



## WHY PARENTS CHOOSE NOT TO VACCINATE: A QUALITATIVE STUDY IN HAZRATBAL AREA OF SRINAGAR.

**Dr. Tanzeela Bashir Qazi\***

Post graduate scholar , Department of Community Medicine, Government Medical College, Srinagar . \*Corresponding Author

**Dr. Rifat Jan**

Lecturer , Department of Community Medicine, Government Medical College, Srinagar

**Dr. S. Muhammad Salim Khan**

Professor & Head, Department of Community Medicine, Government Medical College, Srinagar.

### ABSTRACT

**Background:** Immunization is considered as one of the key interventions for protection of children against life threatening conditions that are preventable. Most of the children today receive lifesaving vaccines. **Objectives:** This study aims to identify the perceived barriers to immunization among parents who have chosen not to have their children immunized and addressing these barriers with communication intervention. **Material And Methods:** It was a qualitative study that was conducted in subcentre area of hazratbal from March 2019 to July 2019. In-depth interview was conducted with the parents with the aim to identify the barriers to immunization using a semi structured questionnaire. In-depth interviews were transcribed verbatim. Communication intervention was carried out with the parents and the number of sessions held were three in number. **Results :** Interviews were completed with seven parents. Parents discussed their perception of immunization and childhood diseases and the risk-benefit analysis that occurred between the two. Majority (71.4%) of the parents identified the risk of side effects as a reason for choosing not to immunize. Communication interventions adopted in the study includes two main strategies: to inform and educate parents about benefits of immunization and later on to remind and recall them for upcoming vaccination of their children. **Conclusion:** Most of the parents were of the view that there is a high chance of Adverse Event Following Immunization (AEFI) and hence had chosen not to immunize their children. Communication intervention was done and all of them turned up for their next scheduled immunization of their children.

**KEYWORDS :** Immunization, Barriers, Communication Intervention , Hazratbal

### INTRODUCTION:

Immunization is considered as one of the key interventions for protection of children against life threatening conditions that are preventable. At the community and national levels, the benefits of immunization go beyond the improvements in health and life expectancy with an impact on social and economic indicators (1). Most of the children today receive lifesaving vaccines. Uptake of new and underused vaccines is increasing. Immunization currently prevents 2-3 million deaths every year. But still an estimated 19.4 million children under the age of one year are not receiving basic vaccines (2). About 1 in 5 (nearly 4 million) of the un- and under-vaccinated infants live in fragile or humanitarian settings. These children are most vulnerable to disease outbreaks (3). An estimated 1.5 million children die annually from vaccine preventable diseases (4).

The immunization programme in India is one of the largest in the world and the programme started as Expanded Programme of Immunization (EPI) in 1978 with DPT, BCG, OPV, and typhoid paratyphoid fever vaccines. Since its inception, the national program on immunization has undergone various changes, which reflects in its current status; the key transition being the revamping of the program as the Universal Immunization Program (UIP) in 1985, with the incorporation into the Child Survival and Safe Motherhood (CSSM) program in 1992, the Reproductive and Child Health Program (RCH-I) in 1997 and RCH II under the National Rural Health Mission (NRHM) in 2005 (1).

The country's immunization schedule included ten vaccines: Bacille Calmette-Guerin (BCG), Hepatitis B, Oral polio vaccine (OPV), Pentavalent (LPV) , fractional IPV, Rotavirus vaccine , Measles Rubella (MR), DPT booster vaccine , Tetanus toxoid and vitamin A. Under UIP, Government of India is providing vaccination free of cost to all the beneficiaries. The programme has helped in bringing down the burden of vaccine preventable diseases and thus saving lives of million of children. Immunization has helped to reduce the annual mortality of children under five, from 3.3 million in 1990, to 1.2 million deaths in 2015; that is 17,000 deaths each day (5).

However, over the past many years, immunization coverage among children aged 12-23 months in the country has increased at a very slow pace of around 1% each year (6). The evaluated data indicate that the coverage has increased from 44% in NFHS-3 (2005-06) to 62% in NFHS-4(2015-16) (1). However in Jammu and Kashmir

immunization coverage has increased from 66.1 % in NFHS-3 to 75.1% in NFHS-4 (6). This slow progress in full immunization coverage in India during 2005-06 to 2015-16 needs attention. It is seen that full immunization coverage is lowest among scheduled tribe population (56%) (1). In addition to the socioeconomic status, maternal education is an important factor in determining full immunization coverage. In India in 2015–2016, children with highly educated mothers aged 20–49 years who belonged to the richest 20% of the population had a 5.3 times higher chance of being vaccinated, compared with children born to teenaged mothers with no education, in the poorest 20% of the population (7). The top three reasons identified in the National Coverage Evaluation Survey of 2009, as the major causes for low demand for vaccines included:

- 1) Not feeling the need for vaccines;
- 2) Lack of awareness about immunization, when and where; And
- 3) Adverse events following immunization

The 2017 concurrent monitoring data from WHO on routine immunization reveal that 74% of reasons for missing immunization were associated with demand side issues like parents not aware of vaccine benefits, fear of adverse event following immunization leading to dropouts and unavailability of children at home to receive services. Hence there is a need to better understand and identify the barriers to immunization and to improve the immunization coverage by various interventions.

### MATERIAL AND METHODS:

It was a qualitative study that was conducted in subcentre area of hazratbal from March 2019 to July 2019. The subcentre provides various services like immunization, antenatal care, postnatal care , contraceptive services, haemoglobin estimation , field visits and health education services to the community members. Routine immunization is the foundation which provides access to vaccines and controls and eradicates vaccine-preventable diseases. It is a continuous service conducted by health workers at subcentre on fixed days. Apart from the routine immunization schedule, several rounds of mass campaigns are also held in the subcentre area in an effort to eradicate poliomyelitis and other vaccine-preventable diseases.

This subcentre caters to a population of 8131, comprised of 1625 families which includes 744 children in the age group of 0-5 years. Although most of the children (in age group 0-5 years) were fully immunized, some of the families mostly from the fishermen colony

were found resistant to immunization. To assess the beliefs, attitudes and the perceived barriers to immunization interview was conducted with the parents of unimmunized children using a semi-structured questionnaire.

A thorough review of the records available with the ASHAs (Accredited Social Health Activist) was done and the children in the age group 0-5 years who had not been fully vaccinated were identified. Communication was established with the parents of these children. Their contact numbers were obtained from the register at subcentre and were called. They were asked to visit the subcentre in view of the immunization of their children. Only two mothers responded back and agreed to pay a visit to subcentre. Personal household visit was made for other parents of the beneficiaries. One household was found locked and was visited on next working day for the same reason. At the time of first contact, in-depth interview was conducted with the parents with the aim to identify the barriers to immunization. The interview lasted between 30-40 minutes. At the end of each interview session, the in-depth interviews were transcribed verbatim. This was followed by a counselling session (communication intervention) for all the parents at individual level. Each counseling session lasted for 45-50 minutes and the parents were educated about the importance of vaccination in preventing diseases, benefits of age appropriate immunization, demerits of not vaccinating children, contraindication to immunization, mentioning the common AEFI and easy availability of vaccines at health care facilities. At the end of each session, all the participants with incomplete immunization of their children were asked to visit the subcentre for getting their children vaccinated and all the associated queries were answered.

Subsequently two more joint sessions for imparting health education was held on pre fixed dates. Only three parents turned up for the first session whereas the remaining ones joined the second session. Mothers of fully immunized children were also made to join the session wherein they shared their views and experiences in order to encourage others to get their children vaccinated. Thereafter, the parents of unimmunized children were reminded about the vaccination dates of their children through phone calls from health workers. Home visits were also made if the calls were not entertained. Appreciation was given to the parents following immunization of their children.

**RESULTS :**

Out of 744, 9 children belonging to 7 families were identified as resistant population. The age of the children ranged from 0-5 years with 3 children under 1 year of age. Most (55.5%) of the children were females. All the mothers were housewives and were not educated. Parents explained a number of conditions that prevents them from getting their children immunized.

Most (71.4%) common barrier identified among mothers was the fear that children become sick following immunization.

*“Children get fever (after vaccination) and this (fever) weakens them.”*

*“Our neighbour's child developed seizure (after vaccination) ; She(the child) was (admitted) at SKIMS hospital for 3-4 days.”*

14.2 % of the mothers reported of an history of AEFI after previous vaccine.

*“My elder daughter developed seizure two and a half month after vaccination ; She was 6 month old at that time . she was admitted at SKIMS Hospital for 3 days .Since then she is on medications (which were prescribed by the doctor) . We didn't take her for vaccination since then and also ( did not take ) her little sister.”*

Another 14.2 % had a belief that a healthy person did not need to be vaccinated.

*“I am 36 years old ; I have never received any vaccine and very much healthy . Even my relatives never received vaccine;they are also normal(free from disease) . We did not vaccinate our children.”* Communication intervention strategies adopted have been described in Table 5.

**DISCUSSION:**

Maternal education is believed to be an important factor in

determining full immunization coverage among children and since in our study all the mothers were illiterate hence showed more scepticism towards immunization .Thus highlighting the association between maternal education and immunization behaviour. Similar association is also seen in a study conducted by Juliet N Babiry et al (2011) in Uganda. (8)

In our study , Parents did not perceive immunization as a necessary practice for their children. They believed that preventing disease was only one component of maintaining and promoting good health. Yet, they did not truly refuse vaccination, rather they had a lack of awareness concerning the benefits of vaccination.71% of the respondents in our study expressed the fear that children become sick following vaccination. They wanted a state free of illness from the vaccines. Other studies have also reported that some parents believed that vaccines could cause minor illnesses and this prevented them from vaccinating their children (9)(10).

14% of the Parents refused vaccination due to a previous perceived bad experience with immunization. Parent's decision to not immunize their children was often the result of weighing the risks against the benefits and they felt that the risks outweighed the benefits. Similar results have been reported by a study conducted by Edwin et al (2014) (11).

One (14%) of the parents discussed his own childhood experiences of not being immunized and that this had not led to any adverse consequences for his own health. And he continued the same with his own children. This belief of not being immunized but still staying healthy have also been reported in other studies(12).

Communication intervention strategies were adopted for bringing about an improvement in immunization coverage in the subcentre area. A wide range of communication approaches for childhood vaccination with the intention of improving vaccination coverage rates has been adopted in various other studies (13). Communication interventions adopted in this study includes two main strategies: to inform and educate parents about immunization and to remind and recall.This may be attributed to the fact that in hazratbal area because of resistance towards immunization, interventions were targeted at informing and educating mothers regarding the benefits of vaccination and countering rumours and misconceptions about immunization. Such interventions proved useful thus contributed in reducing vaccine hesitancy.

**CONCLUSION:**

Most of the parents were of the view that there is a high chance of AEFI occurring as a result of immunization and hence had chosen not to immunize their children. Their decision was based on an assessment of risks and benefits of immunization. Communication intervention was done which aimed to inform and educate the parents and to remind and recall them about upcoming vaccination of their children and all of them turned up for their next scheduled vaccination.

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**Table 1: Age Distribution Of Children In Years**

Age (years)	Number (%)
<1 year	3 (33.3)
>=1 year	6(66.6)

**Table 2: Gender Distribution Of Children**

Gender	Number (%)
Male	4(44.4)
Female	5(55.5)

**Table 3: Education Of Mother Of Children**

Education of mother	Number (%)
Illiterate*	7(100)
Primary school passout	0
Middle school passout	0

**\*No Formal Education****Table 4: Barriers Identified Among Parents Of Beneficiaries**

Barriers identified	Number (%)
Fear that the children become sick following vaccination	5(71.4)
History of AEFI after previous vaccine	1(14.2)
Belief that parents were never vaccinated and never became sick	1(14.2)

**Table 5: Communication Intervention Strategies Adopted**

Inform or educate	Health education was imparted to parents of the beneficiaries .Three sessions were conducted in this regard.
Remind or Recall	All the 7 parents were reminded about the upcoming vaccination of their children.
Provide support	Interventions were also done to provide support by addressing specific challenges that parents face when decided whether to vaccinate their child or not.Interventions to provide support for vaccination was combined with intervention to inform or educate
Praise	Appreciation was given to the parents on performing vaccination of their children and encouraging them to continue doing so.

**REFERENCES:**

1. Universal immunization programme. Comprehensive multi – year plan.2018-2022. Ministry of health and family welfare . Government of India.
2. World Health Organization Fact Sheets. Global immunization coverage 2019. <https://www.who.int/news-room/fact-sheets/detail/immunization-coverage>.
3. UNICEF.Child health immunization data . July 2019. <https://data.unicef.org/topic/child-health/immunization/>
4. World Health Organization . Global Immunization Data. [https://www.who.int/immunization/monitoring\\_surveillance/global\\_immunization\\_data.pdf](https://www.who.int/immunization/monitoring_surveillance/global_immunization_data.pdf)
5. Child mortality estimates, UNICEF Global Data Base, 2015.
6. International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India.
7. Explorations of inequality: Childhood immunization. World Health Organization . 2018.
8. Juliet N Babirye, Elizeus Rutebemberwa, Juliet Kiguli et al. More support for mothers: a qualitative study on factors affecting immunisation behaviour in Kampala, Uganda. BMC Public Health 2011, 11:723.
9. Lyndal Bond ,Terry Nolan et al. Vaccine preventable diseases and immunisations: a qualitative study of mothers' perceptions of severity, susceptibility, benefits and barriers Aust N Z J Public Health 1998; 22: 440-6.
10. KeaneV, Stanton B, Horton L, et al. Perceptions of vaccine efficacy, illness, and health among inner-city parents. Clin Ped 1993; 2-7.
11. Edwin.L.Anderson. Recommended Solutions to the Barriers to Immunization in Children and Adults. The journal of the Missouri State Medical Association. 2014 Jul-Aug; 111(4): 344–348.
12. Ahmet Topuzoglu et al. The barriers against childhood immunizations: a qualitative research among socioeconomically disadvantaged mothers. European Journal of Public Health, Volume 17, Issue 4,1 August 2007, 348–352.
13. NDHS (2013). Nigeria demographic and health survey. Abuja: National Population Commission and ICF Macro.