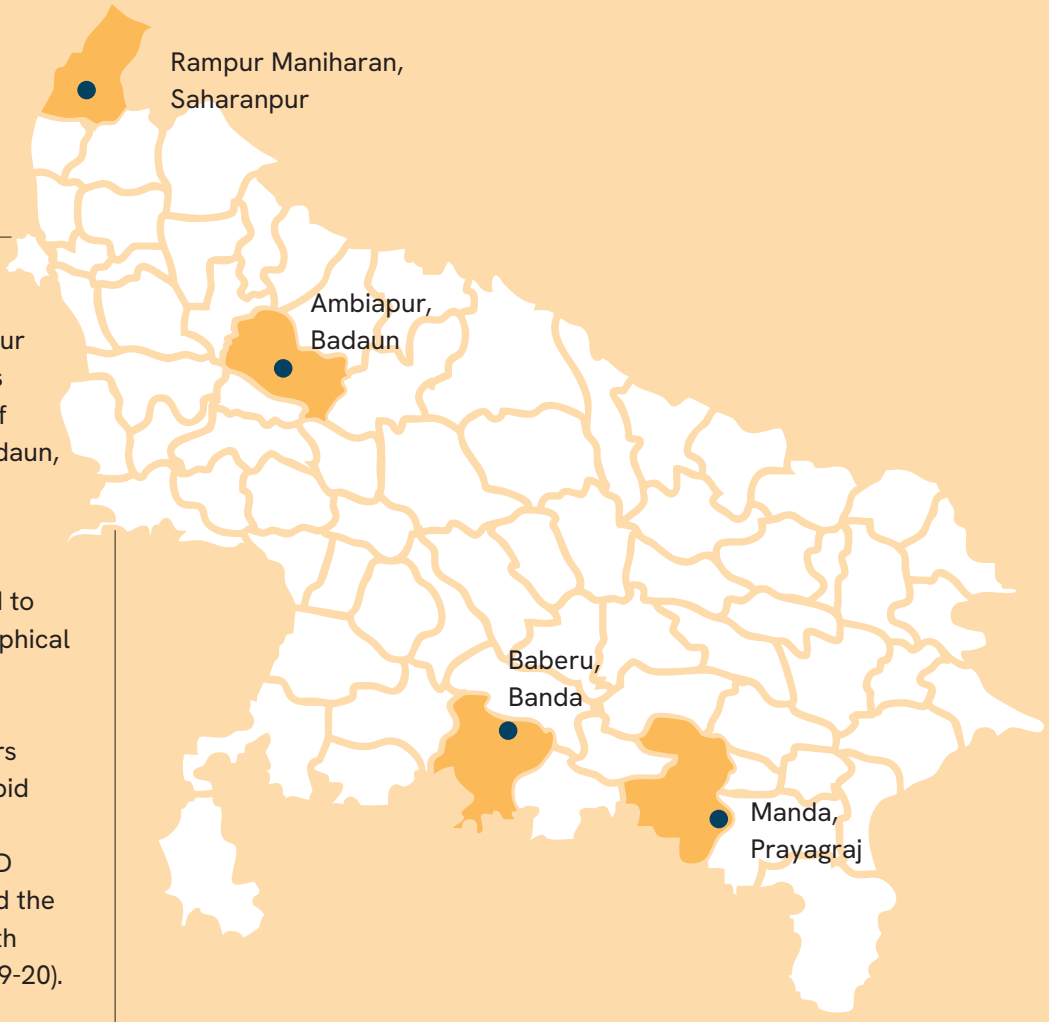
ZERO DOSE CHILDREN

Exploring the context & drivers of missed vaccination of children in Uttar Pradesh using a gender lens

1 BACKGROUND

In-person exploratory conversations were conducted with mothers of zero dose children[1] by the Uttar Pradesh Technical Support Unit (UP TSU), as part of the initial diagnostics phase of the Zero Dose Learning Agenda (ZDLA), to understand local determinants leading to children being zero dose in specific geographies. As one part of this exercise, this brief summarizes the insights exploring gendered barriers impacting childhood immunization and strategies to mitigate these barriers with a focus on gender inequality.

[1] Zero-dose children are those who have not received any routine vaccine. For operational purposes, Gavi defines zero-dose children as those who lack the first dose of diphtheria-tetanus-pertussis containing vaccine (DTP1). Gavi: The Vaccine Alliance. [Internet]. Washington; c2024. Reaching Zero-dose Children; 2022 Jan. 17 [cited 2024 Dec. 16]. Available from: https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities.



These conversations were conducted in four administrative blocks across the districts of Prayagraj, Banda, Badaun, and Saharanpur.

These districts were strategically selected to represent the geographical and socio-economic diversity of the state, informed by indicators derived from: the Rapid Assessment Survey (RAS) (2021); CiVHSND observation data, and the National Family Health Survey (NFHS-5) (2019-20).

2 METHODS & APPROACH

A total of 54 mothers of zero-dose children participated in these conversations. They were primarily from marginalized Hindu communities, from relatively lower socioeconomic strata. These conversations with mothers explored knowledge, experiences, perceptions, and household dynamics, with a particular focus on the decision-making processes related to childhood immunization. The open-ended nature of these conversations explored individual, family, community, and facility and health system factors shaping vaccination behaviors based on gendered attitudes, beliefs and norms.

Content analysis of the insights drawn from these conversations was initially conducted to summarize findings by domains and topics including: knowledge, awareness, and perceptions of vaccines; values and beliefs; community norms around vaccines and decision-making; prior experiences with vaccination and the health system; individual and structural barriers to vaccination; trust; and agency. Additional thematic analysis of the data summary was conducted to further explore drivers of zero dose immunization and underlying issues at individual, family, community, facility and systems levels using a gender lens[2] and ecological framework.

[2] India Health Action Trust (IHAT). Gender Analysis Framework. 2023. https://www.ihat.in/wp-content/uploads/2024/06/Gender-Analysis-Framework.pdf

3 CONTEXT & REASONS FOR MISSED VACCINATION

Knowledge, perceptions, and experiences of mothers of zero dose children

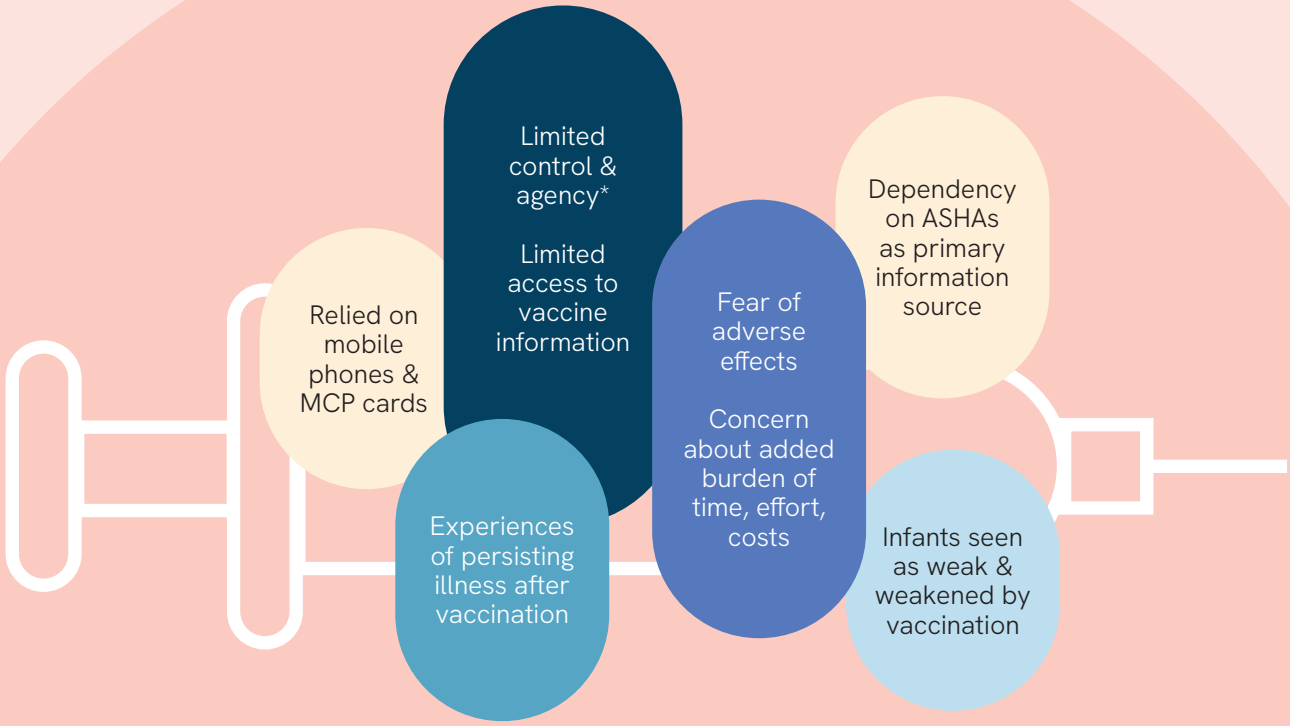
A. Individual Level Factors

Knowledge about vaccines

- Mothers had limited awareness of specific immunization schedules and benefits of accessing vaccines but generally understood the importance of vaccines for the health of their children and for prevention of diseases.

Perceptions & beliefs

- Significant concerns about potential side-effects of vaccines including excessive crying, fever, immunization site infection, swelling, and infant death were raised by mothers based on what they had heard and experienced.
- Mothers worried about how to manage post-vaccination effects along with their household work and caring for other children with little support from the family.



*Larger shapes in figure above show the strongest themes and ideas that emerged consistently in the results.

B. Family Level & Interpersonal Factors

Family values & beliefs

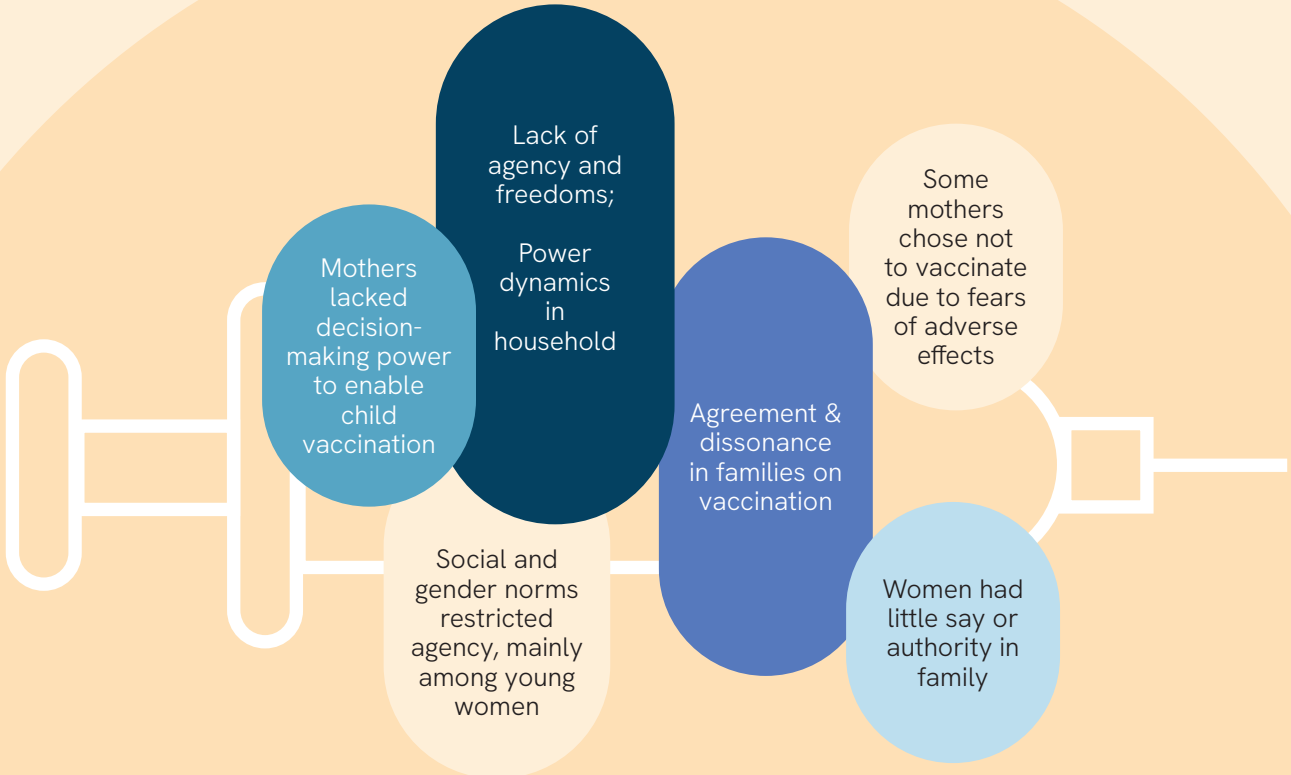
- Vaccination aligned with the values and beliefs of many families, who viewed it as beneficial.
- Families also sometimes had conflicting views on vaccination.

Decision-making

- Healthcare decisions were typically made by husbands, in-laws, and respected elders in the family.
- Women sometimes made decisions about vaccination of children either independently or jointly with their husbands.

Restricted mobility and travel

- Mothers felt capable of independently taking their child for vaccination but faced many obstacles and constraints in doing so.
  - Women sometimes were not permitted to take their child for vaccination unless accompanied, usually by men in the family.
  - Inconvenient routes, weather, and time deterred travel to facilities.
- Some women were also reluctant to travel alone to a vaccination location.



C. Community Level Factors

Expectations of women's roles

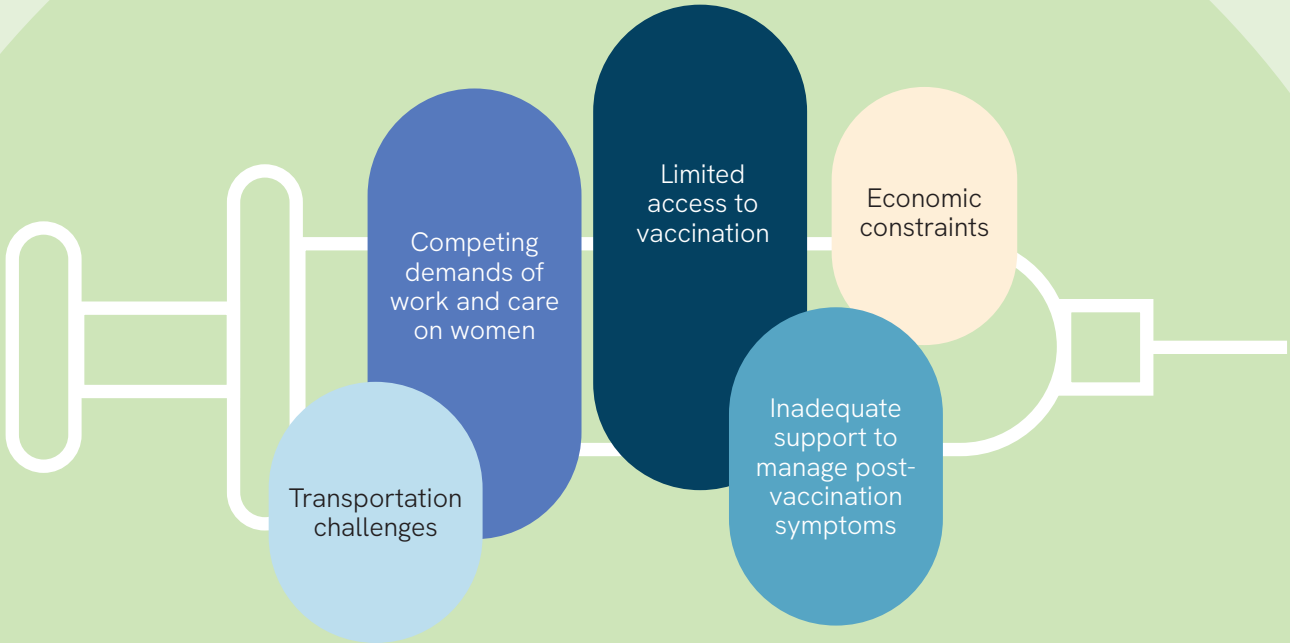
- Vaccination appointments were sometimes missed by mothers due to competing demands of work (such as farming), household chores, and caring for other children
- Women, particularly younger women, were sometimes expected to limit interactions with people outside household.

Access to vaccinations

- Distant vaccination sites posed logistical challenges.
- Navigating deserted roads and walking during hot and rainy seasons proved to be challenging.

Costs

- Loss of income due to post-vaccination effects was a concern.
- Transportation costs posed significant barriers for a few.



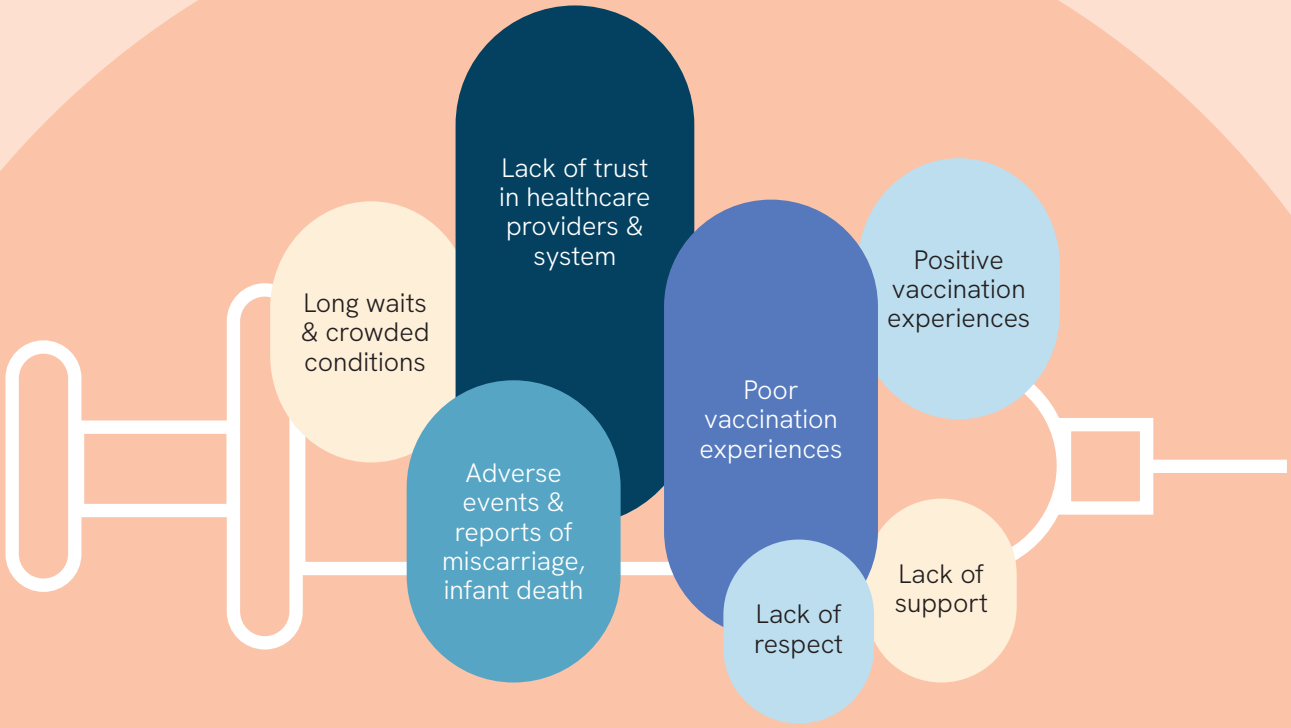
D. Facility & Health System Level Factors

Past experience with vaccination

- Many mothers reported generally positive past experiences with vaccination.
  - Adequate information and medication provided by ANMs to manage post-vaccination symptoms.
- Some families had poor past experiences including: witnessing adverse events after immunization; negative interactions with providers; cases of miscarriage following maternal vaccination; and infant death.
- Mothers reported challenges of: long waits in crowded settings; children having symptoms and complications post-vaccination; and distressed/crying children causing anxiety.

Past experiences with healthcare providers & health system

- Mothers reported positive experiences with providers and facilities including getting lifesaving care for children and comprehensive explanations by providers about health issues.
- Some mothers expressed dissatisfaction with interactions with providers
  - Lack of respect from providers.
  - Lack of support from ASHAs.
- Some mothers expressed distrust and concern with the formal healthcare system
- A few mothers expressed a preference for the private health system over the government health system.



4 SIGNIFICANCE & LIMITATIONS

These in-person exploratory conversations draw insights into the drivers of zero dose vaccinations among children in UP to inform the development of actionable and context-specific solutions. These insights are based on a small subset of summary of information from these conversations with mothers. Highlighting the voices of mothers of zero-dose children and their direct experiences with decision-making around vaccination would further enhance understanding of strategies to optimize immunization.

Key Insights

- Mothers of zero dose children generally understood the importance of immunization but **relied almost exclusively on ASHAs for vaccine information, which was complicated to remember.**
- Mothers and families had **significant concerns and fears of adverse effects following immunization based on their experiences and on what they had heard.** Many were hesitant about perceived risk of immunization and the potential loss of income managing post-vaccination adverse events.
- **Poor past experiences with vaccinations and the health system** including witnessing adverse events, disrespectful care, long waits, and distressed/crying children decreased trust and deterred future immunization.
- Mothers who wanted their children to be vaccinated faced **social and gender norms that restricted their decision-making authority and freedoms** to act independently in the home and community.
- **Mothers had to balance competing pressures of work, household responsibilities, and childcare with limited supports** to access vaccinations and manage post-vaccination illness and complications.

RECOMMENDATIONS

- **Engage closely with mothers of zero dose children on specific strategies to support women** and families and to address challenges in vaccination of children

- **Strengthen the capacity of ASHAs to disseminate vaccination information in a way that is accessible** and easy to remember, and to empower mothers in facilitating vaccination.
  - › ASHAs should be trained to counsel and address mothers' concerns and fears regarding adverse effects following immunization.
  - › ASHAs should also be equipped to help mothers manage post-vaccination adverse events.

- **Explore alternative mechanisms for facilitating vaccination and sharing information** with mothers and families to reduce reliance on ASHAs.
  - › Engage other providers in the continuum of immunization such as:
    1. facility-based providers in starting the process and creating a culture of immunization in facilities; and
    2. community-based providers including ANMs in education pre-vaccination and in management of adverse effects post-vaccination.

- **Explore strategies to engage family members to take greater responsibility for childcare,** especially in managing post-vaccination illnesses and complications, to ensure that mothers are supported with balancing the pressures of work and household responsibilities.

- **Address social norms and social structures that impact women's freedoms** and decision-making authority to ensure women can make informed choices about vaccination of their children.
  - › Initiate individual and structural level interventions – such as behaviour change communication campaigns or community dialogues through ASHAs and elected representatives, Jan Arogya Samiti (JAS), Village Health Sanitation and Nutrition Committees (VHSNC) – to change norms within the community, to support equal decision-making authority for women, and to enable freedoms for women to have mobility and act independently regarding the health of their children.

- **Enhance capacity and mentorship of frontline staff to provide respectful care and to create a positive experience for mothers** when visiting facilities/outreach sites.
  - › Develop monitoring and supervision mechanisms to ensure a supportive environment for all is created at vaccination delivery points with a special focus on mothers with young children.

Uttar Pradesh Technical Support Unit

Uttar Pradesh Technical Support Unit (UP TSU) was established in 2013 under a Memorandum of Cooperation signed between the Government of Uttar Pradesh (GoUP) and Bill & Melinda Gates Foundation (BMGF) to strengthen the Reproductive, Maternal, Newborn, Child, Adolescence Health and Nutrition (RMNCAH+N). University of Manitoba's India based partner, India Health Action Trust (IHAT) is the lead implementing organization.

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