Psychosocial influences on routine childhood immunization in Sokoto, Kebbi and Zamfara States

Breakthrough RESEARCH Nigeria
Behavioral Sentinel Surveillance (BSS)
Webinar Series - Key Baseline Results

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Breakthrough RESEARCH
Webinar overview

• About Breakthrough RESEARCH

• What is the Behavioral Sentinel Surveillance (BSS) survey?

• Focus on routine childhood immunization
  • How did formative research inform the BSS survey?
  • New ideational metrics
  • Key BSS findings
  • SBC program implications

• Future work
About Breakthrough RESEARCH
Breakthrough RESEARCH

- USAID’s flagship project for social and behavior change (SBC) research and evaluation

- Five-year project: August 2017 to July 2022

- B-R Nigeria activity start: January 2019
  B-R Nigeria office opened: September 2019

- Close collaboration with sister project
  Breakthrough ACTION and other IPs
Breakthrough ACTION in Nigeria

Overall Result

- Increase 17 priority health behaviors in the areas of maternal, newborn, and child health plus nutrition (MNCH+N), family planning and malaria

Intermediate Results

- Improved individual and social determinants of health
- Strengthened SBC coordination and collaboration among USG partners
- Strengthened SBC capacity of national and sub-national public sector entities
Priority Behaviors for Integrated SBC

**Milestones**

- **Pre-pregnancy**
  - Use a modern contraceptive method, including long-acting reversible contraceptives (LARCs), to avoid pregnancy for at least 24 months after a live birth.
  - Attend a complete course of ANC.
  - Take intermittent preventive treatment of malaria (IPTp) during ANC visits.

- **Pregnancy**
  - Attend a health facility for delivery and/or deliver with a skilled attendant.
  - Provide essential newborn care immediately after birth.
  - Initiate exclusive breastfeeding within 1 hour after delivery.

- **Childbirth**
  - Breastfeed exclusively for six months after birth.

- **First 6 months**
  - Feed adequate amounts of nutritious, age-appropriate foods to children from 6 to 24 months of age, while continuing to breastfeed.
  - Complete full course of timely vaccinations for infants and children under 2 years.
  - Caregivers provide appropriate treatment for children with diarrhea at onset of symptoms.

- **6 - 24 months**
  - Seek prompt and appropriate care for signs and symptoms of malaria.

- **2 - 5 years**
  - Accept and adhere to the full course of seasonal malaria chemotherapy for eligible children.
Coordinated Multi-Channel Approach

- Community Mobilization
  - Community Social Behavior Change (SBC)
  - Community Capacity and Sustainability
- Mass Media
- Mobile/Digital
- Advocacy: Religious, Traditional and Opinion Leaders
- Provider Behavior Change
Breakthrough ACTION implements SBC programs in 11 States and FCT

Breakthrough RESEARCH will implement the study in Kebbi and Sokoto (integrated) and Zamfara (malaria-only)
What is the Behavioral Sentinel Surveillance (BSS) Survey?
What does the BSS measure?

- Aims to assess the effectiveness of integrated vs. malaria-only SBC on malaria, family planning and MNCH+N behaviors and ideations among pregnant women and women with a child under 2 years in program areas.

- BSS measures priority behavioral outcomes including:
  
  - **Malaria** (LLIN use, IPTp, fever treatment/diagnosis); **family planning** (modern contraceptive use, postpartum family planning); **MNCH+N** (ANC, facility-based delivery, newborn and postpartum care, routine immunization, breastfeeding/nutrition, childhood illness care-seeking and treatment)

- BSS measures psychosocial influences or ideations – cognitive, emotional, social – theorized as intermediate determinants of behavioral outcomes.
Kincaid’s Theory of Strategic Communication and Behavior Change
**BSS design**

<table>
<thead>
<tr>
<th>Study population</th>
<th>Pregnant women and women with a child under 2 years living within Breakthrough ACTION program areas in the 3 states *(not representative at state level)*</th>
</tr>
</thead>
</table>
| Study design     | Cross-sectional and cohort components  
|                  | Quasi-experimental and dose-response designs  
|                  | Conducted in September 2019, midline and endline planned |
| Sample size      | 3,032 pregnant women  
|                  | 3,043 women with a child under 2 years |
| Sampling method  | 108 wards across three states; census of pregnant women and random selection of women with children under 2 years |
| Data analysis    | Predicted probabilities of outcomes were derived using mixed-effects logistic regression models adjusted for ideational and sociodemographic variables: wealth, age, education and employment (respondent and spouse) |
Highlights

• Describes theory, rationale and study methods

• Summarizes results for ~500 questions by state (Kebbi, Sokoto and Zamfara)

• Estimates standard DHS indicators by state across malaria, family planning and MNCH+N

• Presents new ideational metrics by state across malaria, family planning and MNCH+N

Available at:
Vaccination:
Formative work and literature reviews
How did formative research inform the BSS?

• Breakthrough ACTION conducted formative research and literature reviews to inform SBC programs in Nigeria

• Breakthrough RESEARCH used this work to inform BSS ideational questions:
  • Vaccination coverage in northwestern Nigeria is extremely low
  • Polio eradication campaigns have faced major barriers, e.g. vaccine fears and community boycotts that also impact routine immunization services
  • Factors associated with not vaccinating children include: low vaccine knowledge, fear of side effects, vaccine mistrust, facility distance, cost and stock-outs, maternal education, maternal employment, and household wealth
<table>
<thead>
<tr>
<th>Age of child</th>
<th>Vaccination</th>
<th>Disease protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>At birth</td>
<td>Hepatitis B vaccine (HBV 1)</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td></td>
<td>Oral polio vaccine (OPV 0)</td>
<td>Polio</td>
</tr>
<tr>
<td></td>
<td>BCG vaccine</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>6 weeks</td>
<td>OPV 1</td>
<td>Polio</td>
</tr>
<tr>
<td></td>
<td>Pentavalent 1</td>
<td>DPT, Hib and Hepatitis B</td>
</tr>
<tr>
<td></td>
<td>Rotavirus vaccine 1</td>
<td>Rotavirus</td>
</tr>
<tr>
<td></td>
<td>PCV 1</td>
<td>Pneumonia and Otitis Media</td>
</tr>
<tr>
<td>10 weeks</td>
<td>OPV 2</td>
<td>Polio</td>
</tr>
<tr>
<td></td>
<td>Pentavalent 2</td>
<td>DPT, Hib and Hepatitis B</td>
</tr>
<tr>
<td></td>
<td>Rotavirus vaccine 2</td>
<td>Rotavirus</td>
</tr>
<tr>
<td></td>
<td>PCV 2</td>
<td>Pneumonia and Otitis Media</td>
</tr>
<tr>
<td>14 weeks</td>
<td>OPV 3</td>
<td>Polio</td>
</tr>
<tr>
<td></td>
<td>Pentavalent 3</td>
<td>DPT, Hib and Hepatitis B</td>
</tr>
<tr>
<td></td>
<td>PCV 3</td>
<td>Rotavirus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pneumonia and Otitis Media</td>
</tr>
<tr>
<td>9 months</td>
<td>Measles vaccine</td>
<td>Measles</td>
</tr>
<tr>
<td></td>
<td>Yellow fever vaccine</td>
<td>Yellow fever</td>
</tr>
</tbody>
</table>

The Nigerian Federal Ministry of Health considers a child fully immunized if he/she receives by the first birthday:

- BCG vaccine
- 3 doses of DPT vaccine
- 3 doses of polio vaccine
- Measles vaccine
Vaccination:
New ideational metrics
Innovative MNCH+N ideational metrics

- Limited ideational research for MNCH+N in contrast to FP and malaria

- Need to develop new MNCH+N ideational questions for BSS using theory-based design and by adapting questions from other settings or health areas

- Adapted WHO vaccine hesitancy metrics for northwestern Nigeria

- BSS ideational questions were reviewed by B-A, USAID and other experts

- BSS asked a limited set of ideational questions within each health area
# Vaccination ideational metrics

## Adapted WHO vaccine hesitancy metrics for northwestern Nigeria

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Domain</th>
<th>Likert-scale statement or question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td>Knowledge</td>
<td>At what age should a child go for his/her first routine vaccination?</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Beliefs about vaccine safety and efficacy</td>
<td>In your opinion, how effective are childhood vaccines?</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Beliefs about vaccine safety and efficacy</td>
<td>Many of the illnesses that vaccines are severe</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Beliefs about vaccine safety and efficacy</td>
<td>Vaccines have chemicals that can be dangerous to a child’s health</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Beliefs about health services</td>
<td>Immunization services in my community are free</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Beliefs about health services</td>
<td>Most people in my community trust health workers who provide immunization services</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Beliefs about health services</td>
<td>Health facilities in my community frequently have the vaccine you need and when you need it</td>
</tr>
<tr>
<td><strong>Emotional</strong></td>
<td>Self-efficacy</td>
<td>I know where and when to get my child vaccinated</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td>Social influence</td>
<td>Besides yourself, who else may influence your decision to get a child vaccinated?</td>
</tr>
<tr>
<td>Social</td>
<td>Norms</td>
<td>Most parents in my community take their children to the facility for routine immunization</td>
</tr>
<tr>
<td><strong>Intentions</strong></td>
<td>Intentions</td>
<td>If you had another infant today, how likely is it that you would make sure he/she received all of his/her recommended vaccines?</td>
</tr>
</tbody>
</table>

**Main references:**
Vaccination:

Key findings
Key findings by SBC program priorities

1. Behavioral patterns
How frequently do respondents practice the promoted health behaviors? What are the key behavioral patterns by geography or sociodemographic characteristics?

2. Knowledge and Beliefs
Are respondents aware of promoted health behaviors, e.g., how to prevent disease? Are certain beliefs held by respondents that could impede progress?

3. Barriers
How do respondents view health services in their communities? What are the main reasons for choosing certain treatment locations or for not using services at all?

4. Social Influence and Decision-Making
How do health decisions get made in households? Who mainly influences women’s healthcare practices?

5. Ideational Relationships
How important are the individual components of behavioral change frameworks? What ideations should SBC programs target to maximize impact?
1. Behavioral patterns
### Fully vaccinated children 12-23 months

Last-born children 12-23 months who received all basic vaccinations (BCG, measles, polio3, DPT3) to be considered fully immunized by the first birthday

<table>
<thead>
<tr>
<th></th>
<th>Kebbi</th>
<th>Sokoto</th>
<th>Malaria-Only (Zamfara)</th>
<th>Integrated (Kebbi/Sokoto)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3.6</td>
<td>482</td>
<td>4.5</td>
<td>548</td>
</tr>
<tr>
<td><strong>Household wealth quintile</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>1.5</td>
<td>149</td>
<td>1.9</td>
<td>172</td>
</tr>
<tr>
<td>Highest</td>
<td>4.2</td>
<td>81</td>
<td>13.3</td>
<td>82</td>
</tr>
<tr>
<td><strong>Maternal education, highest level attended</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3.7</td>
<td>365</td>
<td>3.6</td>
<td>401</td>
</tr>
<tr>
<td>Secondary or higher</td>
<td>9.3</td>
<td>58</td>
<td>31.2</td>
<td>35</td>
</tr>
</tbody>
</table>
MNCH+N behavioral patterns

**ANC4+**
(High variation: 8.1% poorest vs. 48.9% richest)

**EXCLUSIVE BREASTFEEDING**
(clustering in southwest Kebbi)

**FACILITY DELIVERY**
(High variation: 5.1% poorest vs. 39.0% richest)

**FULLY VACCINATED RATES**
(very low rates across the 3 states)

**DIARRHEA FORMAL CARESEEKING**
(despite relatively high formal care-seeking…)

**DIARRHEA ORS/ZINC USE**
(…lower and more variable ORS/zinc use)
Percent of children aged 12-23 months who received each vaccine type by his/her first birthday

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Coverage Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG vaccination</td>
<td>27.4</td>
</tr>
<tr>
<td>Polio vaccination (3 doses)</td>
<td>26.7</td>
</tr>
<tr>
<td>Measles vaccination (1 dose)</td>
<td>18.0</td>
</tr>
<tr>
<td>DPT vaccination (3 doses)</td>
<td>9.6</td>
</tr>
<tr>
<td>All basic vaccinations</td>
<td>6.3</td>
</tr>
</tbody>
</table>
2. Knowledge and Beliefs
Most women don’t know immunization timing

Only one-quarter (25%) knew that a child should get their first routine vaccination at birth.

Half explicitly stated they don’t know when a child should get their first routine vaccination, while many others gave a wrong response.

At what age should a child be taken for his/her first routine vaccination?

- Don't know
- At birth
- After naming ceremony but before coming out
- Before naming ceremony
- At coming out / six weeks
- Three months
- Other
- After one year

Don't know 45.8
At birth 24.7
Before naming ceremony 10.7
After naming ceremony but before coming out 11.5
Three months
Other
After one year
Some doubts about vaccine efficacy persist ...

In your opinion, how effective are childhood vaccines?

More than one-quarter (28%) of respondents believed vaccines are not effective or were unsure about their effectiveness.
Vaccine beliefs hold back progress...

More than half (54%) believed or were unsure if vaccines have chemicals that are dangerous to children’s health.

43% don’t think (or unsure) that it’s easy for mothers in my community to take children for routine immunizations.
3. Barriers
Among women who did not vaccinate their child ....

One-third (33%) cited **spousal opposition** as the reason for not doing so.

Facility problems (distance, closure and cost), vaccine concerns and fear of needles were also barriers.
4. Social influence and decision-making
Most respondents (73%) cite **spouse/partner** as influencers of vaccination decisions.

Few (5%) respondents cited **health providers** as influencers of vaccine decisions, but their support is critical according to regression analyses.

Besides yourself, who else may influence your decision to vaccinate your child?

- Spouse: 73.0%
- No one else: 22.0%
- Mother-in-law: 7.7%
- Mother: 5.9%
- Health provider: 5.1%
- Friends: 2.7%
- Community or religious leader: 1.3%
Spousal and health provider support is critical

Women who cited health providers as supporting vaccine decisions were 2.6x and 1.6x as likely to have a child get all basic vaccinations and measles vaccine.

Women whose spouses influenced vaccine decisions were 1.6x and 1.4x as likely to have a child get 3 doses of DPT and measles vaccine.

Differences in likelihood are statistically significant at <0.05 level in mixed-effects logistic regression analysis adjusted for ideational and sociodemographic variables, e.g. wealth, age, employment and education (respondent and spouse).
5. Ideational Relationships
Vaccine beliefs are critical for uptake...

Women who believed the illnesses vaccines prevent are severe were 2.6x as likely to have a child get measles vaccine or 3 doses of DPT vaccine.

Women who believed that most people in her community trust immunization health workers were 3.1x as likely to have a child get 3 doses of DPT vaccine.

Differences in likelihood are statistically significant at <0.05 level in mixed-effects logistic regression analysis adjusted for ideational and sociodemographic variables, e.g. wealth, age, employment and education (respondent and spouse).
Is ANC a gateway for downstream MNCH+N?

Women who attended ANC4+ are more than 2x as likely to have a fully vaccinated child than ANC4+ non-users.

Is ANC a “gateway moment” for downstream MNCH+N behaviors? – How to enhance the ANC multiplier effect?

Differences in likelihood are statistically significant at <0.05 level in mixed-effects logistic regression analysis adjusted for ideational and sociodemographic variables, e.g. wealth, age, employment and education (respondent and spouse)
Program Implications
Program implications

Very low and inequitable routine immunization rates

- Nearly all study areas had <10% children 12-23 months who were fully vaccinated
- Despite low rates, wealthiest quintile were 8x more likely to have a fully vaccinated child
- SBC programs must work at multiple societal levels and use different channels to shift societal norms and entrenched behaviors

Focus on the role of men in vaccination decisions

- Spousal opposition was the most cited reason for not vaccinating a child, and women with spousal support were more likely to have vaccinated children
- SBC programs must specifically target men in their messaging and activities
- More research is needed to understand male ideations and behaviors around vaccination
Program implications

Importance of health services quality and trusted providers

• Women with health worker support were more likely to have a fully vaccinated child
• Trust in immunization health workers was significantly associated with DPT3 uptake
• Facility problems (distance, closure and costs) were commonly cited barriers to vaccination
• Programs must address perceived (and actual) health services for immunizations

Tailor SBC messaging to improve vaccine knowledge and dispel myths

• Emphasize vaccine efficacy and awareness of the severity of vaccine-preventable diseases
• Ensure women know when, where and how many times a child should get vaccinated
• Dispel misperceptions that vaccines are dangerous to children’s health and have side effects
• Engage religious and community leaders to shift norms and beliefs about vaccination
What’s next?
Next steps

• Conduct BSS analyses to inform SBC program adaption and scale-up
• Prepare manuscripts and research briefs to disseminate results
• Plan the BSS midline survey (although delays due to COVID-19)
• Present BSS results by specific health area in our webinar series
## Future webinar events

<table>
<thead>
<tr>
<th>Webinar Topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global webinar – BSS results overview</td>
<td>June 11</td>
</tr>
<tr>
<td>National webinar – BSS results overview</td>
<td>June 25</td>
</tr>
<tr>
<td>Pregnancy and childbirth</td>
<td>July 23</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>August 6</td>
</tr>
<tr>
<td>Vaccination</td>
<td>August 20</td>
</tr>
<tr>
<td>Sick child care-seeking and treatment</td>
<td>Sept 3</td>
</tr>
<tr>
<td>Malaria</td>
<td>Sept 17</td>
</tr>
<tr>
<td>Family planning</td>
<td>Sept 30</td>
</tr>
<tr>
<td>Inequalities</td>
<td>Oct 7</td>
</tr>
</tbody>
</table>
Future work and significance

• BSS baseline results are a first step for assessing the effectiveness and cost-benefit of integrated versus malaria-only SBC programs in Nigeria

• Highlight ideations and behaviors during this baseline period to inform SBC program scale-up and adaption

• Present new ideational metrics across MNCH+N areas and quantify their relationship with behavioral outcomes to test behavioral change theories

• Link BSS results with routine program data or health facility records to examine impact of supply- and demand-side factors on service use
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ABOUT BREAKTHROUGH ACTION + RESEARCH

Breakthrough ACTION and Breakthrough RESEARCH are USAID’s flagship programs for social and behavior change working to increase the practices of priority health behaviors for improved health and development outcomes.