PULSE
UPDATING YOU ON HEALTH DEVELOPMENTS

8. BARRIERS TO ACCESSING CHILD IMMUNISATION SERVICES

BACKGROUND GETS IN THE WAY

This note describes the barriers poor people experience accessing and using child immunisation services. Table 1 shows the recommended course of vaccines for young children, with multiple shots for polio and DPT-Hep B–Hib.

Although the uptake of child immunisation is high in Nepal, there is a need to increase coverage. The Nepal Demographic and Health Survey 2011 (MoHP et al. 2012) found that:

- children in the highest wealth quintile were more likely to be fully immunised (96%) than those in the lower three wealth quintiles (less than 85%);
- only 85% of children were fully immunised in the Tarai compared to 90% in the hills;
- children of women with no education (78%) were less likely to be immunised than children of educated women (+90%);
- 91% of first-born children were fully immunised compared to 60% of children who were the sixth or later child; and
- boys were slightly more likely than girls to be fully immunised (88% versus 86%).

Pandey et al. (2013) reports that Muslims (57%) were much less likely to be fully immunised than the average for Nepal (87%). The highest percentage was among hill Brahmins (94%)

Table 1: Schedule of Nepal's National Immunisation Programme (DoHS annual report 2011/12)

Type of vaccine	Number of doses	Recommended age
BCG	1	At birth
OPV (polio)	3	6, 10, and 14 weeks
DPT-Hep B–Hib	3	6, 10, and 14 weeks
Measles	1	9 months
Japanese encephalitis	1	12-23 months

PERCEIVED SIDE EFFECTS, DISTANCE AND COST DETER IMMUNISATION

The Access to Health Services Study (Thomas et al 2012) found that the main obstacles to child immunisation were perceived side effects and the distance from and costs of

THE ACCESS TO HEALTH SERVICES STUDY

A study was carried out in 2012 to understand the socio-cultural, economic and institutional barriers that poor and excluded people face accessing health services in Nepal. It used the rapid participatory ethnographic evaluation and research (rapid PEER) method, which is designed to explore sensitive issues with non- and low literate marginalised populations. Rapid PEER interviews happen in the third person to avoid response biases and are carried out by 'ordinary' members of target groups to elicit frank responses. The study examined experiences of accessing essential health care services at sub-health posts, health posts and outreach clinics.

Six social groups were studied: Chepangs, Muslims, Madhesi Dalits, Other Backward Classes (OBCs or other Madhesi castes), hill Dalits, and poor hill Chhetris and Brahmins, thus covering caste, ethnic, and religious differences. Each group was studied in two districts giving 12 sub-studies with 374 interviews in all.

Eight briefing notes have been produced to disseminate the findings. Note 1 gives the background and methodology while notes 2, 3 and 4 present the findings on the effects on accessing health care of poverty, caste and ethnicity (2); gender (3) and geography (4). Note 5 presents the findings on access to family planning, note 6 on access to safe abortions, note 7 on access to maternal health services and note 8 on access to child immunisation services. The study report (Thomas et al. 2012) is available at http://www.nhssp.org.np/gesi/Nepal%20PEER%20Revised%20Report.pdf

getting immunised. Immunisation is not always prioritised by households where access to services is difficult because of terrain, lack of transport, absence of menfolk to assist with transport, and financial and opportunity costs. Older female household heads are more likely to view child immunisation as unnecessary because of their own experiences and thus are less willing to invest time and money accessing services in the absence of ill-health.

The study found that lack of awareness of the health benefits and anxiety and misunderstanding of the side-effects of immunisation inhibit access to child immunisation services.

Most study participants were aware of child immunisation services. However, a lack of understanding of the benefits, reinforced by older women's views and social controls over married women's use of their time and public space, limits their access to information and networks outside the family that could build up their knowledge and confidence to challenge traditional family norms. Women were also said to face difficulties completing immunisation schedules, particularly when they have many young children.

Misunderstanding of the immunisation process and the short-term side effects were also said to be barriers to completing courses of immunisation. Actual side-effects range from children being upset by the pain of injections to fevers that last for several days. The risk of mothers being scolded, punished or beaten if children become upset or ill or need additional health care, with associated costs, as a result of immunisation, decreases the likelihood of them accessing immunisation services without family consensus. Some participants had heard stories that immunisation had caused the deaths of children.

"A lady of ward nine gave birth to a son. When the child got the first vaccine, it only cried and nothing happened. But the second time there was swelling in the child's thigh. Pus came from there. After treatment, 10-15 days after, the child recovered. But, now the woman is thinking of not taking her child for the next immunisation because after that immunisation they had to spend NPR 500 on the child's treatment."

Female, Saptari

A child being immunised at Koshi Zonal Hospital

ISSUES TO CONSIDER

1. How to identify left out and drop-out children and communities, and the reasons for non-use and drop-out from courses of immunisation? Could household visits, the review of data and consultations with local leaders and communities assist? Could such activities be included in the programme directives sent out by the Child Health Division to districts after approval of annual work plans and budgets?
2. Can local plans be developed for immunisation in consultation with communities to ensure that excluded groups are included?
3. Could interventions such as the following be developed and implemented to address barriers to child immunisation:
   - Discussions at ward, VDC and mothers' group meetings and imams (leaders) talking to Muslim communities?
   - Targeting outreach clinics to areas where children have been left-out or dropped-out of vaccination schedules?
   - Follow-up by health facility management committees to ensure that unimmunised children are reached?
4. Could service providers that represent targeted communities be contracted to provide immunisation services?
5. Could extra inputs be provided to fill gaps in immunisation coverage and monitor progress in immunisation take-up by children who have been left out or dropped out?
6. How can the implementation of the Child Health Division's Reaching Every Child programme be reviewed and strengthened to bring services close to all children, especially those from poor and excluded communities?
7. How to build the capacity of village health workers, auxiliary health workers and contracted service providers to address the barriers to immunisation experienced by different social groups?

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The Nepal Health Sector Support Programme (NHSSP) is funded and managed by DFID and provides technical assistance to the Nepal Health Sector Programme (NHSP-2). Since it began in January 2011, NHSSP has facilitated a wide variety of activities in support of NHSP-2, covering health policy and planning, human resource management, gender equality and social inclusion (GESI), health financing, procurement and infrastructure, essential health care services (EHCS) and monitoring and evaluation. For more information visit www.nhssp.org.np.