

Social and Behaviour Change Interventions for Promoting

Childhood Immunisation

Statement of Issue

All the countries need to ensure universal coverage of quality healthcare including prevention and treatment of communicable and non-communicable diseases, sexual and reproductive health, family planning, routine immunization (percentage of children receiving full immunization as recommended by WHO), and mental health (SDG, 2015), by 2030.

Complete immunisation of children against various vaccine preventable diseases is one of the most cost-effective ways of enhancing child survival (WHO, 2005). Implementation of the National Health Mission (NHM) gave momentum to coverage and spread of immunisation services that resulted in universal coverage of polio vaccination wherein full immunisation increased from 54 per cent to 70 per cent among children aged 12–24 months (IIPS, 2011). The recently concluded RSOC (2013-14) data shows that in India 65.3 percent of children aged 12-23 months are fully immunized and 6.6 percent have received no vaccination.

During the last decade, the Government of India has made enormous efforts to increase complete immunisation coverage. The Mission Indradhanush recently launched by Ministry of Health and Family Welfare (MoHFW) Government of India on 25th December, 2014 has its objective to ensure that all children under the age of two years as well as pregnant women are fully immunized with seven vaccine preventable diseases. In the first phase of the mission, 75.5 lakh children have been vaccinated and about 20

Methodology

Under Call to Action, Population Council in partnership with UNICEF and USAID conducted an evidence review to identify key social and behaviour change (SBC) strategies and health outcomes supporting child survival in the South Asia region, especially in India. More than 7605 articles on Maternal and Child Health published during the last 13 years (2002-2015) were scanned after database searching, and of these, 142 intervention studies were selected for analysis. On Childhood Immunisation behaviour, a total of 272 articles were identified and screened, 112 abstracts were read, 17 articles were downloaded and reviewed and 14 were selected for final review. The outcome of the review was a Report, “*Evidence Review on Population Level Social and Behaviour Change in South Asia for Enhancing Child Survival and Development*” on which this policy brief is based. In addition, a technical group in UNICEF India has enhanced the findings and recommendations with new literature and relevant evidence.

lakh children fully vaccinated, and the second phase has started from 7th October, 2015. Despite this, there is considerable inequity in vaccination coverage in different states; traditionally poor performing states have greater inequities - inequities based on factors related to individual (gender, birth order), family (area of residence, wealth, parental education), demography (religion, caste), and the society (access to health-care, community literacy level) characteristics (Mathew, 2012).

Available literature for India suggests that reasons for the poor completion rate of routine immunisation can be divided into two groups: supply and demand side. The first is essentially operational: erratic vaccine supplies to the point of disbursement and vaccination, cold chain problems, vacant staff positions, weak surveillance of vaccine preventable diseases other than polio, poor implementation of fixed-day fixed-place strategy, lack of active targeting of potential non-acceptors etc. In addition, there is limited capacity for counselling by health workers and health personnel, which clearly shows lack of training in interpersonal communication, lack of refresher training/in-service training for staff, lack of supportive supervision of staff, poor motivation of health workers and lack of recognition of health provider's inputs (Khan, et. al., 2011).

On the demand side, data from the Coverage Evaluation Survey (UNICEF, 2009) identifies four factors associated with non-immunization of children: (1) 44 per cent of mothers did not feel the need for immunisation; (2) 50 per cent did not know about the vaccine and age at which it should be administered; (3) 13 per cent did not know the place of immunisation; (4) 14 per cent were afraid of the side-effects.

Literature Review: Key Findings

The results of evidence review suggested the following interventions could lead to increase in compliance to complete immunisation and coverage.

1. Community engagement leads to significantly higher vaccination rates: The results of the evaluation of the RACHNA programme showed a 16 per cent increase in complete immunisation coverage among children aged 12–23 months in the intervention districts from baseline to endline. Similarly, a study by Anderson et. al. (2009), showed that community mobilisation and community engagement lead to significantly higher vaccination rates for measles in the intervention group compared to the control group (50% vs. 30%). The logit analysis showed more than two measles vaccinations in the intervention group as compared to the control group (OR=2.20).

SMNet and the RACHNA programme demonstrated that systematic social mobilisation and engagement of communities at various levels of implementation in hard-to-reach areas and areas where there is resistance to vaccination resulted in increased immunisation coverage.

[Anderson et al. (2009), CARE-India, (2008), IPE Global (2012), Goel et al. (2012), Prinja et al. (2010), Uddin et al. (2010) and UNICEF (2004)]

2. Counselling and interpersonal communication increase the chances of completion of immunisation schedule: A research paper demonstrated that targeting high-risk areas for house-to-house visits played key role in increasing routine polio vaccination. Children in those households where the caregivers received a household visit by health workers were more likely to be fully

immunized for polio through routine immunization than other children. Several studies suggested that CHWs counseled beneficiaries at different contact points viz. during immunisation sessions, home visits, and at the time of seeking health care from government health providers or private practitioners. A study by Bhandari et al., 2005, highlighted importance of repeated counselling which significantly improved immunisation rates in the intervention sites compared to the control sites; the reported immunisation rates in intervention versus control sites were 64.6 vs. 20.6 per cent for BCG, 65.2 vs. 23.1 per cent for the first dose and 18 vs. 5.8 per cent for the second dose of OPV and DPT vaccines respectively. Similarly, in a study by Owais et al., home-based short information sessions on the importance of vaccination for DPT/Hepatitis-B immunisation were provided to eligible mothers by CHWs. The multivariate analysis showed a significant difference of 39 per cent between the intervention and control arms in the completion rate of three doses of DPT/Hepatitis-B immunisation. The results also showed that improved maternal knowledge and perception regarding the importance of vaccination led to higher DPT/Hepatitis-B immunisation rates.

[Bhandari et al. (2005); CARE-India, (2008); Owais et al. (2011); UNICEF (2004), Usman et al. (2011)]

- 3. Strengthen service delivery system:** Several studies have demonstrated that improvement in service delivery system like availability of service provider, availability of supplies, regular and fixed days for immunisation, and community outreach activities increases the access to and utilisation of services. The study conducted by Uddin et al. (2010) focused on community mobilisation and strengthening of the service delivery system which resulted in significant improvement in complete immunisation coverage from 43 per cent at baseline to 99 per cent at endline, while the dropout rate decreased from 33 per cent to 1 per cent. Similarly, strengthening of routine immunisation delivery services through the *muskan-ek-abhiyan* campaign showed a marked improvement in complete immunisation coverage in Bihar. The proportion of fully immunised children 12–23 months old increased significantly from a low of 19 per cent in 2005 to 49 per cent in 2009. The RACHNA programme demonstrated that providing support to strengthen the service delivery system, including improving the technical skills of service providers, as well as logistics, community mobilisation through community participation and coordination among frontline health workers could effectively increase immunisation coverage.

[CARE, (2008), Goel et al., (2012), Paxman et al., (2005), Prinja et al., (2010), Uddin et al. (2010)].

Policy Recommendations

- 1. Use community mobilisation and community engagement as a key strategy to increase access and service utilisation:** Several studies show that community mobilisation and community engagement is a key strategy to increase childhood immunisation. This includes appointment of community volunteers, formation of committees, engagement of community leaders, and group meetings at community level where groups within the community identified the challenges and barriers to complete immunisation of the children and developed action plans to address them.
 - Community mobilisation and engagement increases demand for services and improves service utilisation
 - People make healthy choices after assessing cost and benefit
 - Community outreach activities bring about attitudinal change
- 2. Improve counselling and interpersonal skills of service providers:** Studies have demonstrated that repeated counselling by service providers at different contact points improves maternal knowledge about vaccination and results in an improvement in completion of vaccination schedule. Enhancing counselling and interpersonal communication skills of CHWs increases the chance of them conveying to mothers the importance of completing the immunisation schedule and explaining the potential adverse impact of incomplete immunisation on the child's health which can significantly influence them to complete the immunisation schedule. Interventions that have proved effective in stimulating demand for vaccination in resource-poor settings among children with incomplete immunisation include sending reminders to the home of target children and door-to-door household visits to notify the parents that their child is late for vaccination.
- 3. Strengthen service delivery system:** The Universal Immunization Programme is possibly the longest and one of the biggest public health intervention measures undertaken in India. To improve immunization coverage in the country various initiatives have been undertaken since the inception of the programme in 1985. To further strengthen and improve service delivery 2012-13 was declared as the "Year of Intensification of Routine Immunization" with the objective of improving immunization coverage rates across poor performing districts and states. Literature review shows substantial increase in adoption of childhood immunisation through strengthening of the health system. Strengthening of routine immunisation (RI) services, regular availability of services, planning and management, monitoring and supportive supervision and training of service providers at different levels triggers change in behaviour at two levels – the provider's level in promoting a certain behaviour, and at the families level in acceptance of it. However, the programme still has challenges across key thematic areas of programme management, cold chain and vaccine management, recording and reporting and injection safety.
- 4. Use a mix of communication channels** that are both culturally acceptable and effective to successfully communicate vaccine safety in a resource limited setting. Social mobilization through cultural, administrative and political leaders, media or text messages (SMS) can be effective in increasing the demand for immunization. WHO and other development partners as well a number of governments especially in Sub Saharan Africa have adopted "task shifting", an approach which reassigns some of the healthcare tasks previously carried out by doctors and nurses at higher-level

health facilities to Community Health Workers (CHWs) also referred to as Village Health Teams (VHT) in Uganda. Within the VHT framework, selected community members are trained to carry out some of the activities previously carried out by health workers.

- 5. Prioritize delivery action plan to confront substantial challenges** in scaling up commitments to vaccines. Public decision-making related to vaccine acceptance is not driven by scientific or economic evidence alone. It is also driven by a mix of psychological, sociocultural, and political factors, all of which needs to be understood and taken into account by policy and other decision makers. Public trust in vaccines is highly variable and building trust depends on understanding perceptions of vaccines and vaccine risks, historical experiences, religious or political affiliations, and socioeconomic status.

Successful immunization programs depend on high vaccine acceptance and coverage rates. In recent years there has been an increased level of public concern towards real or perceived adverse events associated with immunizations, leading to many people in high- as well as low-resource settings to refuse vaccines. Health care workers therefore must be able to provide parents and guardians of children with the most current and accurate information about the benefits and risks of vaccination.

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