Bridging Culture and Immunization: Community-Led Dialogue to Overcome the Hamachisa Practice and Promote Timely Childhood Vaccination in Welmera Woreda, Oromia Region

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1. Introduction

Hamachisa is one of the most important and joyful milestones in the life of an Oromo child and family. Following the birth of a baby, the family does not immediately give the child a permanent name. Instead, they traditionally wait for a 40-day period while preparing for the Hamachisa ceremony, which is presided over by the Qaalluu, the Oromo community's spiritual and cultural leader, at their home. During the ceremony, the Qaalluu formally blesses the child, bestows the child's name, and introduces the newborn to the community as a recognized member. The blessing is traditionally believed to bring the child health, protection, and prosperity throughout their life.

In Welmera Woreda, Oromia Region, this deeply rooted cultural tradition had become a significant barrier to timely childhood vaccination of newborns. Mothers were culturally expected to remain at home with their newborns throughout the 40-day period, and sometimes beyond, while awaiting the Hamachisa ceremony at the Qaalluu's home. This period of restricted movement coincided with critical points in the immunization schedule, particularly the birth-dose vaccinations and the first vaccine dose due at six weeks of age. As a result, routine immunization services were sometimes placed in tension with an important and highly valued cultural practice, increasing the risk of missed or delayed vaccinations among newborns.

2. Problem statement

Health facility records and community surveys in Welmera Woreda consistently revealed that newborns were brought for vaccination late or with significant delays. The rapid situational assessment and community survey further confirmed that vaccination coverage was markedly lower during the first weeks of life. The underlying issue was not a lack of parental concern for child health, but rather cultural practices influencing timely childhood vaccination. In particular, families believed that vaccination should be postponed until the Hamachisa ceremony was completed, that immunization could conflict with cultural or spiritual values, and that fathers often opposed taking newborns to health facilities during the 40-day period. These beliefs contributed to systematic delays in early childhood vaccination, resulting in zero-dose and under-vaccinated children and, ultimately, lower immunization coverage across the woreda. The magnitude of the problem was significant, with hundreds of children across all kebeles remaining at risk of vaccine-preventable diseases. Consequently, the immunization program struggled to achieve its intended impact without directly addressing these cultural barriers.

During the rapid situational assessment, barriers to immunization were examined at both health facility and community levels. One of the most significant cultural barriers identified was the **Hamachisa practice**. Families adhering to this tradition often delayed bringing their newborns for vaccination, believing that immunization should only take place after the Hamachisa ceremony had been completed. The assessment clarified that the primary barrier was not the Hamachisa ceremony itself, but rather the belief or practice that Hamachisa prohibited vaccination before the ceremony. As a result, families postponed immunization until after the ceremony, leading to missed vaccination opportunities and increasing children's vulnerability to vaccine-preventable diseases. This challenge was illustrated by a case encountered during the assessment:

A grandmother brought her six-month-old grandchild for their first vaccination. When the health worker asked about the delay, the grandmother explained that, in accordance with their cultural traditions, immunization had been postponed until the completion of the Hamachisa ceremony.



Figure 1. W/ro Shashitu Hirpha. Photo: PATH.

A mother interviewed during the 2025 measles SIA reported that she had not vaccinated her 12-month-old child because she was preparing for the Hamachisa ceremony. Following the delay, she was hesitant to bring the child to the health facility, fearing that health workers might be angry or criticize her for the missed vaccination.



Figure 2. Mother of a zero-dose child during the 2025 measles SIA

3. Intervention objectives

3.1. General objective

- To improve timely uptake of routine immunization among children by addressing sociocultural barriers associated with the Hamachisa traditional practice through strengthened engagement and collaboration with cultural leaders and communities.

3.2. Specific objectives

- To engage cultural leaders and strengthen their capacity to identify and address sociocultural barriers associated with Hamachisa that contribute to delays in childhood vaccination.

- To facilitate dialogue among cultural leaders, health workers, and community members to improve understanding and address perceived conflicts between Hamachisa practices and timely routine immunization.
- To promote timely access to and uptake of routine immunization services among children affected by sociocultural practices that may contribute to vaccination delays.
- To strengthen community ownership, participation, and acceptance of routine immunization through meaningful involvement of cultural leaders and community structures.
- To document the intervention experience, lessons learned, and key success factors to inform adaptation, replication, and potential scale-up of the approach in other communities facing similar sociocultural barriers to immunization.

4. Implementation strategies

The Welmera Woreda Health Office, in partnership with PATH, implemented a community dialogue approach that emphasized cultural traditions and immunization as complementary rather than conflicting priorities. The approach was framed as a bridge between two highly valued community goals: preserving cultural traditions and protecting children through immunization, rather than as an effort to overcome resistance. By positioning vaccination as compatible with and complementary to cultural practices, the approach fostered trust, encouraged open dialogue, and created space for mutual understanding and consensus.

The dialogues were conducted using community dialogue guidelines developed by the project team. The sessions engaged a broad range of stakeholders, including mothers, fathers, lactating and pregnant women, religious and cultural leaders (including priests, pastors, sheikhs, Ayantu, Abba Gedaa, and Haadha Siinqee), Women and Social Affairs officials, kebele leaders, village health leaders, traditional birth attendants, immunization advocates, health workers, and other influential community members. This inclusive approach helped ensure that the dialogues were gender-responsive, culturally sensitive, and grounded in community perspectives, while fostering trust and strengthening community ownership of immunization efforts.

Accordingly, four community dialogue sessions were organized across three primary health care units and reached a total of 150 participants (67 men and 83 women). The sessions were conducted from June 5 through 8, 2025, and on March 16, 2026. The project provided both technical and logistical support to ensure effective planning, facilitation, and implementation of the dialogues. The dialogues emphasized respect for local values, inclusive participation, active listening, and culturally sensitive messaging. By acknowledging and validating community traditions, the facilitation teams created a constructive environment for mutual understanding. Mothers and fathers were initially given the opportunity to describe their understanding of Hamachisa, express their concerns regarding the timing of vaccination, and identify practical barriers to accessing immunization services. Facilitators actively listened to these concerns and documented them without judgment. This approach helped clarify the underlying misconceptions and demonstrated that community members' experiences and perspectives were genuinely valued.

A focused discussion was then held on Hamachisa practices and their perceived implications for childhood vaccination. A key turning point in each session occurred when Qaalluu leaders were invited to share their perspectives. They clarified that Hamachisa does not contradict childhood immunization and that nothing in the ceremony or its spiritual requirements prevents a child from being vaccinated before, during, or after the 40-day period. This clarification helped address the

perceived conflict between cultural practice and immunization and enabled participants to reach a shared understanding that the two can be observed simultaneously.

Following the community dialogue sessions, the program established a network of trusted community messengers in each kebele, including religious and cultural leaders, mothers, community health volunteers, and trained health promoters, both men and women. Equipped with simple and accurate key messages on the compatibility of Hamachisa and childhood vaccination, these messengers continued to communicate the agreed messages within households, in marketplaces, and at community events. This helped embed the change in a sustained, community-owned communication system that extended beyond the initial dialogue sessions.

Action plans developed during each dialogue were documented and used to guide follow-up actions. These actions were subsequently integrated into ongoing community engagement activities to reinforce the shared understanding reached during the dialogues, sustain the gains achieved, and strengthen community ownership of timely childhood immunization.



Figure 2. Community dialogue sessions with different community groups, Welmera Woreda, 2025. Photos: PATH

5. Results of the practice

Following the community dialogues, several important qualitative outcomes were observed. Qaalluu leaders provided formal public clarification that the Hamachisa ceremony does not prohibit vaccination. This marked an important breakthrough and was accompanied by a visible increase in maternal confidence. Mothers who had previously been reluctant to vaccinate their newborns began actively seeking support for timely childhood vaccination.

In addition to these qualitative changes, clear measurable improvements were documented following the community dialogue sessions. Timely vaccination coverage increased from 61% before the intervention to 84% after the sessions, based on Expanded Programme on Immunization (EPI) registration records, demonstrating a substantial improvement in timely childhood immunization. Similarly, the dropout rate from the first dose of pentavalent vaccine to the first dose of measles-containing vaccine declined from 7% to 2%, reflecting improved continuity of the vaccination

schedule. This progress was supported by strengthened community ownership, active engagement of volunteer health leaders, and more effective use of the defaulter-tracking mechanism.

A total of 1,792 households across 18 kebeles were reached through the active involvement of key community influencers, including Qaalluu leaders, volunteer health leaders, Abba Gadaa elders, and religious leaders. These influential figures raised awareness and addressed misconceptions about Hamachisa during various community meetings. Qaalluu leaders also engaged participants attending Hamachisa ceremonies, ensuring that these important cultural gatherings served as platforms for clarifying that vaccination is compatible with and does not conflict with traditional practices.

This combination of community dialogue, engagement of influential community leaders, and systematic follow-up not only shifted perceptions but also resulted in measurable improvements in vaccination coverage and continuity.

The approach stands out as a promising approach for integrating cultural values with immunization services, demonstrating how respectful dialogue and community-driven strategies can overcome sociocultural barriers and strengthen routine immunization. Monitoring and follow-up further confirmed improvements in timely vaccination and a reduction in the number of children who defaulted from vaccination services.

The dialogue process also empowered caregivers, particularly mothers and grandmothers, to reconsider long-held beliefs and adopt timely vaccination. Their personal experiences illustrate how community conversations were translated into concrete changes in knowledge, attitudes, and vaccination practices. One grandmother, **W/ro Alemitu**, described how her understanding evolved after participating in the dialogue:

“In the past, I believed visiting the health facility before Hamachisa was against our culture. I always waited until Hamachisa was completed before vaccinating my children. After participating in the community dialogue, I realized that timely vaccination protects a child more effectively. I counseled my daughter after the dialogue, and together we took her newborn for immunization at six weeks—before Hamachisa.”



Figure 4. W/ro Alemitu(left). Photo: PATH.

Her testimony reflects a broader shift among caregivers, demonstrating how evidence-based discussions, when delivered in culturally appropriate and acceptable ways, can help replace misconceptions with informed decision-making while respecting and preserving valued traditions. The transformation was equally evident among cultural leaders themselves. Through the dialogue process, Qaalluu leaders became strong advocates for routine immunization, using their influence to reassure families that cultural practices and modern health services are complementary rather than contradictory. One Qaalluu leader explained:



“Hamachisa is about blessing and protection, and vaccination is also protection. They do not contradict each other. After participating in the community dialogue, we began to reshape perceptions. We now explain during community meetings that Hamachisa can be performed after vaccination, and that both practices complement each other. At ceremonies, we have started assessing the vaccination status of newborns who are brought for Hamachisa. When we see a child has not yet been vaccinated, we provide advice and encourage the family to visit the health center.”



Figure 5. Post-community-dialogue visit to a Qaalluu leader’s home with ceremony participants. Photo: PATH.

This shift in leadership practices represents one of the most significant achievements of the intervention. Cultural leaders moved beyond simply endorsing vaccination to actively promoting timely immunization,. Their continued engagement has strengthened community ownership of routine immunization and contributed to more timely vaccination of newborns. One of Qaalluu leader shared the following testimony:

“Hamachisa is about blessing and protection, and vaccination is also about protection. They do not contradict each other. After participating in the community dialogue, we began to reshape perceptions. We now explain during community meetings that Hamachisa can be performed after vaccination and that the two practices complement each other. At ceremonies, we have also started checking the vaccination status of newborns brought for Hamachisa. When we find that a child has not yet been vaccinated, we advise and encourage the family to visit the health center.”

Kasech Belew, the Expanded Programme on Immunization (EPI) focal person at Asgori Health Center, coordinates routine immunization services and supports health workers to improve vaccination coverage. Reflecting on the intervention, she shared: *“The Inter Personal Communication training also strengthened my communication skills, enabling me to discuss vaccination in ways that respect local cultural practices while effectively addressing caregivers’ concerns. Today, families are more confident in immunization, and many mothers express their appreciation for the services after their children receive vaccinations.”*

“Before the community dialogue sessions, we frequently saw children who had never been vaccinated or who started immunization late because of cultural beliefs and limited awareness. After the intervention, more mothers began bringing their babies on time, and I even saw fathers accompanying their wives to the health facility, which was a significant change.”

Figure 6. Kasech Belew, Expanded Programme on Immunization (EPI) focal person. Photo: PATH.

Gelana Abera, EPI focal person at the Welmera Woreda Health Office, oversees routine immunization activities and supports health facilities in improving vaccination coverage across the woreda. Reflecting on the intervention, he said:

"This initiative has demonstrated that cultural values can be effectively integrated with routine immunization through respectful dialogue and meaningful community engagement. We have observed improved vaccination coverage and fewer barriers associated with traditional beliefs. The dialogue approach has also strengthened community ownership, with families increasingly recognizing immunization as a shared responsibility."



Figure 7. Gelana Abera, Expanded Programme on Immunization (EPI) focal person, Welmera Woreda Health Office.

6. Lessons learned

The implementation of the Hamachisa community dialogue approach generated several important lessons that can inform future immunization and social and behavior change interventions in culturally sensitive settings.

Address misconceptions, not cultural practices: The most significant lesson was that Hamachisa itself was not the primary barrier to immunization; rather, the main challenge was the widespread misconception that Hamachisa prohibited vaccination before the traditional ceremony. Once respected Qaalluu leaders, Abba Geda elders, and other community influencers clarified that timely vaccination does not contradict cultural values, caregivers quickly demonstrated more positive health-seeking behaviors. This experience highlights the importance of distinguishing cultural practices from misconceptions associated with them before designing interventions.

Engage trusted and culturally credible leaders: The intervention reinforced the importance of working through trusted community leaders and culturally credible messengers. Although the core immunization message remained unchanged, its acceptance increased substantially when it was delivered by individuals whom community members already respected and trusted. Engaging traditional and religious leaders from the outset strengthened the legitimacy of the intervention, built trust, and accelerated community acceptance.

Build community ownership through dialogue: Another key lesson was that community ownership is more effective than one-way message dissemination. The dialogue sessions created safe spaces where participants could openly discuss concerns, question existing beliefs, share experiences, and reach collective conclusions. Because community members participated in identifying solutions rather than simply receiving health education messages, they became active advocates for routine immunization within their families and communities. This increased the likelihood of sustained behavior change.

Strengthen interpersonal communication skills among health workers: The initiative demonstrated that strengthening health workers' interpersonal communication (IPC) skills is essential when addressing culturally sensitive issues. Equipping health providers with respectful and culturally responsive communication techniques increased their confidence, strengthened trust with caregivers, and enabled them to address misconceptions and concerns more effectively. This suggests that IPC capacity-building should be an integral component of immunization demand-generation interventions.

Engage men as partners in child health: The experience also highlighted the critical role of engaging men in immunization and child health. In communities where fathers and male household heads have significant influence over decisions related to maternal and newborn health, involving men in community dialogue contributed to stronger family support for timely vaccination. Community engagement strategies that intentionally include both mothers and fathers are therefore more likely to achieve equitable and sustained improvements in immunization uptake.

Sustain engagement beyond the initial dialogue: The experience further suggests that community dialogue should be viewed as an ongoing engagement process rather than a one-time activity. Continued involvement of cultural leaders, health workers, and other trusted influencers is important for reinforcing accurate information, addressing emerging concerns, and sustaining positive behaviors over time.

Overall, the Hamachisa experience demonstrates that culturally informed dialogue, trusted local leadership, effective interpersonal communication, inclusive family engagement, community ownership, and continuous follow-up are essential for increasing demand for routine immunization and sustaining behavior change in communities where cultural norms strongly influence health-seeking practices.

7. Conclusion

The experience demonstrates that deeply rooted cultural barriers to immunization can be addressed without challenging or diminishing cultural values and traditions. By correctly identifying the barrier as a misconception rather than the cultural practice itself, and by working with respected cultural authorities to provide clarification, the PATH and Welmera Woreda team transformed a longstanding misconception into a sustainable channel for health promotion. The approach was respectful, locally led, low-cost, and community owned. Importantly, it established a network of trusted cultural messengers who can continue promoting timely immunization beyond the intervention period, thereby contributing to sustained improvements in vaccination practices.

A key lesson from this experience is that programs addressing cultural barriers should first determine whether the barrier lies in the practice itself or in a misunderstanding of what the practice requires. Once misconceptions are clarified through trusted community structures, greater ownership and acceptance can emerge naturally. The experience also highlights the importance of early stakeholder engagement, trust-building, continuous follow-up, and the use of routine data to identify and address context-specific barriers to immunization.

In short, the Hamachisa community dialogue approach demonstrates that culturally sensitive, community-led engagement can effectively bridge the gap between traditional practices and modern health services. By respecting cultural identity and working through trusted community structures, the approach provides a sustainable model for improving access to and uptake of routine immunization.

8. Recommendations

The experience from Welmera Woreda demonstrates that addressing vaccine hesitancy rooted in cultural beliefs requires more than simply disseminating health information. It requires meaningful engagement with trusted community structures, cultural institutions, and local decision-makers, while ensuring that these mechanisms are integrated into existing health system and community structures for long-term sustainability. Based on the implementation experience, the following recommendations are proposed to support replication, scale-up, and sustainability in similar settings:

- **Conduct comprehensive influencer mapping before implementation.** Programs should systematically identify and engage both formal and informal community influencers, including Qaalluu leaders, Abba Gadaa elders, religious leaders, respected women, teachers, and other trusted community members. Mapping should identify their level of influence, areas of authority, and potential roles in immunization promotion so that behavior change messages are communicated through credible and trusted voices.
- **Begin community engagement by acknowledging and respecting local culture.** Dialogue sessions should be conducted in the local language and should intentionally recognize community values, beliefs, and traditions. Establishing cultural respect from the outset helps build trust, reduce resistance, and create a constructive environment for discussing sensitive health issues. Cultural engagement should be integrated into routine community meetings and existing social and cultural gatherings rather than being implemented only as a project-specific activity.
- **Facilitate community-led identification of barriers and misconceptions.** Rather than assuming the causes of low immunization uptake, programs should create safe and inclusive spaces where community members can openly express their concerns, beliefs, and perceptions. This participatory approach enables interventions to address the actual drivers of vaccine hesitancy and develop context-specific solutions that communities can own and sustain.
- **Ensure that clarification of cultural misconceptions comes from legitimate cultural authorities.** Behavior change is more likely when respected cultural and religious leaders directly communicate that immunization is compatible with local traditions and values. Their voices often carry greater credibility and influence than externally delivered health information. Programs should therefore invest in building the capacity of trusted leaders to provide accurate, consistent, and culturally appropriate vaccination messages during community gatherings, cultural events, and routine interactions.
- **Strengthen the engagement of male decision-makers.** Since fathers and male elders often play an important role in household health decisions, programs should include dedicated dialogue sessions that encourage peer-to-peer learning among men and promote their active support for childhood immunization. Engaging male decision-makers as advocates can help address household-level barriers and strengthen timely decision-making on vaccination.
- **Institutionalize community messenger networks within existing structures.** Networks of trained cultural leaders, community influencers, and health extension workers should be maintained beyond the initial intervention period and integrated into routine immunization and primary health care activities. These networks can provide a locally owned platform for continuous

health promotion, reinforce positive immunization behaviors, address emerging misinformation, and prevent the resurgence of misconceptions after project completion.

- **Integrate community dialogue and cultural engagement into routine immunization activities.** Community dialogue should be incorporated into regular kebele meetings, health extension activities, cultural gatherings, and other existing community platforms rather than operating as standalone project interventions. This can reduce dependence on external funding and help ensure that community engagement remains part of routine immunization demand-generation efforts.
- **Strengthen the role of health extension workers in sustaining community engagement.** Health extension workers should continue household-level engagement through routine visits, newborn identification and tracking, vaccination counseling, and follow-up of children who miss scheduled doses. Strong collaboration between health extension workers and community leaders should be maintained to ensure that community concerns are identified early and addressed through trusted local channels.
- **Embed the approach within woreda health system planning and supervision.** Woreda health offices should incorporate community engagement, cultural leader involvement, and immunization demand-generation activities into routine immunization and primary health care plans. Routine monitoring, supportive supervision, documentation of lessons, and periodic review of community feedback should be used to maintain quality and strengthen the approach over time.
- **Promote local ownership and scalability.** Sustainability should be built around existing community structures, cultural institutions, and the primary health care system, minimizing reliance on external project resources. The established partnership among community leaders, cultural institutions, health extension workers, and the health system provides a practical platform that can be adapted and replicated in other culturally diverse and hard-to-reach communities.

Overall, the Welmera experience demonstrates that sustainable improvements in immunization demand are more likely when communities are not treated merely as recipients of health messages but as active partners in identifying barriers, shaping solutions, and promoting vaccination. Institutionalizing trusted community messenger networks and strengthening their partnership with the health system can build community resilience to misinformation and provide a practical, locally led, and scalable model for sustaining routine immunization uptake.