation coverage and an increase in infant and under age five mortality rates.⁵ Health sector reforms have been a challenge to operationalize. In addition, Tanzania has had an influx of refugees fleeing conflict-torn countries on its borders.

Percentage DPT and TT Vaccination Coverage among Children 12 – 23 Months and Women, based on Coverage Survey Data, by Year

	1989	1991	1991/1992	1993	1996
DPT-1	91.4	85.5	94	83.4	95
DPT-3	84.7	78.8	80	68.6	85
TT-2 (Women)	39.7	44.0			74.3

Source: Msamanga, Dr. Gernard. *A Review of the Situation of Expanded Programmeme on Immunisation in Tanzania*. February 2000. Prepared for the Ministry of Health and WHO Office. Dar es Salaam. pp. 36 – 38.

The antigen with the lowest overall rate of immunisation is tetanus toxoid, the one given to women of childbearing age. Thus, Tanzania faces two challenges: raising the immunisation coverage of all children for all antigens, and raising the level of TT vaccinations among women of childbearing age.

Tetanus Toxoid Vaccinations

The WHO webpage gives a detailed account of the epidemiology and prevention of tetanus. (http://www.who.int/vaccines/intermediate/neotetanus.htm) Neonatal (newborn) tetanus is the most common form of tetanus in developing countries. The disease is caused by contamination of the umbilical stump following childbirth through cutting the cord with an unsterile instrument, or by applying animal dung to the cut cord. Three to 14 days after birth, the infant suddenly fails to suck properly and becomes irritable; convulsions occur with increasing frequency and intensity. Case fatality is very high.

Source: Mid Term Review of Danida Support to the Expanded Programm on Immunisation, Tanzania 9-12 January 1994

⁵ Report of EPI Annual Evaluation Meeting Held in Dar es Salaam Msimbazi Centre. April 2000. Ministry of Health Department of Preventive Services. Dar es Salaam.

WHO Policy on TT

WHO policy calls for prevention of tetanus in all age groups.

In all countries protection against tetanus begins with immunisation in the newborn period, followed with reinforcing doses at older ages. A reinforcing dose of TT at approximately 6 months to one year after the third dose is given in a number of countries.

EPI in Tanzania would require every female between 15 and 45 years to get five doses of TT to ensure lifetime immunity. Yet the majority of women got only prenatal vaccinations. While it is widely believed by many health officials that rumours may have affected the rate of coverage, since the coverage for TT is low all over the country, other factors may play a role in stopping women from getting vaccinated except during their pregnancies. For example, in some interviews, health workers said that it is often difficult for young women 15 or 16 years of age to come alone to get TT.

While there may be some constraints, health workers also noted that mothers do not question whether TT contains contraceptives. TT cannot sterilize them if they are already pregnant, and they have seen many women who have received TT and become pregnant again.

Tetanus Toxoid Coverage, in Percentage, Women 15-45 Years of Age, Tanzania

T T Dose Coverage Level (%)	1991	1992	1993 January to August only
TT-1	18	20	21
TT-2	13	15	14
TT-2 plus	19	22	23

Source: Ministry of Health, EPI Annual Report, 1993

The 1993 EPI report notes that the dropout rate from first to second tetanus toxoid dose rose between 1992 and 1993. This could have been a result of a rumour "alleging that the strategy of vaccinating women of childbearing age is associated with attempts to enforce involuntary contraception." The report makes no reference to the source of the rumour.

Rumours

They (health officials) thought I was against vaccinations, but I was not. I come from the medical side not the church in this matter.

- Sr. Dr. Birgitta Schnell, O.S.B., Director, St. Benedict's Mission, Ndanda

Sr. Dr. Birgitta Schnell, O.S.B. has run the St. Benedict's Mission Hospital in Ndanda for thirty years. It is the largest hospital in the Mtwara Region. As documented in the hospital's annual report, the outpatient department alone saw nearly 66,000 persons yearly. In addition to being the largest regional hospital, St. Benedict's operates a number of dispensaries and clinics in other areas of the region. Its reputation and range of services brings patients from all over the region.

During several meetings and conversations with Sr. Dr. Birgitta, when queried, she could not always remember exact dates. She said that sometime in the early 1990's she received a number of reports and newspapers concerning anti-fertility research in the Philippines, Mexico, and India, as well as other countries. One of her documents is a summary from a WHO Progress report that highlights phase II of an anti-hCG vaccine trial report from the Philippines. ¹⁰ Sr. Dr. Birgitta said that she did not actually conduct research, or go looking for this information. All of her documents and articles were sent to her. She reads a great deal. (The Philippines rumour campaign, which formed the basis of the Tanzania backlash against TT, is detailed in Annex I).

What she was reading began to alarm her, especially when word was surfacing about the anti-fertility trials at a time when Tanzania EPI was promoting TT vaccinations. When Sr. Dr. Birgitta attended a zonal meeting in 1994, she shared with the Ruvuma, Lindi, and Mtwara Regions the information she was getting. She and others were suspicious about why only women were told to get TT in Dar-es-Salaam, where vaccinations had already begun in the schools.

The vaccinations (TT) are very good and people need to try to get them.

- Sr. Dr. Birgitta Schnell, O.S.B., Director, St. Benedict's Mission, Ndanda

¹⁰ "Anti-hCG vaccine phase II clinical trial – status report." *Progress, No. 30. Special Programmeme of Research, Development and Research Training in Human Reproduction.* The World Health Organization. 1994. P.8.

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After that zonal meeting, different areas of the country began to question the TT vaccinations. In the Moshi Region around Kilamanjaro, Pro-Life activity promoted rumours and questions. Pro-Life produced anti-vaccination materials and gave them out to people to keep them from getting vaccinated. But Sr. Dr. Birgitta said that these activities were not a result of the zonal meeting and what was discussed there. Those activities were the work of the Pro-Life organisation.

When asked what happened following the zonal meeting, she said that Ministry of Health was very angry that she raised questions and wrote her a letter. (An Ministry of Health official said that the Ministry of Health held a meeting with EPI and church officials, had the vaccine tested, and sent Sr. Dr. Birgitta a letter.)

When asked if mothers were now getting TT vaccinations at the hospital, she said that she supported the EPI programme and that vaccinations are given routinely. She told of having the TT vaccine tested by an independent laboratory, so that she could assure herself that the Tanzanian TT vaccine was safe. When she saw that it was not contaminated, vaccinations were given at the hospital.

She said in her interview that she believes that it is very important to vaccinate and that it is very bad that WHO is mixing vaccinations with anti-fertility. "The vaccinations," as they were intended, "are very good and people need to try to get them." She recalled that 30 years ago when she first came to the hospital in Ndanda, she saw many people die from tetanus. So when people (*i.e.*, health officials) thought that she was against vaccinations, she was not. She made it very clear, too, that her opinions on this matter come from the medical side - not the church. (From a walk through the hospital and observation of posters and other posted materials, it is readily apparent that her views are Pro-Life.)

Health officials and UNICEF personnel noted that the Mtwara Region has good coverage (over 80 percent) on TT.

Rumours with Legs

The rumours now discounted in Ndanda have surfaced in other parts of the country. The Tanzania *Daily News* on Friday, August 17, 2001, reported in an article titled "Isles adopts new anti-polio strategy" that in a seminar organised for journalists in Zanzibar on polio and measles campaigns, participants were critical of tendencies that discouraged efforts to immunise children. They cited a Muslim leader in Pemba who went around convincing followers that immunisations are anti-Islamic. He said that Muslim parents are offered drops of water and dates, and that this religious rite is as good as medicine.

They also decried the rumour that in the islands children exposed to vaccines will be rendered sterile.

Several people said that the rumours in the Kilamanjaro area were started by a Pro-Life⁹ organisation. Most of the rumours in all areas of Tanzania alleged that the TT vaccine was laced with contraceptives, or that it was anti-fertility.

Nearly everyone interviewed for this report said that Sr. Dr. Birgitta was spreading rumours, but none of those making this claim had actually spoken with her. She says that she did not spread rumours. She took the information she had discovered about antifertility clinical trials associated with hCG and raised questions at a zonal meeting. After she was convinced that the vaccine was safe, it was given out at her hospital. She shared her findings that the local vaccine was safe with her counterparts in the region.

Mothers do not question whether it (TT vaccine) contains contraceptives. They can see that TT does not sterilize. They are pregnant and they see others. All pregnant women get TT.

- Ms Vivian J. Kilimba, Regional Maternal Child Health Coordinator, Mtwara Region

are considerably less than compelling; i.e., basically convenience. There are many different terms applied to abortion, most of which overlap to some degree and are confusing to most members of the public unless explained clearly."

⁹ Pro-Life organisations or members of organisations have the religious belief that life begins at the moment a sperm fertilises a human egg and that it is tantamount to murder to do anything that harms it or the developing foetus. Abortion for any reason is prohibited. According to Human Life International: Abortion is defined by Williams' Obstetrics as "The interruption of pregnancy before viability at the request of the woman, but not for reasons of impaired maternal health or foetal disease. The great majority of abortions now being done belong in this category." HLI states that "This definition by an authoritative source confirms that most abortions are performed for reasons that

Annex I: The Rumour Campaign against TT in the Philippines

(Excerpted, with permission, from the unpublished report, "Deadly diseases, deadly vaccines, or deadly rumours?" by L. Luwaga, R. Wellington, and J. Clements)

In the spring of 1995, an international "pro-life" organisation spread rumours that the tetanus toxoid vaccine (TT) was being administered to women of childbearing age by immunisation programmes in developing countries and that a contraceptive hormone was included in the vaccine. IN a press release circulated via the Internet to its affiliates in more than 60 countries, the organisation said tests of TT carried out in Mexico had shown in t contained the pregnancy hormone, human chorion gonadotrophone (hCG). Tests in the Philippines performed by local hospital laboratories using pregnancy tests kits also reportedly showed the presence of hCG in TT. The organisation alluded to reports that "millions of women in Mexico and the Philippines have unknowingly received antifertility vaccinations under the guise of being inoculated against tetanus." It charged the WHO and UNCIEF of using these women as "uninformed, unwitting, non-consenting guinea pigs" in several countries with high population growth rates, notably Mexico, Nicaragua, Philippines and Tanzania.

With support from WHO, six independent laboratories in five countries ran tests on TT from seven different manufacturers, including those supplying the four countries affected directly by the campaign. WHO issued a statement in 1995 to the effect that the rumours "are completely false and are totally without any scientific basis."

This is a classical example of "part-truth" in the rumour – a vaccine (TT) was being administered to childbearing-aged women, and it did test positive for hCG. Worse, Indian researchers reported a small trial of contraceptive vaccine using hCG coupled to tetanus toxoid to enhance immunogenicity in 1994. The reported presence of hCG in the Mexican and Philippiine tests of TT was clearly shown by subsequent tests to be below the limits of accuracy of the test kits using and was probably related to interference from the adjuvant and preservatives used in the vaccine. The findings of the Mexican and Philippine tests were called "an artifact rather than a true value" by Professor Salvatore Mancuso of the Vatican's Catholic University of the Sacred Heart. The subsequent tests conducted in several national control laboratories revealed no undeclared substances in the vaccine.

At the height of the rumours, TT immunisation suffered in all four countries. A Manila court injunction (subsequently lifted) banned the use of TT in immunisation campaigns in the Philippines. . . . The drop in vaccine coverage rates coinciding with these rumours in the Philippines is shown in Table 1.

Table 1 Coverage for Tetanus Toxoid in the Philippines, 1993-1995

Year	TT2+ Coverage (%)
1987	289
1988	37.2
1989	43.6
1990	42.3
1991	53.7
1992	16.8*
1993	70.0
1994	69.3
1995	57.5
1996	47.0

^{*} Incomplete reporting

Source: File of the Maternal and Child Health Services, Department of Health (1997). Manila, Philippines

To its credit, the Catholic Church has in some cases made efforts to combat the rumours spread by Profamilia. It was professor Salvatore Mancuso of the Vatican's Catholic University of the Sacred Heart hospital who said that the findings ogf the Mexican and Philippines tests were "an artifact rather than a true value" during the Tetanus toxoid controversy in the Philippines in 1995. (See the document from the Web site at http://www.who.int/vaccines-diseases/safety/infobank/ttox.shtml).

Annex II: The Failed Attack on Polio NIDs, Kinshasa

In August 2001, just before the start of Round 2 of the polio campaigns of that year, thousands of handbills were circulated on the streets of Kinshasa. Excerpts follow at the end of this text

The remarkable thing about this handbill blitz against the polio NIDs was that it failed completely. The absence of effect during Round 2 of the Kinshasa polio campaign is clearly evident from a comparison of figures: Round 2 registered a 2 percent increase in vaccinations over Round 1 (unpublished data, UNICEF/Kinshasa).

The lesson to be drawn from the Kinshasa experience is that the public is not always gullible. The most strident and incredible claims do not necessarily get a hearing. In such cases, the best reaction is not to overreact.

EXCERPTS FROM HANDBILL DISTRIBUTED IN KINSHASA BEFORE ROUND 2 OF THE 2001 POLIO CAMPAIGN (TRANSLATED FROM THE FRENCH):

VACCINATION IS NOT FOR THE BENEFIT OF CHILDREN

Vaccines attack the immune system and provoke a reaction from this system. Every vaccination carries a risk of causing the disease, and hence of death. The child must be in good health for the immune system to react well to the vaccine. Thus, one does not vaccinate sick children, those with coughs, and <u>especially not the malnourished</u>, since the immune system depends directly on good nutrition.

Nonetheless, the World Health Organization (WHO), contrary to all medical principles, decides to vaccinate the children of the Congo.

ARE VACCINES TRULY USEFUL?

Here are the viewx of Neil Miller, journalist and specialist in natural medicine:

- Many vaccines were not the real reason behind the decline in disease occurrence. This came more from nutritional and sanitation improvements.
- No vaccines confer real immunity. It is often the opposite which is the case: the vaccine increases the chances of catching the disease
- All vaccines can cause side effects, including brain damage and death.
- Long term effects of all vaccines are unknown.
- Many vaccines are especially dangerous.

DOES W.H.O. CARE FOR THE HEALTH OF CONGOLESE CHILDREN?

WHO has decided to eradicate poliovirus from the earth by 2005. WHO never stated that the vaccination campaign was good for the children of the Congo. WHO says that it is

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urgent so that the Congo does not infect other countries. WHO decides to vaccinate during war, with a maximum of risks for the population. WHO lacks even the compassion to wait for the war's end and the children to be healthy before vaccinating. There is no epidemic declared in the Congo. The last epidemic in the region dates from April 1999 in Angola.

WHAT DOES W.H.O. HAVE TO DO FOR THE BENEFIT OF THE CONGOLESE?

The Congolese are dying of such diseases as kwashiorkor, which are easily treated. Why vaccinate against polio instead of curing the real killer diseases? Today, the priority of the Congolese children is not vaccination of any kind. It is first of all and especially to control the malnutrition caused by the war of the multinationals and the pro-American invaders of the Congo.

VACCINATION CAMPAIGNS CAUSE EPIDEMICS

A vaccination campaign against polio caused an epidemic in the Dominican Republic. The vaccine contains the virus. The child, once vaccinated, keeps the virus in the throat for two weeks, and in its intestines for up to two months. The vaccinated child is contagious for two months. So the vaccine can cause the epidemic. Contagion is riskier in situations of war and poverty, which make hygiene more difficult.

WHAT ARE THE RISKS OF THIS CAMPAIGN?

A child has few risks of catching polio if there is no vaccination campaign. Every child vaccinated runs the risk of catching polio. Every vaccinated child runs the risk of transmitting the disease to other children. If the vaccination campaign takes place, unvaccinated children risk getting the polio from those who are vaccinated. A total, 100 percent vaccination places all children in danger. A partial vaccination also places all children in danger. The only acceptable option is no vaccination campaign.

CAN WE BELIEVE IN THE SUDDEN COMPASSION OF THE WEST FOR THE CONGOLESE PEOPLE?

The West created the war, feeds the war and profits from the pillage of the Congo. The children are the main victims of this war. In some regions, three children out of four do not reach their second birthday. To decimate a population, one must first kill the children. Why vaccinate against polio, since they do not die of polio. Why is there no effective humanitarian aid? Why does the West not apply the recommendations of the report on the illegal exploitation of the Congo's riches in order to stop the war?

WHY PASS IN SILENCE OVER THE GENOCIDE OF THE CONGOLESE?

Polio vaccines have already been contaminated:

Poisoned vaccines have already killed children in South Kivu. Polio vaccine has long contained carcinogenic viruses. Another vaccine contains leukaemia viruses. Oral polio vaccine is controversial. A great specialist, Dr John Martin of the University of Southern California, has demanded in vain an investigation of this vaccine.

WHO announces that it will no longer use this vaccine after this vaccination campaign in the Congo because it has a better option. The American citizens have demanded a parliamentary investigation of vaccines in October 1999. Do Congolese scientists analyse the vaccines before giving them to children?

WHO DECIDES?

Vaccines = WHO = UN = USA = Uganda –Rwanda-Burundi = war. The UN has done nothing to stop the war (though it knows how to stop it) and has also decided on the polio vaccination campaign.

Annex III: Sources

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Interviews and Meetings

Acting Head, Department of Social Work

and Social Administration, Makerere

University

Mr. Asingwire Narathius

Uganda Ministry of Health, Ministry of Parliament, UNEPI, UNICEF, WHO

Minister of State for Health (GD) Hon. Mike Mukula

Personal Assistant to Minister of Health Mr. Charles Ebalu Kobowe

Member of Parliament Hon. Dr. Richard Nduhuura

Former WHO Medical Officer Dr. Mark Grabowsky (interviewed in

Washington, DC)

Senior Project Officer, UNICEF/

Kampala

Dr. Iyorlumun Uhaa

Health Project Officer, UNICEF/

Kampala

Dr. Eva Kabwangera

Assistant Commissioner, Health Mr. Paul Kagwa

Promotion and Education, Ministry of Health

ACHS (HRD), Ministry of Health Dr. E. K. Kanyesigye

Programme Manager, UNEPI Dr. Issa Makumbi

UNEPI Dr. Possy Mugyenyi

National Programme Officer,

Routine Immunisation, WHO Ms. Rachael Seruyange

Minister of Health, Buganda Kingdom

District Governor 9200, Rotary

Hon. Robert B.K. Ssebunnya

Data Entry Clerk, UNEPI Ms Justine Wailoi

Bushenyi, Mbarara, and Ntungamo Districts

LC V Chairman, Bushenyi District Mr. Joash Makaru

Secretary of Social Services, BLG Mrs. Nnalomgo Otafire

Vice Chairman, Social Services Dr. Gubare Lasto

Assistant Resident District Mr. Tumwine Polly Commissioner, Bushenyi

Chief Administrative Officer,

West, Mbarara Town

Bushenyi District Mr. Bitarabeho Johnson

Speaker, Bushenyi District Mr. Peter Rwakifaari

Director, District Health Services Dr. F. Nuwake

Bushenyi District

Head of Service, Greater Afrikan Radio, Dr. Nkamuhayo Rwacumika Mbarara City, aka Kihura Nkuba

Senior Programme Officer, Radio Ms Rose Rwankore

District Director of Health Services, Dr. Kaguna
Mbarara District

Enrolled Midwife, Bwizibwera Health Ms Justine Brungi Sub District, Mbarara District

Chairman, Local Council V, Mr. John Karazarwe

Ntungamo District

Secretary for Health and Child Mr. Dan Buteera Welfare, Ntungamo District

Assistant District Director of Health Mr. William Karikwitsya Services, Ntungamo District

Health Management Information Ms Shebah Turyagira
Systems Officer, Ntungamo District

District Health Visitor, Ms Florence Rwabahima Ntungamo District

Mothers at Bwizibwera Health Sub District, Mbarara District

Name	VillageChildren	Observat	tion
Ms Scovia Twikirize	Biyeze 1 child/	First child 1 yr. old	died after polio immunisation during NIDs
Ms Evalyen Siku	Migyera	1 child/ 8 mons.	Saw deaths of children in her village after polio NIDs
Ms Monica Kyomugisha	Rubindi	1 child 1.5 yr. old	Her other child died after polio immunisation during NIDs
Ms Justina Musiime	Rwetonjo 1 c	child out 3 died of 4 living	d/not from polio vaccination
Ms Grace Mbabazi	Kaguhazya 1 c	child Reported : 2.5 yrs.	seeing many children in village die after polio NIDs
Ms Donota Kibetenga	a Rubindi 4 c	hildren Re	eported that several children died in area immediately after polio vaccination during NIDs

Fathers at Bwizibwera Trading Centre, Mbarara District

Mr. Muhammad Rukanyangira	Vice Chairman, LC 1, Bwizibwera
Rev. Ephraim Koojo	Pastor, Nshongi Parish
Mr. Apollo Rwabiita	Chairman, LC 1, Bwizibwera
Mr. Frank Mukama	Resident, Bwizibwera LC 1
Mr. Francis Mpumwire	Secretary for Information, LC 1, Bwizibwera
Mr. Erikadi Mworozi	Resident, Bwizibwera, LC 1.

Annex A: Participants in the 5th NCC Meeting 11/9/2001

No.	Name	Title	Organisation/Telephone				
1	Henry K. M. Kyemba	Chairman, PPC Committee	Rotary International				
2.	Benjamin Sensasi	Information Officer	WHO				
3.	Rosamund Lewis	EPI Advisor	WHO				
4.	Dr. A. Musingunzi	D/P/H	UPDF				
5.	Dr. Angela Akel	Senior National	Population Secretariat				
		Programme Officer	_				
6.	Zura Asanda	PHN	AMREF				
7.	Dr. Ismail Ndifuna	Ex. Sec. UMMB	UMMB				
8.	Dr. Eva Kabwongera	PHO-UNICEF	234591/2				
9.	Joyce A. Kramer	Consultant – UNICEF	UNICEF,ESARO				
10.	Dr. Miriam Nanyunja	Medical Research Officer	EPI Laborary, UVRI				
11.	Dr. Possy Mugyenyi	A/PMO	UNEPI – Ministry of Health				
12.	Mrs. Liliane Luwaga	SHE	Ministry of Health/HP&E				
13.	Paul Kagwa	ACHE (HP&E)	Ministry of Health				
14.	Charles Muhumuza	SHE	HP&E-Ministry of Health				
15.	Dr. Barungi T.C	Deputy Director Police	Police 077 405447				
		Med. Service					
16.	Isingoma B.M.P.	PHI/Operations	UNEPI				
17.	Elly Tumwire	IC Cold Chain	UNEPI				
18.	Rose Kinuka	Health Projects Officer	Uganda Red Cross				
19.	Dr. Nyabwana D.	Member/DPMS	Prisons 255419				
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21.	Mukuye	ACHS					
22.	Lt. Col. Dr. Bukenya	Zonal Medi. Officer UPDF	UPDF				
23.	Kaggwa ddumba	Executive Director	CHECEA				
24.	Edward Mugyimba	AC/PEECR/MGLSD	MGLSD				

Annex B

REPORTED ROUTINE IMMUNISATION COVERAGE FOR UGANDA, 1985 – 2000

Antigen %	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
BCG	37	51	74	77	100	100	100	98	100	98	96	102	88	85	93	82
DPT3	14	21	39	40	60	77	77	71	73	79	74	72	61	56	61	56
Polio3	13	21	40	40	60	77	77	70	74	78	78	71	62	57	63	56
Measles	17	32	48	49	60	74	74	68	73	79	82	70	64	59	63	60
TT (Preg)			13	14	20	31	99	83	84	76	72	58	48	48	50	45
TT (NON- Preg)							22	16	16	16	13	10	9	7	9	7

Source: UNEPI

Note: In 1997 there were 39 districts in Uganda.

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Kenya Expanded Programme on Immunisation - KEPI

KEPI Manager Dr. Stanley Sonoiya

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Vaccine Logistics Officer Mr. Amos M. Chweya

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Deputy KEPI Administrator Ms Eunice W. Ngugi

Mr. Waithaka Githitu Cold Chain Logistics

MNT Control Officer Ms Grace Saita

Measles Control Officer Ms Josephine Odanga

Logistics Information Officer Mr. Charles W. Kinuthia

Social Mobilisation Officer Mr. Munene J. S. Ngaruiya

KEPI Data Officer Mr. David M. Kiongo

KEPI Cold Chain Engineer Mr. Gregory Kiluva

Central Province

Provincial Medical Officer Dr. Olango Onundi Ms Lucy N. Kiruki Provincial Matron Mr. Erastus N. Kihumba

Deputy Provincial Public Health Officer

Provincial Health Records and

Information Officer Mr. Charles Chiuri Provincial Clerical Officer Mr. J. Mwangi Kabanya

Former Provincial Medical Officer Dr. Mwangi

until 2000

District Public Health Nurse at Ms Martha Muriithi

District Medical Health Offices housed at

Provincial General Hospital, Nyeri

Deputy District Public Health Nurse Ms Lucy Gichuki

Hospital Matron, Mathari Consulata Sister Kaniekai Arockiasamy

Mission Hospital, Nyeri

Anti-Vaccination Rumour Campaigns in Eastern Africa - UNICEF

Deputy Hospital Matron Ms. Edith Githii

Incharge, Ihururu Dispensary

Ms Margaret Irungu

Deputy

Ms Mary Gacheru

Assistant Chief, Ihururu Sublocation Mr. Mwangi Kagoiyo

Priest Fr. Njoroge

Roman Catholic Church, Karatina Township

Pastor Reverend Kathuni

Presbyterian Church of East Africa

Public Health Officer, Karatina Mr. Hezron M. Wachira
Public Health Technician Mr. Silas M. Munyua
Public Health Technician Mr. Joseph Mbirwa Njeru

Mr. Peter Wachira Maina Mayor Councillor, Nyeri Deputy Mayor Councillor Mr. George Kiranga Deputy Town Clerk Mr. John K. Munyi Councillor Mr. Dickson Kanyingi Councillor Ms Veronica Muthoni Councillor Mr. John Kabui Councillor Mr. Jeremiah Nyaga Councillor Mr. John Gitonga

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Project Officer, EPI Mr. Robert Davis

Communication Officer, EPI Mr. Arthur Tweneboa-Kodua

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Ministry of Health and Expanded Programme on Immunisation

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Regional Maternal Child Health Ms Vivian J. Kilimba

Coordinator

Regional Planning Officer Mr. Smythes Pangisa

Director, St. Benedict's Mission Sr. Dr. Birgitta Schnell, O.S.B.

Ndanda

Matron Incharge, St. Benedict's Mrs. Mary Nandonde

Mission Hospital, Ndanda

Incharge, Maternal and Child Ms Libina Makwinya

Health, St. Benedict's

Clinical Officer, MCH Ms Oresta Dionis

Nurse Officer IV Ms Christina Ngambeki District Maternal and Child Health Ms Trifonia Malificihe

Coordinator, Masasi

District Cold Chain Operator, Mr. Maurus Hokoror

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Project Officer, Health Dr. Rosemary Kigadye Representative Bjorn Ljungqvist Administrator Ms Eshe Dodo APO-Nutrition/WES Ms Jane Bammeke Mr. Isiye Ndombi Senior Programme Officer Ms Riitta Poutiainen Head, Health Unit Project Officer, Health Mr. Suleiman Kimatta Head, ECD Cluster Ms Meera Shekar Assistant Project Officer, Health Ms Ulla Bisgaard

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www.usp.org Poliomyelitis, OPV, and Misconceptions on Vaccinations
This document was created to support the global campaign to eradicate polio. It addresses misinformation and superstitions about OPV and other vaccines that are held by people in various parts of the world which may inhibit them from fully immunising their families. The information is based on the consensus of USP DI expert committees and selected polio expert reviewers.

<u>http://www.who.int/vaccines/intermediate/neotetanus.htm</u>
Neonatal Tetanus – disease, treatment, vaccines, WHO policy, special issues

http://www.who.int/vaccines-diseases/safety/infobank/ttox.htm A situation arose in 1995 whereby tetanus toxoid being administered in the Philippines immunisation programme became discredited. We provide on this web site two versions of the story:

- The WHO summary report "Concerns for the safety of Tetanus Toxoid in the Philippines 1995."
- <u>An in-depth report</u> provided by a team of Philippine social scientists led by Pilar Ramos-Jimenez.

Lessons Learned and Conclusions

- □ Tailor immediate and ongoing strategies and respond promptly to questions and rumours.
- □ Build ongoing relations with all communities (religious, social, media).
- □ Disseminate consistent messages.
- □ Lack of information creates questions --- leading to apprehension and fears --- which in turn lead to rumours.
- Take time to deal with rumours. Benefits will accrue to routine EPI.
- □ Social mobilisation should be a continuous process, continuously informing about the importance of routine immunisation through all channels: e.g. film vans, drama, media (radio, television and newspapers).
- □ Timing rumours occur mostly during NIDs.
- □ Resources for adequate and on-going social mobilisation are rarely included in the budget.
- □ Communications are viewed as a "technical priority," but these communications are vital to reach resistant groups and to avoid the emergence of rumours.

In each country where vaccination rumours were examined the conclusions are similar: a sustained, well-planned and implemented social mobilisation campaign must be conducted. Special attention must be given to the campaign on the ground. Yet this is the one aspect that is most neglected. Officials noted in each country that competing priorities and the lack of resources --- primarily financial resources, personnel, and time --- were constraints to doing what they know needs to be done. Intense and thorough sensitization and education of the masses takes time and money.

While the donor organizations place much emphasis on delivering vaccines and technical support, communication elements of vaccination campaigns are overlooked. EPI heads in some countries suggest that UNICEF and WHO should commission technical reports to investigate social mobilisation for EPI. Also, appoint a panel of experts to make recommendations to the country officials about how to improve communications.

Other suggestions for improving EPI and future mass campaigns:

- □ Ensure adequate planning for clear campaign objectives, clearly defined audiences, messages appropriate for each audience, and activities that readily lend themselves to implementation and evaluation. Planning should involve programme staff, communication specialists and other relevant persons to develop communication activities guided by results of qualitative research.
- □ Conduct planned social mobilisation throughout the year, not just during national campaigns. Social mobilisation is almost always too short. Plan enough time to sensitize; messages in mass media are not necessarily on the ground. Be sure to include staff sessions for health clinic and hospital workers. Start early and address

questions. Involve those who are trusted by the community and supportive of campaign objectives, especially religious and local leaders, chiefs, and elected officials.

- Organize at least two stakeholders meetings a year at provincial and district levels. It takes time and resources to cultivate organizations and their leaders. Many people who were interviewed were willing to participate in the NIDs, but the context or a forum must be implemented.
- Pay particular attention to health workers. Coverage surveys and interviews conducted for this study confirm that mothers cite the health worker as the single most important source of information on vaccinations. Another reason for social mobilisation all year is that mothers asked questions about the NIDs in the clinics, but health workers did not have time to educate them.
- Use religious and political leaders and the business community to promote EPI services. Religious organizations have comprehensive distribution networks. They are also among the most credible organizations. To gain greater organizational support from religious bodies, future mobilisation strategies should aim at building partnerships by giving religious leaders and other leaders some advisory role at the local level to increase their sense of ownership.
- □ Encourage sponsorship of innovative community based activities that provide a mechanism for engaging leaders and their communities. These can be in the form of sporting events, rallies, contests, tours, etc. Use these spokespersons to promote EPI and mass campaigns.
- Develop materials that are technically sound but assure that communities can easily understand IEC materials. Be aware of language, literacy barriers, and cultural issues in some regions.
 - Put special emphasis on importance of immunisation, side effects of vaccinations, schedule of immunisation and timely completion of antigens, reasons (e.g. future investment).
- □ Address vaccine safety issues and other issues raised by mothers and fathers. Conduct focus groups with parents to assess potential questions. Address the issues before questions arise.(suggestions from Dr. Grabowsky)
 - Canned radio and TV spots addressing safety
 - Written materials that emphasize safety
 - Other materials available with specific refutation of the issues raised.
- □ Some important points from interviews for mass campaigns and routine immunisation:
 - Churches are an effective tool to counter rumours because the religious leaders are credible and trusted – get priests to understand (when they didn't understand, they passed along their own doubts)

- Schools engage headmasters to give children facts who then give information to parents
- Development Groups women, youth, etc.
- Baraza district meetings, groups are effective and strong
- Mobile Units conduct outreach clinics
- □ Examine the Ministry of Health expectations are they too high; are they based on accurate information to begin with?
- □ Possible ways to address rumours are to:
 - Immunise health workers against rumours!
 - Determine if people or organizations have refused immunisation or government services in the past and provide information through inter-personal communication with these groups and their leaders well in advance of the campaign. This may prevent or avoid suspicion or rumours.
 - Clarify the extent of the rumour or misinformation (type of messages circulating, source, persons or organizations spreading the rumour).
 - Determine the motivation behind the rumour (lack of information, questioning of authority, religious opposition, or other).
 - Conduct the campaign with local leaders at sites where the individuals/groups are comfortable and can feel at ease to ask questions and have peers present.
- □ Make information available on how to combat rumours and/or create a rumour registry or toll-free rumour hotline; or create a rumour call in radio programme. Have a place to register rumours.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS Acquired Immunodeficiency Syndrome

BASICS Basic Support for Institutionalizing Child Survival

BCG Bacille Calmette-Guérin (tuberculosis vaccine)

CBS Central Broadcasting Service radio

CDC Centres for Disease Control and Prevention

CHANGE The Communication for Behaviour Change Project

DANIDA Danish International Development Agency

DPT3 Diphtheria, Pertussis and Tetanus – third dose

EPI Expanded Programme on Immunisation

FGD Focus Group Discussion

GD General Duties

hCG Human chorionic gonadotrophin, naturally occurring female hormone that

helps maintain a woman's pregnancy

IEC Information, Education and Communication

IMCI Integrated Management of Childhood Illness

IPV Injectable Polio Vaccine (Salk vaccine)

JICA Japanese International Cooperation Agency

KAP Knowledge, Attitudes and Practices

KEPI Kenya Expanded Programme on Immunisation

LC 5 Local Council – 5th Level – the highest politically elected

leader of a district in Uganda

MCH Maternal and Child Health Services

MP Member of Parliament

NGOs Nongovernmental Organizations

NIDs National Immunisation Days

OPV Oral Polio Vaccine (Sabin vaccine)

O.S.B. Order of St. Benedict

PEI Global Polio Eradication Initiative

SNIDs Sub-National Immunisation Days

TDHS Tanzania Demographic Health Survey

TT Tetanus Toxoid

UN United Nations

UNICEF United Nations Children's Fund

UNEPI Uganda National Expanded Programme on Immunisation

USAID United States Agency for International Development

WHO World Health Organization