

Facilitating Behavioral Change for Acceptance of Oral Polio Vaccine

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A child aged 26 months could not be vaccinated initially during pulse polio immunisation due to parental fear of untoward side effects. Owning responsibility of child's welfare, indepth counselling and involvement of community leaders are crucial in this regard.

Key words: *Oral polio vaccine.*

We report of a female child aged 26 months residing in a slum like area of Surat whose migrant family had refused OPV, despite repeated counselling. This case was presented to us as a challenge during the Sub-National Pulse Polio monitoring process.

Initially this family refused to meet us as they did not wish to receive OPV. We cajoled and persisted with holding a dialogue irrespective of outcomes. They felt no need for vaccination as their 5 children had escaped vaccine preventable diseases despite no vaccinations. Upon entry we persisted with

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efforts to convince both of them for vaccination and the fact that this was the only case of refusal in that area, so their daughter alone was at the peril of lameness. Would he like to see children playing around and his daughter limping about? Since we had given this vaccine to all children, we were concerned that his daughter should not be the sole victim. We also explained that their children had luckily escaped from vaccine preventable diseases due to operational health programs, concept of chances and risk and herd immunity. Our strategy utilised various psychosocial theories of behavior and behavioral change such as Risk Perception Models, Fear Arousal, Social Comparison Theories, etc.(1).

Their refusal and nervousness was based on rumors that OPV had caused harm among recipients from the area that they had migrated from there. Their nervousness had convinced them not to get their children vaccinated. We allayed their fear and owned responsibility for their child's welfare. Another reason for their resentment was poor health services provided to them and they had retaliated by their refusal. We introduced them to health team of their area and promised cooperation in future. The family had not seen or heard of any case of vaccine preventable diseases in their neighborhood, relatives or any acquaintances. This incident highlights need for dialogues, persistence and training in behavioral change communication(2) among health staff while dealing with resistance. Rude behavior of people could hide their fears, frustrations and anger as in this case. Similarly, religious leaders and opinion leaders need to be mobilised. The universal administration of OPV is necessary in our current eradication drive. Fortunately, this Herculean task is aided by an excellent Public-Private-Partnership in India. Yet, India accounts for maximum cases worldwide. Though health authorities report of over 100

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percent coverage of children, monitoring reveals non-vaccinated children. We need to bring to notice such cases to health experts and openly deal with such issues.

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