1 *Factors associated with routine childhood vaccine uptake and*
2 *reasons for non-vaccination in India: 1998 – 2008*

3 Mark Rohit Francis [a], Heidi Larson [b], Hanna Nohynek [c], Vinohar Balraj [d], Venkata Raghava
4 Mohan [e], Gagandeep Kang [f], J.Pekka Nuorti [a,c, *]

5

6 [a] Department of Epidemiology, SOC Health Sciences, University of Tampere, Tampere, Finland

7 [b] Department of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine,
8 London, UK

9 [c] Department of Health Protection, National Institute for Health and Welfare, Helsinki, Finland

10 [d] Society for Applied Studies, Vellore, Tamil Nadu, India

11 [e] Department of Community Health, Christian Medical College, Vellore, Tamil Nadu, India

12 [f] Division of Gastrointestinal Sciences, Christian Medical College, Vellore, Tamil Nadu, India

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30 * **Corresponding author at:** Department of Epidemiology, SOC Health Sciences, University of Tampere,
31 33520 TAMPERE, Finland; Email: Pekka.Nuorti@uta.fi

32

Abstract

Background: Despite almost three decades of the Universal Immunization Program in India, a little more than half the children aged 12-23 months receive the full schedule of routine vaccinations. We examined socio-demographic factors associated with partial-vaccination and non-vaccination and the reasons for non-vaccination among Indian children during 1998 and 2008.

Methods: Data from three consecutive, nationally-representative, District Level Household and Facility Surveys (1998–99, 2002–04 and 2007–08) were pooled. Multinomial logistic regression was used to identify individual and household level socio-demographic variables associated with the child's vaccination status. The caretaker's reported reasons for non-vaccination were analyzed qualitatively using a previously published framework.

Results: The pooled dataset contained information on 178,473 children 12–23 months of age; 53%, 32% and 15% were fully vaccinated, partially vaccinated and unvaccinated respectively. Compared with the 1998-1999 survey, children in the 2007–2008 survey were less likely to be unvaccinated (Adjusted Prevalence Odds Ratio (aPOR): 0.92, 95%CI = 0.86 – 0.98) but more likely to be partially vaccinated (POR: 1.58, 95%CI = 1.52 – 1.65). Vaccination status was inversely associated with female gender, Muslim religion, lower caste, urban residence and maternal characteristics such as low educational attainment, home delivery, lack of antenatal participation and non-receipt of maternal tetanus vaccination. The mother's reported reasons for non-vaccination indicated gaps in awareness, acceptance and affordability (financial and non-financial costs) related to routine vaccinations.

Conclusions: Persisting socio-demographic disparities related to partial- and non-vaccination were associated with many childhood, maternal and household characteristics.

2

57   Further research investigating the causal pathways through which important maternal and

58   social characteristics influence decision-making for childhood vaccinations is much needed

59   to improve uptake of routine vaccination in India. Also, governmental efforts to increase

60   uptake would benefit from addressing parental fears related to vaccination and improving

61   trust in government health services as part of ongoing social mobilization and

62   communication strategies.

63   **Keywords:** socioeconomic factors, partial or non-vaccination, routine immunization, EPI

64   **Abbreviations:** UIP, Universal Immunization Program; EPI, Expanded Program on

65   Immunization; DLHS, District Level Household and Facility Survey; BCG, Bacillus

66   Calmette-Guerin; DPT, Diphtheria-Pertussis-Tetanus; OPV, Oral Polio Vaccine; NFHS,

67   National Family Health Survey; PSU, Primary Sampling Unit; ANM, Auxiliary Nurse

68   Midwife.

69

70

71

72

73

74

75

76

77

78

Introduction

Globally about one-third of the annual vaccine preventable child deaths or 500,000 deaths occur in India [1,2]. While most vaccine preventable deaths in India are due to pneumonia and diarrhea, complete immunization with existing routine vaccines against tuberculosis, diphtheria, pertussis and tetanus, polio, measles, hepatitis B and *H. influenzae* type b are essential to avert the associated mortality, morbidity and to prevent future outbreaks of these vaccine preventable diseases [3]. However, despite almost three decades of the UIP, the proportion of children aged 12-23 months receiving the full schedule of vaccinations in India is around 61% and for third dose DPT (DPT3) coverage is 72%, still below the global average of 86% [4]. The persisting low routine immunization coverage implies that one in three children born every year still do not receive complete protection against the diseases currently covered by the UIP, placing them at the highest risk of mortality and morbidity [2,5].

India's slow progress to achieving universal immunization for all children has generally been attributed to its sheer population size, high growth rate, geographic and cultural diversity and limited healthcare spending [6,7]. However, large inter-state and inter-district disparities in immunization coverage have helped uncover important supply and demand-side factors associated with uptake of routine vaccinations [7–9]. Supply-side factors generally include a lack of trained personnel to manage and deliver immunization services, poor relationship between health care workers and mothers, inconvenient timing or location of immunization services and even vaccine stock outs [6,8,10]. Demand-side factors associated with routine vaccination uptake however are complex and often multi-faceted. Previous research from India tends to highlight socio-demographic characteristics associated with uptake such as child's gender, order of birth, place of delivery, maternal age at childbirth, parental education, caste and religious preference, household wealth and

4

location (urban or rural) , [6–8,11,12]. Of late, non-socio-demographic demand-side issues

such as awareness regarding the need for and timing of routine childhood vaccinations,

fears regarding some or all routine vaccines and parental beliefs regarding false

contraindications to routine vaccinations have been reported as reasons linked to partial-

vaccination and non-vaccination of Indian children [4,12,13]. As, the Indian Government

aims to boost full immunization coverage of UIP vaccines to 90% through the Mission

Indradhanush initiative by 2020, it is important to track the various socio-demographic and

non-socio-demographic factors influencing suboptimal vaccination over the years to

identify key areas of intervention and further research.

To this end, we used pre-existing, nationally-representative datasets from three rounds of

India's District Level Household and facility Survey's (DLHS) conducted from 1998 to 2008

to: 1) examine the socio-demographic factors associated with vaccination status of

children aged 12 – 23 months at the time of survey (focusing on partial- and non-

vaccination) and 2) categorize the reasons reported for non-vaccination by using the

previously published "5A's Taxonomy for Determinants of Vaccine Uptake" [14], intended

for non-socio-demographic factors.

Methods

Data Source, Sampling and Survey questionnaire

The DLHS cross-sectional surveys are conducted periodically to monitor and assess

reproductive and child health program indicators in every district of India. To date, four

rounds of the DLHS have been completed (DLHS-1 in 1998–99, DLHS-2 in 2002–04,

DLHS-3 in 2007–08 & DLHS-4 in 2012-13). To date, four rounds of the DLHS have been

completed (DLHS-1 in 1998–99, DLHS-2 in 2002–04, DLHS-3 in 2007–08 & DLHS-4 in

2012-13). Data from DLHS-4 were excluded because the survey was not nationally

5

128   representative (DLHS-4 covered 336 of 640 Indian districts). Each DLHS round employed

129   a similar systematic, multi-stage stratified sampling scheme. Additional detail on the

130   survey design and calculation of sampling weights are available in the Appendix and

131   elsewhere [15–18]. Interviews with currently married (or ever married) women and with

132   any adult family member (aged 18 years and above) collected information for the

133   "women's questionnaire" and "household questionnaire" respectively. We used information

134   from the "women's questionnaire" containing relevant information on socio-demographic

135   characteristics and childhood immunization information. The type and number of questions

136   providing information on household, maternal and child characteristics and immunization

137   histories were generally similar for the DLHS surveys, however, there were more

138   questions about child and maternal health from DLHS-1 to DLHS-4 [19] (See Appendix for

139   more details on questionnaire). In the DLHS, immunization histories for the last two

140   surviving children were obtained from the vaccination card of the children. If the

141   vaccination card was not available immunization data were based on maternal recall. The

142   study sample comprised the most recently born children aged 12-23 months at the time of

143   survey to limit the influence of poor maternal recall on immunization histories of older

144   children. Also, for consistency and pooling we further restricted analysis to children of

145   mothers who were currently married (*i.e.* ever-married mothers were excluded as they

146   were only interviewed in DLHS-3) and aged 15 – 44 years at the time of survey (*i.e.*

147   mothers aged >44 years from DLHS-3 were excluded).

148

149

150   **Socio-demographic variables**

6

Individual, household and regional characteristics having a previously reported association with children's vaccination status and with complete data available in the survey datasets were chosen for analysis. Individual characteristics included child-specific characteristics such as gender, age in months and place of birth and maternal characteristics such as mother's age at childbirth, educational attainment, antenatal participation and maternal tetanus vaccination [20–23]. In addition, caste and religious preference of the head of household were selected [22,24]. Household characteristics included urban or rural location and in the absence of a readily available wealth index measure (for DLHS-1), type of dwelling (Mud, semi-cemented or cemented) was used as a proxy measure of household wealth. And, geographical region of residence in India categorized as North, Central, North-East, West and South was used as the regional indicator for adjustment [7]. Further details on the variables are provided in the Appendix.

Outcome variable

The current Indian UIP schedule recommends one dose of BCG vaccine at birth (or as soon as possible), three doses of DPT, OPV and Hepatitis B (added in 2007) or pentavalent vaccine (available in some Indian states since 2011) and OPV vaccination provided at 6, 10 and 14 weeks of age and one dose of measles vaccine at 9 months of age. The main outcome of study was the vaccination status of children 12 – 23 months of age, defined using EPI recommendations which were in use during the surveys as follows [22,25]:

  1) <u>Fully vaccinated</u> – children who received one dose of BCG, three doses of DPT, three doses of OPV (excluding the zero dose) and one dose of measles vaccine by 12 months of age

7

175   2) <u>Partially vaccinated</u> – children who received at least one but not all the

176   recommended vaccines by 12 months of age

177   3) <u>Unvaccinated</u> – children who did not receive any of the recommended vaccines by

178   12 months of age

179

180 **Statistical Analysis**

181 Data from the three DLHS surveys were pooled to examine the socio-demographic factors

182 associated with children's vaccination status over the ten-year period covered by the

183 surveys. Similar pooling of data to assess trends and determine predictors of immunization

184 coverage have been reported using the National Family Health Survey (India's

185 Demographic & Health Survey)) datasets [26]. Because of the complex, stratified sampling

186 design, appropriate weighting of coverage proportions and regression estimates was done

187 using the supplied national sampling weights for each survey. Univariate regression

188 analysis was performed to examine associations between the socio-demographic

189 variables and children's vaccination status for all surveys combined (see Appendix for

190 technical details). All the socio-demographic variables which had a significant univariate

191 association with vaccination status at the p≤ 0.05 level were included in the multivariate

192 regression analysis to examine factors associated with partial-vaccination and non-

193 vaccination compared with full vaccination for children aged 12 – 23 months [22]. Also,

194 since the outcome of children's vaccination status had three levels, a pooled multinomial

195 logistic regression adjusted for age of the child, type of dwelling, survey period and

196 geographic region. Results of the multivariate regression modelling are presented as

197 adjusted Prevalence Odds Ratio's (aPOR's) with 95% Confidence Interval's (CIs). The

198 relative importance of each socio-demographic variable in the multivariate regression

199 model was assessed using Wald Test *p*-values. We also performed secondary analyses

8

restricting the analytical sample to the partially vaccinated children to explore differences

in the factors associated with vaccination status based on whether children received "very

few" vaccines (1 – 2 doses), "some" vaccines (3 – 5 doses) or "almost all" vaccines (6 – 7

doses). The survey analyses were performed using the "*svy*" package in STATA version

12 and figures made using Excel 2013.

Categorization of reasons for non-vaccination

In the DLHS "women's questionnaire", mothers whose children had not received even a

single dose of recommended UIP vaccines were asked to choose either one important

reason (DLHS-1 & DLHS-2) or one or more reasons (DLHS-3) from a list of pre-

determined responses to the question "Why was your child not given any vaccination?". To

organize the reported reasons for non-vaccination we used a semi-qualitative, framework-

based methodology to categorize individual responses (separately for each survey) using

the recently published "5A's Taxonomy for Determinants of Vaccine Uptake" to help

identify the important underlying reasons for non-vaccination among Indian children [14].

The working definitions for each of the root causes in the 5As taxonomy are presented in

Table 1.

Results

There were a total of 58,777 (31% of all surveyed children), 58,416 (30%), 61,280 (28%)

and 178,473 (30%) eligible children aged 12 – 23 months in the DLHS-1, DLHS-2, DLHS-3

and the combined surveys respectively. Of these children, 74% lived in rural locations and

38% in mud households. Fifty-three percent of the children were male and 78% of the

children were Hindu (Supplemental Table 1). Also, 50% of the children had mothers

without any formal schooling and 59% of mothers had non-institutional deliveries.

9

224   Coverage of important UIP vaccine doses and children's vaccination status for the

225   individual and combined surveys are presented in Table 2. Of the eligible children, 32%

226   did not have a vaccination card and 30% reportedly had vaccination cards which could not

227   be presented at the time of survey. Overall, coverage of BCG vaccination was highest

228   (81%) and coverage of the third dose DPT (DPT3) vaccine was 62%, similar to third dose

229   OPV (68%) and first dose measles (66%) vaccines. Coverage of BCG and measles

230   vaccination increased from 74 % to 87% and 60% to 74% respectively from 1998-1999

231   (DLHS-1) to 2007-2008 (DLHS-3). However, DPT3 coverage decreased from 66% to 61%

232   for the same period. Fifty-three percent of the eligible children were fully vaccinated, with

233   32.1% and 14.6% partially vaccinated and unvaccinated respectively. The proportion of

234   unvaccinated children was reduced from 18% to 9% and the proportion of partially

235   vaccinated children increased from 27% to 35% from the 1998-1999 (DLHS-1) period to

236   the 2007-2008 (DLHS-3) period.

237   Results of the pooled multivariate analysis are presented in Table 3. Children in the 2007-

238   2008 (DLHS-3) period were less likely to be unvaccinated (aPOR: 0.92, 95%CI = 0.86 –

239   0.98) and more likely to be partially vaccinated compared to the 1998 -1999 period (DLHS-

240   1) (aPOR: 1.58, 95% CI = 1.52 – 1.65). After adjusting for age of the child, type of

241   dwelling, survey period and geographic region, female children were more likely to be

242   unvaccinated than males (aPOR: 1.16, 95%CI = 1.10 – 1.21)and children born at home

243   were more likely to be unvaccinated and partially vaccinated compared to children born in

244   governmental institutions. Children living in urban households (compared with rural

245   households) were more likely to be unvaccinated (aPOR: 1.37, 95% CI = 1.26 –

246   1.49).Compared to Hindu children, Muslim children were more likely to be unvaccinated

247   (aPOR: 2.03, 95% CI = 1.89 – 2.18) and partially vaccinated (aPOR: 1.44, 95%CI = 1.37 –

248   1.51).And, relative to children belonging to the general class, those belonging to scheduled

10

caste and other backward classes were more likely to be unvaccinated. Decreasing

maternal education, antenatal care participation, non-receipt of maternal tetanus

vaccination and non-retention of children's vaccination cards were similarly associated

with increased odds of children being unvaccinated and partially vaccinated. The findings

of the secondary analysis restricting the analytical sample to the partially vaccinated

children were generally consistent with those of the primary analysis (see supplemental

Table 2).

Across the three surveys, the most frequently occurring reason for non-vaccination was

that mothers were "unaware of the need for immunization" (Figure 1). Other noteworthy

reasons were not knowing the place for and timing of vaccinations, fear of side-effects

following vaccination, access to immunization facilities ("place of immunization too far")

and the absence of health workers ("ANM absent"). Most reported reasons for non-

vaccination could be categorized as issues of awareness, acceptance or affordability. Four

of the 17 reported reasons, mainly involving supply-side issues such as absence of health

workers, vaccine stock outs and missed opportunities for vaccination could not be

classified using the 5As taxonomy domains. Over the ten years spanning the surveys,

issues of poor parental awareness (regarding the need for, place and timing of

immunizations), acceptance of vaccines (including fear of side effects, lack of trust and

false contraindications) and affordability (financial and non-financial costs) were the most

important underlying reasons for non-vaccination among children aged 12-23 months in

India (Figure 2).

Discussion

11

India has the largest number of unvaccinated children globally. Our research indicates that the proportion of unvaccinated children decreased between 1998 and 2008, the proportion of partially vaccinated children increased slightly for the same period, concurring with previous reports from India [27,28].The increase in partially vaccinated children, while suboptimal, possibly implies that greater numbers of children are receiving at least some of the recommended UIP vaccines compared with earlier years. Persisting socio-demographic disparities in children's vaccination status were found associated with individual characteristics such as child gender, mother's education, maternal antenatal participation, receipt of maternal tetanus vaccination, place of delivery, religious preference and caste. And, most reported reasons for non-vaccination could be categorized as issues of awareness, acceptance and affordability related to routine childhood vaccinations.

Of the many potential demand-side factors, social determinants are known to have a significant impact on routine immunization programs in countries regardless of their income level [29]. They are also considered indicators of inequalities in access to immunization services or uptake of vaccinations among different populations [29,30]. In this study, children were more likely to be partially vaccinated in urban areas compared to rural areas, similar to the findings of a recent study using data from DLHS-3 [22]. An important reason for this might be the presence of underserved populations living in urban slums with limited access to primary health infrastructure and consequently routine immunization services compared to non-slum urban and rural dwellers [21,22]. Additionally, female children were more likely to be unvaccinated than males, potentially highlighting the chronic issue of gender discrimination for preventive health care within some Indian households [11,20].

Lower maternal education and antenatal participation, non-institutional delivery and non-receipt of maternal tetanus vaccination were found associated with higher odds of children being partially vaccinated and unvaccinated. The pathways through which maternal characteristics may influence immunization decisions for children are complex [31]. For example, previous research from India highlights the role of health knowledge and the ability to communicate in mediating the effect of maternal education on childhood immunization decisions [31]. Interventions to improve utilization of maternal health services, may help improve childhood immunization outcomes [22].It is unclear if the associations between religion and caste with children's vaccination status represent differential access to routine immunization services or perceived barriers, health beliefs and lack of awareness regarding vaccinations in general [22,30]. Further research disentangling the role of supply-side and demand-side barriers to immunization and investigating the causal pathways through which important maternal and social characteristics influence decision-making for childhood vaccinations is much needed to inform governmental interventions to improve uptake of routine vaccination in India.

Since socio-demographic characteristics are often difficult to interpret and modify, we also attempted to organize mother's reported reasons for not vaccinating their children using the "5As Taxonomy for Determinants of Vaccine Uptake", intended for non-socio-demographic determinants [14]. In addition to gaps in awareness, the categorization helped identify issues of acceptance and affordability as other important underlying reasons for non-vaccination among Indian children. These findings suggest that governmental communication strategies to increase immunization coverage focusing on improving parental knowledge alone may not be sufficient to change vaccination behavior as previously indicated [32]. Although models elucidating parental decision-making for childhood vaccinations are available, studies examining the applicability of the existing

13

theoretical frameworks in India are not available and the complex interplay of several

social, cultural, political, economic and religious influences on parental decision-making for

childhood vaccinations in India make the use of existing frameworks difficult. Therefore,

contextual research investigating these factors in India is needed to develop interventions

to improve vaccination acceptance rates [33–35]. Past and recent reports of vaccine

refusal related to the OPV and DPT vaccines from different parts of the country and

clustering of vaccine-refusing households can provide some insights on other dynamics

affecting vaccine decisions. [36–38]. Expanding and leveraging the successful Social

Mobilization Network (SMNet) approach used in the National Polio Eradication

Programme, incorporating the use of local religious leaders and community influencers

may improve trust between parents and health providers [39]. The Indian UIP may also

consider parental time constraints through the organization of regular catch-up sessions

for missed vaccinations and the wider use of mobile immunization reminder services such

as the "vRemind" and "IAP-ImmunizeIndia" to help reduce India's immunization gap [40,41].

Large-scale, periodic surveys providing data on health indicators in India such as the

DLHS and National Family Health Survey (NFHS) have typically focused on capturing a

wide range of maternal and child health outcomes, including details on recommended

vaccinations for the most recently born children [19]. As the DLHS survey is currently

combined with the National Family Health Survey, it is important for future NFHS "women's

questionnaires" to include questions on why children missed some or all vaccinations [17].

As demonstrated in this study, it is possible to categorize mother's reported reasons using

an analytical framework such as the 5As Taxonomy to aid identification of the possible root

causes for suboptimal vaccination among Indian children. To better capture issues of

parental "acceptance" of childhood vaccination, the Parent Attitudes about Childhood

Vaccination (PACV) short scale could be adapted for use in the NFHS surveys [42]. Also,

14

since supply-side issues were consistently reported as important reasons for non-vaccination by mothers across the surveys, it may be valuable to include an additional dimension (a sixth "A") such as the "availability" of vaccinators, vaccines and timely vaccination services to the 5As Taxonomy, especially for use in developing countries such as India. Comparison of the 5As taxonomy categorization to standard categories (supply or demand-side) and the "Classification of Factors Affecting Receipt of Vaccines" are presented in Supplemental Table 3 [43].

Among the important limitations of this study, the first is the use of relatively old datasets for analysis. The analysis was restricted to the first three DLHS rounds since the fourth round (DLHS-4) was not nationally-representative. Furthermore, the NFHS datasets could not be utilized for analysis as its fourth round is currently underway and it does not include mother's reasons for not vaccinating their children. Even still, the use of the first three rounds of the DLHS datasets allowed pooling for the study sample, increasing analytical power and facilitating investigation of the various socio-demographic factors associated with suboptimal vaccination which are unlikely to change drastically over time. Second, the vaccination status of children was categorized using maternal recall in addition to vaccination card information. Because of differential recall, estimates of vaccine coverage and vaccination status may have been under or overestimated (Supplemental Table 4). Many earlier studies from India have conducted similar analyses combining immunization information based on maternal recall and vaccination cards and in our study, a vast majority of the unvaccinated children (89%) would have been excluded if the analyses were restricted to information based on maternal recall alone [7,12,22,23,26,28,44,45]. Third, a recent study observed age misreporting and likely underreporting of recent pregnancies among female respondents, highlighting potential selection and information biases in large scale surveys such as the DLHS [46]. Fourth, the DLHS surveys were cross-sectional in

15

371 design, limiting the ability to draw causal inference from the observed associations. Fifth,

372 the association of important characteristics such as parental employment, birth order and

373 household size with vaccination status could not be assessed as those data was

374 incomplete. Sixth, the wealth index for households in the first DLHS survey (DLHS-1) was

375 not available, therefore type of dwelling was used as an "absolute" measure of household

376 wealth to help quantify the level of poverty of survey households as opposed to wealth

377 indices which are "relative" measures of wealth generally created using Demographic and

378 Health Survey data [47].

379

380 **Conclusions**

381 This study utilized mixed methods to examine the socio-demographic and non-socio-

382 demographic factors influencing suboptimal routine vaccination among Indian children.

383 Persisting socio-demographic disparities in children's vaccination status were found to be

384 associated with important childhood, maternal and household characteristics. This analysis

385 found that gaps in awareness, acceptance and affordability (financial and non-financial

386 costs) were the most important underlying reasons for non-vaccination among Indian

387 children, but further research investigating the causal pathways through which important

388 maternal and social characteristics influence decision-making for childhood vaccinations is

389 much needed to improve uptake of routine vaccination in India. Governmental efforts to

390 increase uptake would benefit from addressing parental fears related to vaccination and

391 improving trust in government health services as part of ongoing social mobilization and

392 programmatic communication strategies.

393

394 **Authors' contributions**

16

395 Study concept and design: MRF, JPN; Acquisition of data: MRF; Analysis and

396 interpretation of data: MRF, JPN; Drafting of the manuscript: MRF, JPN; Critical revision of

397 the manuscript for important intellectual content: All authors; Statistical analysis: MRF;

398 Obtained funding: JPN; Study supervision: JPN; Final approval: All authors

402 **Conflict of interest**

403 The LSHTM (to which HL belongs) have received funding from Novartis for maternal

404 immunization acceptance research; funding from GSK for advising on vaccine hesitancy

405 issues; and funding from both GSK and Merck to convene research symposiums. HJL

406 served on the Merck Vaccines Strategic Advisory Board. None of the funders had any role

407 in the preparation of this paper and none of the other authors declare any competing

408 interests.

409

410

411 **References**

412 [1] Black RE, Cousens S, Johnson HL, Lawn JE, Rudan I, Bassani DG, et al. Global,

413   regional, and national causes of child mortality in 2008: a systematic analysis. The

414   Lancet 2010;375:1969–87. doi:10.1016/S0140-6736(10)60549-1.

415 [2] Vashishtha VM, Kumar P. 50 years of immunization in India: progress and future.

416   Indian Pediatr 2013;50:111–8.

17

[3] Liu L, Johnson HL, Cousens S, Perin J, Scott S, Lawn JE, et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. The Lancet 2012;379:2151–61. doi:10.1016/S0140-6736(12)60560-1.

[4] India Coverage Evaluation Survey 2009-2010 | GHDx n.d. http://ghdx.healthdata.org/record/india-coverage-evaluation-survey-2009-2010 (accessed November 8, 2016).

[5] Mission Indradhanush to Put Vaccination Efforts on High Speed n.d. http://pib.nic.in/newsite/mbErel.aspx?relid=117759 (accessed January 5, 2017).

[6] Laxminarayan R, Ganguly NK. India's Vaccine Deficit: Why More Than Half Of Indian Children Are Not Fully Immunized, And What Can—And Should—Be Done. Health Aff (Millwood) 2011;30:1096–103. doi:10.1377/hlthaff.2011.0405.

[7] Singh PK. Trends in Child Immunization across Geographical Regions in India: Focus on Urban-Rural and Gender Differentials. PLoS ONE 2013;8:e73102. doi:10.1371/journal.pone.0073102.

[8] Barman D, Dutta A. Access and Barriers to Immunization in West Bengal, India: Quality Matters. J Health Popul Nutr 2013;31:510–22.

[9] Johri M, Chandra D, Koné GK, Dudeja S, Sylvestre M-P, Sharma JK, et al. Interventions to increase immunisation coverage among children 12–23 months of age in India through participatory learning and community engagement: pilot study for a cluster randomised trial. BMJ Open 2015;5:e007972. doi:10.1136/bmjopen-2015-007972.

[10]　　　Jheeta M, Newell J. Childhood vaccination in Africa and Asia: the effects of parents' knowledge and attitudes. Bull World Health Organ 2008;86:419.

18

441 [11]   Corsi DJ, Diego BG, Kumar R, Awasthi S, Jotkar R, Kaur N, et al. Gender

442   inequity and age-appropriate immunization coverage in India from 1992 to 2006. BMC

443   Int Health Hum Rights 2009;9:S3. doi:10.1186/1472-698X-9-S1-S3.

444 [12]   Ghosh A, Laxminarayan R. Demand- and supply-side determinants of

445   diphtheria-pertussis-tetanus nonvaccination and dropout in rural India. Vaccine

446   2017;35:1087–93. doi:10.1016/j.vaccine.2016.12.024.

447 [13]   Favin M, Steinglass R, Fields R, Banerjee K, Sawhney M. Why children are

448   not vaccinated: a review of the grey literature. Int Health 2012;4:229–38.

449   doi:10.1016/j.inhe.2012.07.004.

450 [14]   Thomson A, Robinson K, Vallée-Tourangeau G. The 5As: A practical

451   taxonomy for the determinants of vaccine uptake. Vaccine 2016;34:1018–24.

452   doi:10.1016/j.vaccine.2015.11.065.

453 [15]   International Institute for Population Sciences (IIPS). Reproductive and Child

454   Health Project, Rapid Household Survey (Phase I and II) 1998 - 1999: India 2001.

455 [16]   International Institute for Population Sciences (IIPS). District Level Household

456   and Facility Survey (DLHS - 2), 2002 - 2004: India 2006.

457 [17]   International Institute for Population Sciences (IIPS). District Level Household

458   and Facility Survey (DLHS - 3), 2007 - 2008: India 2010.

459 [18]   International Institute for Population Sciences (IIPS). District Level Household

460   and Facility Survey (DLHS - 4), 2012 - 2013: India 2014.

461 [19]   Dandona R, Pandey A, Dandona L. A review of national health surveys in

462   India. Bull World Health Organ 2016;94:286–296A. doi:10.2471/BLT.15.158493.

463 [20]   Mathew JL. Inequity in childhood immunization in India: A systematic review.

464   Indian Pediatr 2012;49:203–23. doi:10.1007/s13312-012-0063-z.

465 [21]   Devasenapathy N, Jerath SG, Sharma S, Allen E, Shankar AH, Zodpey S.

466   Determinants of childhood immunisation coverage in urban poor settlements of Delhi,

467   India: a cross-sectional study. BMJ Open 2016;6:e013015. doi:10.1136/bmjopen-2016-

468   013015.

469 [22]   Shrivastwa N, Gillespie BW, Kolenic GE, Lepkowski JM, Boulton ML.

470   Predictors of Vaccination in India for Children Aged 12–36 Months. Am J Prev Med

471   2015;49:S435–44. doi:10.1016/j.amepre.2015.05.008.

472 [23]   Sissoko D, Trottier H, Malvy D, Johri M. The Influence of Compositional and

473   Contextual Factors on Non-Receipt of Basic Vaccines among Children of 12-23-Month

474   Old in India: A Multilevel Analysis. PLOS ONE 2014;9:e106528.

475   doi:10.1371/journal.pone.0106528.

476 [24]   Pande RP, Yazbeck AS. What's in a country average? Wealth, gender, and

477   regional inequalities in immunization in India. Soc Sci Med 1982 2003;57:2075–88.

478 [25]   Keja K, Chan C, Hayden G, Henderson RH. Expanded programme on

479   immunization. World Health Stat Q Rapp Trimest Stat Sanit Mond 1988;41:59–63.

480 [26]   Kumar C, Singh PK, Singh L, Rai RK. Socioeconomic disparities in coverage

481   of full immunisation among children of adolescent mothers in India, 1990–2006: a

482   repeated cross-sectional analysis. BMJ Open 2016;6:e009768. doi:10.1136/bmjopen-

483   2015-009768.

484 [27]   Kumar A, Mohanty SK. Socio-economic differentials in childhood

485   immunization in India, 1992–2006. J Popul Res 2011;28:301. doi:10.1007/s12546-011-

486   9069-y.

487 [28]   Prusty RK, Kumar A. Socioeconomic Dynamics of Gender Disparity in

488   Childhood Immunization in India, 1992–2006. PLoS ONE 2014;9:e104598.

489   doi:10.1371/journal.pone.0104598.

20

490 [29]   Glatman-Freedman A, Nichols K. The effect of social determinants on

491   immunization programs. Hum Vaccines Immunother 2012;8:293–301.

492   doi:10.4161/hv.19003.

493 [30]   Rainey JJ, Watkins M, Ryman TK, Sandhu P, Bo A, Banerjee K. Reasons

494   related to non-vaccination and under-vaccination of children in low and middle income

495   countries: Findings from a systematic review of the published literature, 1999–2009.

496   Vaccine 2011;29:8215–21. doi:10.1016/j.vaccine.2011.08.096.

497 [31]   Vikram K, Vanneman R, Desai S. Linkages between Maternal Education and

498   Childhood Immunization in India. Soc Sci Med 1982 2012;75:331–9.

499   doi:10.1016/j.socscimed.2012.02.043.

500 [32]   Nyhan B, Reifler J, Richey S, Freed GL. Effective Messages in Vaccine

501   Promotion: A Randomized Trial. Pediatrics 2014:peds.2013-2365.

502   doi:10.1542/peds.2013-2365.

503 [33]   Janz NK, Becker MH. The Health Belief Model: a decade later. Health Educ Q

504   1984;11:1–47. doi:10.1177/109019818401100101.

505 [34]   Godin G, Kok G. The theory of planned behavior: a review of its applications

506   to health-related behaviors. Am J Health Promot AJHP 1996;11:87–98.

507 [35]   Public trust in vaccination: an analytical framework | Indian Journal of Medical

508   Ethics n.d. http://ijme.in/articles/public-trust-in-vaccination-an-analytical-

509   framework/?galley=html (accessed May 26, 2017).

510 [36]   Onnela J-P, Landon BE, Kahn A-L, Ahmed D, Verma H, O'Malley AJ, et al.

511   Polio vaccine hesitancy in the networks and neighborhoods of Malegaon, India. Soc

512   Sci Med 1982 2016;153:99–106. doi:10.1016/j.socscimed.2016.01.024.

513 [37]   Orr D. India's last bastion of polio at "tipping point." Bull World Health Organ

514   2007;85:828–9. doi:10.2471/BLT.07.031107.

21

515   [38]   Polio risk over dose refusal. The Telegraph n.d.

516   http://www.telegraphindia.com/1160405/jsp/bihar/story_78360.jsp (accessed

517   December 7, 2016).

518   [39]   Siddique AR, Singh P, Trivedi G. Role of Social Mobilization (Network) in Polio

519   Eradication in India. Indian Pediatr 2016;53 Suppl 1:S50–6.

520   [40]   vRemind - Immunisation Awareness and Vaccination Reminders n.d.

521   http://vremind.org/ (accessed January 13, 2017).

522   [41]   Immunize India n.d. http://immunizeindia.org/ (accessed January 16, 2017).

523   [42]   Oladejo O, Allen K, Amin A, Frew PM, Bednarczyk RA, Omer SB.

524   Comparative analysis of the Parent Attitudes about Childhood Vaccines (PACV) short

525   scale and the five categories of vaccine acceptance identified by Gust et al. Vaccine

526   2016. doi:10.1016/j.vaccine.2016.08.046.

527   [43]   Hadler S, Dietz V, Okwo-Bele J, Cutts FT. Immunization in developing

528   countries. Vaccines. 5th edition, 2008, p. 1541–72.

529   [44]   Valadez JJ, Weld LH. Maternal recall error of child vaccination status in a

530   developing nation. Am J Public Health 1992;82:120–2. doi:10.2105/AJPH.82.1.120.

531   [45]   George K, Victor S, Abel R. Reliability of mother as an informant with regard

532   to immunisation. Indian J Pediatr 1990;57:588–90.

533   [46]   Borkotoky K, Unisa S. Indicators to Examine Quality of Large Scale Survey

534   Data: An Example through District Level Household and Facility Survey. PLoS ONE

535   2014;9. doi:10.1371/journal.pone.0090113.

536   [47]   Morris SS, Carletto C, Hoddinott J, Christiaensen LJM. Validity of rapid

537   estimates of household wealth and income for health surveys in rural Africa. J

538   Epidemiol Community Health 2000;54:381–7. doi:10.1136/jech.54.5.381.

539

22

542 **Tables**

543 **Table 1:** Definitions and contributing factors of the "5As Taxonomy for Determinants of
544 Vaccine Uptake" [14]

Root causes	Definition
Access	The ability of individuals to be reached by, or to reach, recommended vaccines
Affordability	The ability of individuals to afford vaccination, both in terms of financial and non-financial costs (e.g. time)
Awareness	The degree to which individuals have knowledge of the need for, and availability of, recommended vaccines and their objective benefits and risks
Acceptance	The degree to which individuals accept, question or refuse vaccination
Activation	The degree to which individuals are nudged towards vaccination uptake

545

546

547

548 **Table 2:** Vaccination proportions for Indian children aged 12 - 23 months, DLHS1-3

Category	Weighted percentages (95% CI)				Relative change (%)*	P-value **
	DLHS-1 (1998-99)	DLHS-2 (2002-04)	DLHS-3 (2007-08)	Combined surveys (DLHS 1 - 3)		
Vaccination card						
No	35.1 (34.5 - 35.6)	39.6 (38.9 - 40.5)	25.1 (24.6 - 25.7)	31.5 (31.1 - 31.9)	-28.4	
Yes (not seen)	30.8 (30.3 - 31.3)	29.0 (28.4 - 29.5)	31.0 (30.6 - 31.4)	30.4 (30.1 - 30.7)	0.6	<0.001
Yes (seen)	34.1 (33.6 - 34.7)	31.4 (30.7 - 32.1)	43.9 (43.3 - 44.4)	38.1 (31.1 - 31.9)	28.7	
BCG	73.9 (73.4 - 74.4)	75.4 (74.7 - 76.1)	87.4 (87.0 - 87.8)	80.7 (80.4 - 81.0)	18.3	<0.001
DPT3	65.9 (65.3 - 66.4)	58.6 (57.8 - 59.3)	60.8 (60.3 - 61.4)	62.2 (61.8 - 62.6)	-7.0	<0.001
OPV3	67.9 (67.3 - 68.4)	59.4 (58.6 - 60.2)	71.2 (71.4 - 72.4)	67.5 (67.1 - 67.9)	4.9	<0.001
Measles	60.0 (59.3 - 60.5)	56.8 (56.0 - 57.6)	73.9 (73.4 - 74.4)	65.7 (65.2 - 66.1)	23.2	<0.001

Fully vaccinated	54.3 (53.7 - 54.9)	47.9 (47.1 - 48.7)	56.0 (55.5 - 56.6)	53.4 (52.9 - 53.8)	3.1	
Partially vaccinated	27.4 (26.9 - 27.9)	32.1 (31.5 - 32.8)	34.6 (34.2 - 35.1)	32.1 (31.7 - 32.4)	26.3	
Very few (1 - 2)	18.3 (17.5 - 19.2)	17.5 (16.1 - 18.8)	11.4 (10.9 - 11.8)	14.6 (14.0 - 15.2)	-37.7	<0.001
Some (3 - 5)	32.8 (31.7 - 33.9)	35.5 (34.4 - 36.6)	35.8 (34.9 - 36.7)	35.0 (34.5 - 35.6)	9.1	
Almost all (6 - 7)	48.9 (47.9 - 49.8)	47.0 (45.3 - 48.8)	52.8 (51.9 - 53.8)	50.4 (49.5 - 51.2)	7.9	
Unvaccinated	18.3 (17.9 - 18.8)	20.0 (19.4 - 20.6)	9.4 (9.0 - 9.7)	14.5 (14.3 - 14.9)	-48.6	

549 N = 58 777, 58 416 & 61 279 for DLHS-1, DLHS-2 & DLHS-3 respectively

550 BCG: Bacillus Calmette - Guerin, DPT: Diptheria-Pertussis-Tetanus, OPV: Oral Polio Vaccine

551 *Relative change calculated as ((DLHS1%/DLHS3%)-1)

552 **P-value of trend from Chi-square using Rao-Scott design adjustment

553

554

555 **Table 3:** Results of multivariate regression modeling for pooled DLHS datasets

	Weighted proportions (95%CI)*			Adjusted Prevalance Odds Ratio (95% CI)**	
Covariates	**Fully-vaccinated**	**Partially-vaccinated**	**Unvaccinated**	**Unvaccinated versus full vaccination**	**Partial versus full vaccination**
Survey period					
1998 - 1999	54.3 (53.7 - 54.9)	27.4 (26.9 - 27.9)	18.3 (17.9 - 18.8)	**Ref**	
2002 - 2004	47.9 (47.1 - 48.7)	32.1 (31.5 - 32.8)	20.0 (19.4 - 20.6)	1.57 (1.47 - 1.67)	1.51 (1.44 - 1.58)
2007 - 2008	56.0 (55.5 - 56.6)	34.6 (34.2 - 35.1)	9.4 (9.0 - 9.7)	0.92 (0.86 - 0.98)	1.58 (1.52 - 1.65)
Location					
Rural	49.4 (48.6 - 50.2)	32.3 (32.0 - 32.7)	18.3 (17.7 - 18.9)	**Ref**	
Urban	65.2 (63.8 - 66.6)	25.1 (24.0 - 26.2)	9.7 (9.2 - 10.3)	1.37 (1.26 - 1.49)	1.03 (0.98 - 1.07)
Religion					
Hindu	54.3 (52.9 - 55.7)	30.7 (30.1 - 31.2)	15.0 (14.1 - 15.9)	**Ref**	
Muslim	43.9 (42.4 - 45.4)	31.7 (30.9 - 32.5)	24.4 (23.2 - 25.6)	2.03 (1.89 - 2.18)	1.44 (1.37 - 1.51)
Christian	58.8 (56.5 - 61.1)	29.0 (27.6 - 30.5)	12.2 (10.8 - 13.5)	0.90 (0.76 - 1.07)	1.01 (0.92 - 1.12)

24

Other***	70.5 (69.0 - 72.0)	21.6 (20.2 - 22.9)	7.9 (7.1 - 8.8)	0.58 (0.50 - 0.69)	0.62 (0.56 - 0.67)
Social class					
General class	50.6 (49.5 - 51.7)	31.6 (30.9 - 32.3)	17.8 (16.8 - 18.7)	**Ref**	
Scheduled caste	47.1 (45.4 - 48.7)	35.7 (34.8 - 36.7)	17.2 (16.2 - 18.2)	1.29 (1.20 - 1.39)	1.11 (1.06 - 1.16)
Scheduled tribe	51.1 (49.8 - 52.4)	30.9 (30.3 - 31.6)	18.0 (17.0 - 18.9)	1.09 (0.99 - 1.19)	1.04 (0.98 - 1.11)
Other backward classes	61.7 (60.5 - 62.9)	26.5 (25.8 - 27.2)	11.8 (11.1 - 12.5)	1.42 (1.34 - 1.52)	1.16 (1.12 - 1.21)
Mother's age at birth of eligible child					
≤ 18	48.2 (46.7 - 49.8)	34.5 (33.5 - 35.4)	17.3 (16.1 - 18.5)	1.21 (1.12 - 1.32)	1.23 (1.17 - 1.30)
19-25	56.8 (55.7 - 57.9)	30.2 (29.7 - 30.7)	13.0 (12.3 - 13.7)	**Ref**	
26-35	51.2 (49.6 - 52.9)	29.6 (28.8 - 30.4)	19.2 (18.1 - 20.2)	1.05 (0.99 - 1.10)	0.95 (0.92 - 0.98)
> 35	37.8 (35.8 - 39.8)	31.0 (29.7 - 32.4)	31.1 (29.4 - 32.9)	1.19 (1.08 - 1.32)	0.95 (0.88 - 1.03)
Mother's education					
High school and above (9 years & above)	76.9 (76.2 - 77.5)	20.3 (19.7 - 20.8)	2.8 (2.6 - 3.1)	**Ref**	
Middle (6 - 8 years of schooling)	65.1 (64.3 - 66.0)	28.2 (27.4 - 28.9)	6.7 (6.3 - 7.1)	1.17 (1.03 - 1.33)	1.19 (1.13 - 1.26)
Primary (1 - 5 years of schooling)	56.2 (55.4 - 56.9)	32.6 (31.8 - 33.3)	11.2 (10.7 - 11.8)	1.50 (1.32 - 1.70)	1.33 (1.27 - 1.41)
No schooling	37.4 (36.5 - 38.1)	35.8 (35.5 - 36.2)	26.8 (26.1 - 27.6)	2.61 (2.33 - 2.93)	1.77 (1.68 - 1.86)
Number of antenatal care visits					
≥ 7	78.5 (77.5 - 79.5)	18.6 (17.7 - 19.5)	2.9 (2.6 - 3.2)	**Ref**	
3 - 6	68.7 (68.1 - 69.3)	26.3 (25.8 - 26.8)	5.0 (4.7 - 5.3)	0.68 (0.58 - 0.80)	1.13 (1.06 - 1.20)
1 - 2	50.4 (49.6 - 51.1)	37.1 (36.5 - 37.7)	12.5 (12.1 - 13.0)	1.09 (0.92 - 1.28)	1.60 (1.50 - 1.70)
None	29.1 (28.3 - 30.1)	35.1 (34.6 - 35.6)	35.8 (34.9 - 36.7)	1.75 (1.50 - 2.06)	1.92 (1.78 - 2.07)
Maternal tetanus vaccination					
Yes	61.7 (60.7 - 62.7)	29.1 (28.5 - 29.7)	9.2 (8.7 - 9.7)	**Ref**	
No	26.2 (25.2 - 27.1)	35.1 (34.5 - 35.6)	38.7 (37.6 - 39.9)	2.82 (2.64 - 3.01)	1.35 (1.29 - 1.42)

Gender of eligible child					
Male	54.4 (53.1 - 55.7)	30.4 (29.8 - 31.1)	15.2 (14.4 - 16.0)	**Ref**	
Female	52.4 (51.1 - 53.4)	30.5 (29.9 - 31.0)	17.1 (16.2 - 18.0)	1.16 (1.10 - 1.21)	1.03 (1.00 - 1.06)
Place of delivery					
Institutional government	69.9 (69.2 - 70.6)	25.3 (24.6 - 25.9)	4.8 (4.6 - 5.1)	**Ref**	
Institutional private	71.7 (70.7 - 72.7)	23.1 (22.4 - 23.9)	5.2 (4.7 - 5.6)	1.11 (0.98 - 1.26)	1.07 (1.02 - 1.13)
Non-institutional	41.0 (40.2 - 41.8)	34.9 (34.6 - 35.3)	24.1 (23.4 - 24.8)	1.53 (1.41 - 1.67)	1.22 (1.17 - 1.27)
Vaccination card					
Yes (seen)	75.7 (75.0 - 76.4)	23.4 (22.7 - 24.1)	0.9 (0.7 - 1.0)	**Ref**	
Yes (not seen)	57.5 (56.8 - 58.2)	37.8 (37.1 - 38.3)	4.7 (4.5 - 5.1)	6.53 (5.51 - 7.75)	1.90 (1.83 - 1.97)
No	22.4 (21.6 - 23.1)	32.0 (31.4 - 32.5)	45.6 (44.8 - 46.4)	118.0 (100.24 - 138.83)	3.57 (3.43 - 3.72)

556   * Coverage proportions presented for combined DLHS surveys and are calculated using the total weighted
557   sample of children in each covariate category as the denominator

558   ** Adjusted for type of dwelling, age of child in months and geographical region

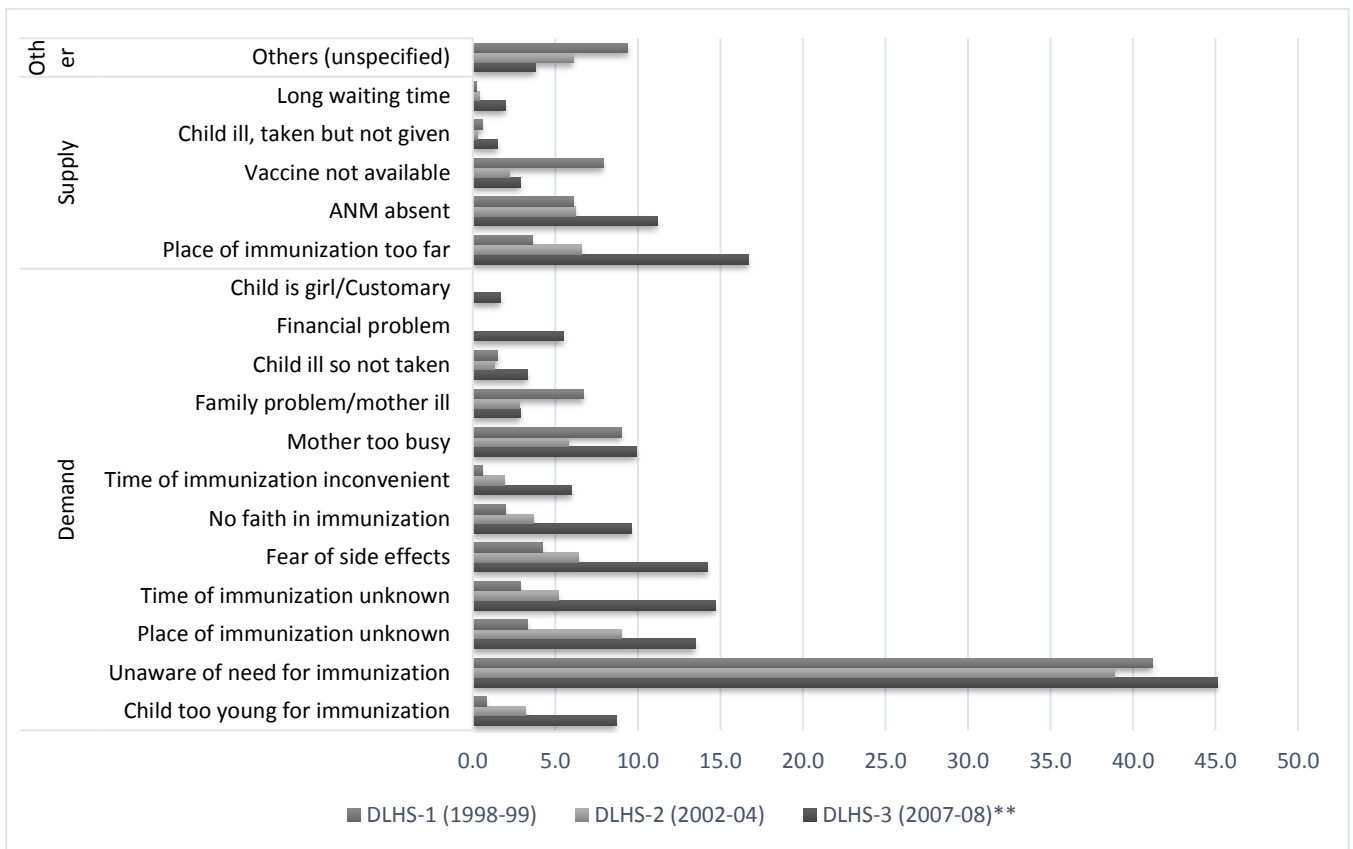559   *** Other religions include Sikh, Buddhism, Jainism, Judaism and Atheism

560

561

562 **Table 4:** Categorizing the reported reasons for non-vaccination among Indian children
563 using the 5As taxonomy for Determinants of Vaccine Uptake [14]

5A's taxonomy domains	Reported reason for non-vaccination
Access	Place of immunization too far
Affordability	Time of immunization inconvenient, Mother too busy, Financial problem, Family problem or mother ill
Awareness	Unaware of need for immunization, place of immunization unknown, time of immunization unknown
Acceptance	Child too young for immunization, Fear of side effects, No faith in immunization, child ill so not taken, child is a girl or customary,
Activation	-
Uncategorized	ANM absent, vaccine not available, child ill, taken but not given, long waiting time

564

Figures

Figure 1: Reported reasons for non-vaccination among children aged 12-23 months of India: 1998 – 2008

** Footnote:

1) DLHS-1 and DLHS-2 allowed only single responses, DLHS-3 allowed multiple responses
2) Demand and supply categorization of reported reasons based on standard operational practice [4]
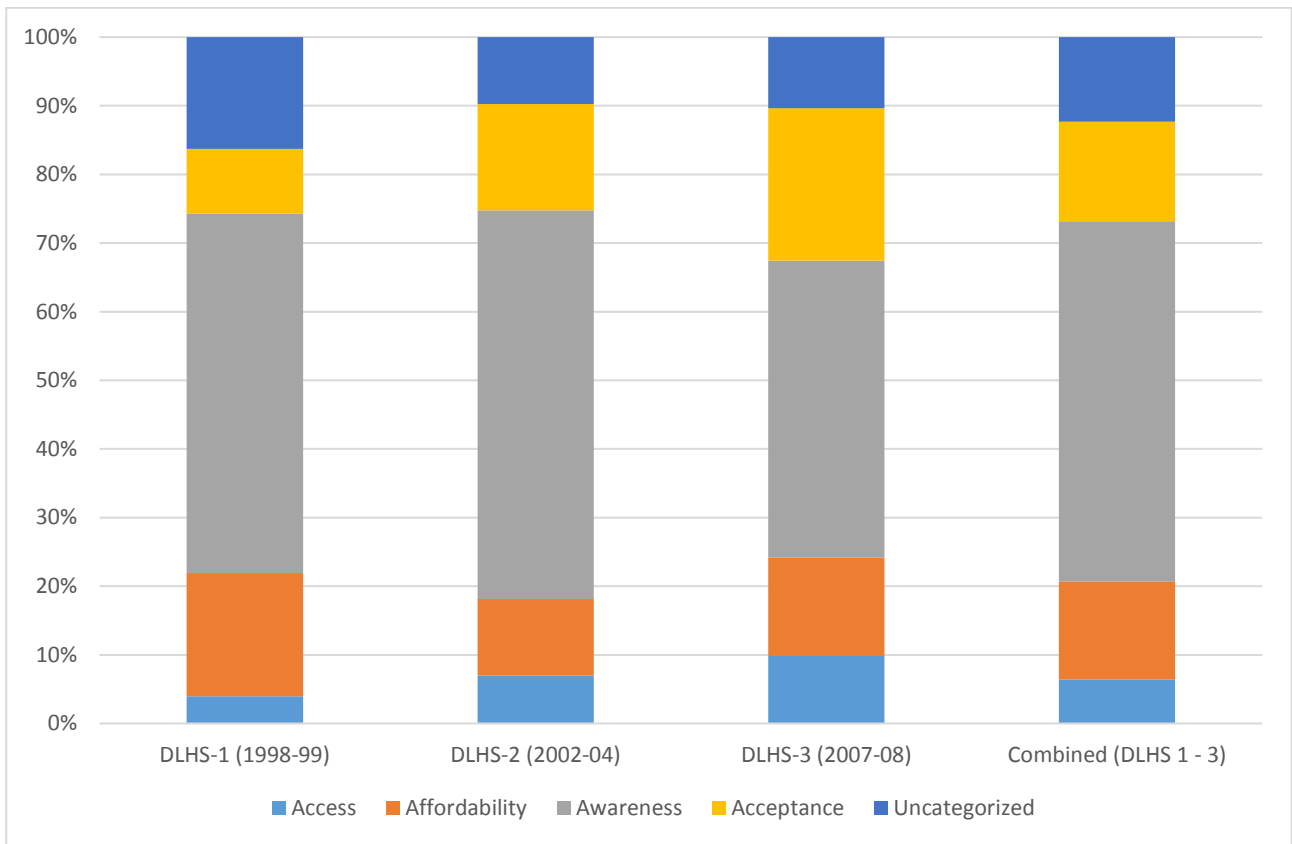3) Reported reasons under the "others" category were unspecified and kept as such

583 **Figure 2:** Reported reasons for non-vaccination among children 12-23 months of India
584 categorized by the 5As taxonomy for Determinants of Vaccine uptake: 1998 - 2008

585

586 *Footnote:

587   1) The 5As of the taxonomy are access, affordability, awareness, acceptance and activation [14].
588   2)   None of the reported reasons could be categorized under activation.
589   3)   Uncategorized reasons were mainly "supply-side" issues such as absence of health workers,
590   missed opportunities for vaccination and vaccine stock outs.