

Coverage Evaluation Survey District – Khowai, Tripura

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Frequently Used Abbreviations

CES	- Coverage Evaluation Survey
CSSM	- Child Survival and Safe Motherhood Programme
EPI	- Expanded Programme on Immunization
MCTS	- Mother and Child Tracking System
NFHS-3	- National Family Health survey
NRHM	- National Rural Health Mission
PPI	- Pulse Polio Immunization Programme
RCH	- Reproductive and Child Health Programme
RI	- Routine Immunization
SC	- Sub-centre
UIP	- Universal Immunization Programme
VHND	- Village Health and Nutrition Day
VPD	- Vaccine Preventable Diseases

INTRODUCTION

Immunization is a highly cost effective way of improving survival in children in developing countries. Every year throughout the world, an estimated 27 million children and 40 million pregnant women do not receive the basic package of immunizations; and two to three million people die from diseases that can be prevented with vaccines. In India, immunization services are offered free in public health facilities, but, despite rapid increases, the immunization rate remains low in some areas. According to the National Family Health survey (NFHS-3), in India only 44% of children aged 1-2 years have received the primary immunization, whereas in Tripura it is 49.7%. The children, who have received BCG as per NFHS – 3 in Tripura is 81.1% and this drops down to 59.9% for measles vaccine. As per Coverage Evaluation Survey (CES) 2009, the full immunization coverage for India was 61% and for Tripura, it was 66%. The children, who have received BCG as per CES 2009 in Tripura was 71.5% and this drops down to 66.3% for measles vaccine.

Under the umbrella of National Rural Health Mission (NRHM) which was launched in 2005, a major thrust was given to improve the RCH services. The link between community and the health care delivery system was enhanced by the introduction of community health volunteers – 'ASHA'. ASHAs over the years have played important role in mobilizing the community in accessing the health care services. Moreover, to further bring the service close to the community, Village Health and Nutrition Days (VHND) are conducted under NRHM where range of activities from ante natal care to post natal care are provided along with the immunization of children the pregnant women are provided ante-natal services and the children are provided immunization. In VHND, other than preventive aspect, the curative and promotive aspects are also covered. These VHND are conducted under Sub-centre (SC) village area so as the beneficiaries do not have to travel long distance losing their wages or compromising their household work. Holding of VHND and incentivizing ASHAs for community mobilization This

conduct of VHND and incentives to the ASHAs to mobilize the community has increased the reach of the services to the community thereby decreasing the morbidity and mortality.

In Khowai district of Tripura under the leadership of the Chairman of the District Health Society, “Mission 100” programme was launched to achieve 100% immunization of the infants (0 – 1 year) during the year 2012-13. The total population of the district is 3,27,391 (as per State report) and the expected no. of infants is 4878. The full immunization coverage of the district as per the state report was 81% in 2007-08 and it increased to 83% in 2008-09; however it dropped down to 69% in 2009-10 and further to 61.5% in 2010-11. Thereafter, it increased to 76% in 2011-12. Under the programme ‘Mission 100’ it increased to 86.9% as per the state report. Under the programme, the district has adopted the following strategy: - (1) Identification of the low performing SC (2) Identification of the underserved population (3) Increase community awareness on benefits of routine immunization (4) Develop mechanism to bring the left out and drop out under Routine Immunization coverage. The district has intensified services under VHND like preparation of due list of the beneficiaries before every session was updated before every session, regular updating of the MCTS and HMIS data and monthly review of the SC performances.

Objective of the Study

To assess the coverage of immunization of children during the year 2012-13 and to find out the factors influencing the immunization services.

IMMUNIZATION IN INDIA

Promotion and protection of Maternal and Child Health in India has been the prime priority of Ministry of Health & Family Welfare, Govt. of India. To achieve this objective, Govt. of India has been making persistent efforts in improving the quality of services under maternal and Child Health and trying to reach out to the remotest unreached areas and vulnerable sections of the community.

Immunization is one of the most cost effective public health interventions since it provides direct and effective protection against preventable morbidity and mortality. It has been a major contributor in the decline of under-5 mortality in last five decades in India. However, vaccine preventable Diseases (VPDs) are still responsible for over 5 lakh deaths annually in India. This underlines the need for further improvement. India, along with many developing countries, is lagging behind in sufficient coverage of Routine Immunization (RI).

By early 1970s, many childhood diseases had almost disappeared from developed countries. These diseases, however, continued to take many lives in poorer countries. In fact, in 1974, fewer than 5% of children, worldwide were immunized by 1 year of age against diphtheria, polio, tuberculosis, pertussis, measles, and tetanus. That is why WHO launched the Expanded Programme on Immunization (EPI) in 1974 to bring vaccination against these six diseases to many underserved areas.

Immunization Programme in India is one of the essential interventions for protection of children from life threatening diseases that are preventable. The Immunization Programme was flagged off in India in 1978 as Expanded Programme of Immunization (EPI). The programme gained momentum in 1985 as Universal Immunization Programme (UIP) with a lofty goal to cover 'all' eligible children in the country, immunization of 'all' pregnant women with TT and to improve quality of services. Although the first booster of DPT was retained in UIP, the second booster at 5 years was reduced to DT (pertussis component was omitted). In the same year,

measles vaccine was added at 9 months of age. In India under UIP, vaccines for six preventable diseases viz. tuberculosis, diphtheria, whooping cough, tetanus, poliomyelitis and measles are available free of cost for all. UIP became a part of the Child Survival and Safe Motherhood (CSSM) programme in 1992-93. In 1995, Govt. of India launched the Pulse polio Immunization (PPI) programme with goal of eradicating polio completely by 2000 AD. Since 1997, immunization became an important component of Reproductive and Child Health (RCH) programme. In April 2005, the Govt. of India launched the NRHM with the aim of improving health care for the rural population. Since then immunization became an important component of RCH-II under the NRHM. Since 2011-12, Hepatitis-B vaccine (3 doses) has been provided to children under 1 year of age free of cost. Hepatitis B vaccine was initially introduced in 10 states and then extended to whole country.

Approximately 27 million children are born in India each year – the largest birth cohort in the world – but less than 61% receive a full schedule of vaccinations. To reach each and every one of such a huge cohort every year is obviously a daunting task. Geographical diversity (snow bound/ hilly areas, deserts, tropical forest areas, remote island territories), cultural diversity (with various religions, languages, traditions, beliefs and customs) and Political instability (“coalition” governments, “politically sensitive areas” like Naxal/terrorist-affected areas) are some problems that are rather unique to India and make the task more complex. Reaching out to mobile/migrant population (that is a significant proportion of population in some states) is another challenge. Special efforts are needed to identify and reach some pockets of low immunization that are still there in many states. CES 2009 found that reason for partially immunization/ non-immunization was “did not feel the need”, “not knowing about the need” and “not knowing where to go for vaccination” in 28.2%, 26.3% and 10.8% cases. This means that lack of awareness is one great barrier to achieve cent percent immunization coverage.

Since lack of awareness has been found to be main barrier, focus should be on increasing demand for vaccination by using effective IEC and bringing immunization closer to the

communities. The immunization services provided at the fixed sites should be improved. There should be better monitoring and supervision, and district authorities should be made accountable for the performance of RI in their district.

Apart from the above mentioned barriers, there are some other issues on “supply side” that pose challenges to achieving high RI rates. They include inadequate delivery of health services (supply shortages, vacant staff positions, lack of training); lack of accountability, inadequate supervision and monitoring; lack of micro-planning at district level; general lack of inter-sectoral coordination and lack of coordination between state and central governments resulting in missed opportunities to improve immunization coverage and quality. Falsification of data and over-reporting of rates are other big concerns as they give false sense of security and interfere with proper planning. At Government level, resource constraints and competing priorities need careful planning and policy making.

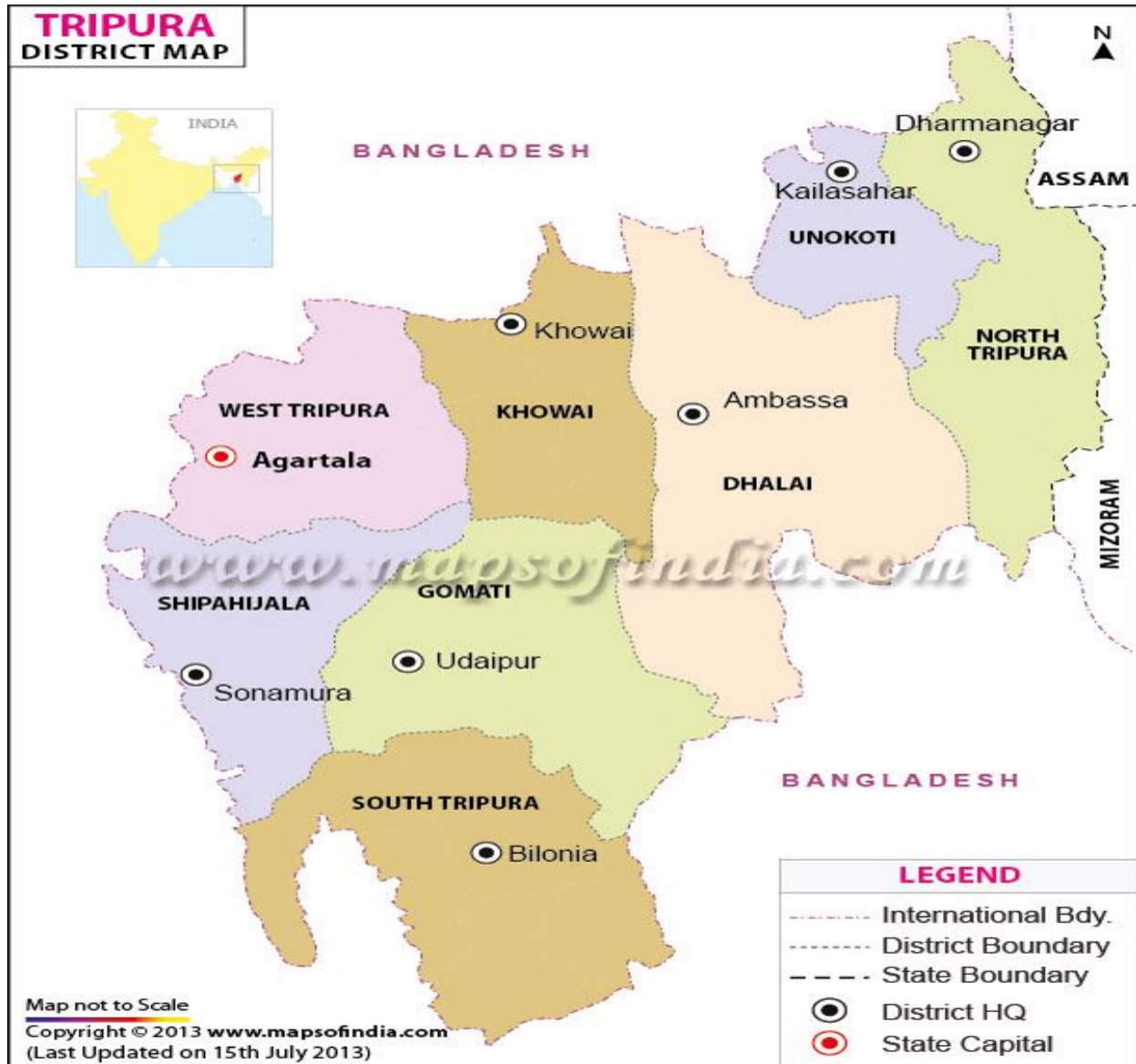
TIPURA AT GLANCE

Tripura is a state in North East India. The third-smallest state in the country, it covers 10,491 km² (4,051 sq mi) and is bordered by Bangladesh to the north, south, and west, and the Indian states of Assam and Mizoram to the east. The length of its international border is 856 km (84 per cent of its total border). As of 2011, the state had 36,71,032 residents, constituting 0.3% of the country's population. Indigenous communities, known in India as scheduled tribes, forms about 30 per cent of Tripura's population. The Kokborok-speaking Tripuri people are the major group among 19 tribes and many sub-tribes; Bengali people forms the ethno-linguistic majority. The literacy rate of the state is 87.22% as per Census 2011.

Tripura lies in a geographically disadvantageous location in India, as only one major highway, the National Highway 44, connects it with the rest of the country. Five mountain ranges - Boromura, Atharamura, Longtharai, Shakhn and Jampui Hills—run north to south, with intervening valleys; Agartala, the capital, is located on a plain to the west. The state has a tropical savanna climate, and receives seasonal heavy rains from the south west monsoon. Forests cover more than half of the area, in which bamboo and cane tracts are common. Tripura has the highest number of primate species found in any Indian state. Due to its geographical isolation, economic progress in the state is hindered. Poverty and unemployment continue to plague Tripura, which has a limited infrastructure. Most residents are involved in agriculture and allied activities, although the service sector is the largest contributor to the state's gross domestic product.

The state had 4 districts till 2011 – North, South, West and Dhalai. In 2011, the districts were bifurcated and at present there are 8 districts – Dhalai, Gomti, Khowai, North Tripura, Sepahijala, South Tripura, Unakoti and West Tripura.

Map of Tripura



Demographic profile of Tripura and India

	Census 2011 (Tripura)	Census 2011 (India)
Total Population	36,71,032	121,01,93,422
Population Urban	26.17 %	37.7 crore (31.15%)
Population Rural	73.83%	83.3 crore (68.8%)
Population (0-6 yrs) – Total	4,58,014	158789287
Population (0-6 yrs) – Male	2,34,008	82952135
Population (0-6 yrs) – Female	2,24,006	75837152
Sex Ratio	960	940
ST Population	54.7%	8.2%
Decadal Growth Rate	14.84%	17.64%
Population density sq km	350	382
Literacy rate (total)	87.22%	74.04%
Male	91.53%	82.14%
Female	78.98%	65.46%

Health Indicator of Tripura

Sl. No.	Indicator	Tripura
1	Infant Mortality Rate	29
2	Crude Birth Rate	14.3
3	Crude Death Rate	3

METHODOLOGY OF THE STUDY

Objective of the Study

To assess the coverage of immunization of children during the year 2012-13 and to find out the factors influencing the immunization services.

Period of the Study

The study was conducted by Regional Resource Centre for NE, Guwahati. The Field Investigators for the study were taken from Tripura who had similar experience earlier in conducting house to house survey in health. They were trained along with field demonstration on data collection for 2 days. The study was conducted in the month of May and June 2013.

Study Population

Children aged 12 to 23 months for immunization coverage

Methodology of the Study

To conduct the study, sample survey was considered fit for evaluation of immunization coverage. To conduct the coverage evaluation, the WHO model of cluster sampling technique of 30 clusters was adopted considering the design effect of 2. In the present study out of the 137 villages in the district, 30 clusters (villages) were selected and from each cluster 10 children in the age group of more than 12 months and less than 23 months were studied. Thus, all total 300 children were studied. The questionnaire used for the study had mostly structured questions with only a few open ended questions.

KEY FINDINGS OF THE STUDY

Immunization status

The **table 1** shows the facility wise distribution of children aged 12 to 23 months by immunization status. It has been observed that full immunization coverage of the district is 93.3%. However, the full immunization coverage under Ampura PHC and Mungiakami PHC is 70% and 73.3% respectively.

Table 1

PHC/CHC	No. of Children	Immunization Coverage							
		Not Immunized		Partially Immunized		Fully Immunized within 12 months		Fully Immunized above 12 month	
		No.	PC	No.	PC	No.	PC	No.	PC
AMPURA PHC	10					7	70.0	3	30.0
BAIJALBARI PHC	20					19	95.0	1	5.0
CHEBRI PHC	20					20	100.0		0.0
HD SMRITI PHC	10					10	100.0		0.0
KALYANPUR CHC	50			2	4.0	46	92.0	2	4.0
KHOWAI SDH	50			1	2.0	49	98.0		0.0
MUNGIAKAMI PHC	30	3	10.0	2	6.7	22	73.3	3	10.0
RATANPUR PHC	10					10	100.0		0.0
TELIAMURA CHC	80					78	97.5	2	2.5
TULASIKHAR PHC	20			1	5.0	19	95.0		0.0
District Total	300	3	1.0	6	2.0	280	93.3	11	3.7

Antigen wise Immunization Status

Table 2 – Showing Facility wise distribution of children aged 12 to 23 months by BCG, DPT, OPV and Measles vaccination. The evaluation study revealed that there are 6 children who have been partially immunized and another 3 children under Mungiakami PHC who have not been immunized. The drop out from BCG to Measles is 1 and is under Khowai SDH.

Table 2

PHC/CHC	No. of Children	Coverage							
		BCG		DPT 1		DPT2		DPT3	
		No.	PC	No.	PC	No.	PC	No.	PC
AMPURA PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
BAIJALBARI PHC	20	20	100.0	20	100.0	20	100.0	20	100.0
CHEBRI PHC	20	20	100.0	20	100.0	20	100.0	20	100.0
HD SMRITI PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
KALYANPUR CHC	50	50	100.0	49	98.0	50	100.0	50	100.0
KHOWAI SDH	50	50	100.0	49	98.0	49	98.0	49	98.0
MUNGIKAMI PHC	27	26	96.3	27	100.0	27	100.0	27	100.0
RATANPUR PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
TELIAMURA CHC	80	80	100.0	80	100.0	80	100.0	80	100.0
TULASIKHAR PHC	20	20	100.0	20	100.0	20	100.0	20	100.0
District Total	297	296	99.7	295	99.3	296	99.7	296	99.7

PHC/CHC	No. of Children	Coverage							
		OPV 1		OPV 2		OPV 3		Measles	
		No.	PC	No.	PC	No.	PC	No.	PC
AMPURA PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
BAIJALBARI PHC	20	20	100.0	20	100.0	20	100.0	20	100.0
CHEBRI PHC	20	20	100.0	20	100.0	20	100.0	20	100.0
HD SMRITI PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
KALYANPUR CHC	50	50	100.0	49	98.0	50	100.0	50	100.0
KHOWAI SDH	50	49	98.0	49	98.0	49	98.0	49	98.0
MUNGIKAMI PHC	27	26	96.3	27	100.0	27	100.0	26	96.3
RATANPUR PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
TELIAMURA CHC	80	80	100.0	80	100.0	80	100.0	80	100.0
TULASIKHAR PHC	20	20	100.0	19	95.0	19	95.0	20	100.0
District Total	297	295	99.3	294	99.0	295	99.3	295	99.3

Immunization status by place of vaccination

It has been observed that in Table 3 out of 297 children fully immunized, 164 i.e. 55.2% availed the vaccination at SC, followed by 24.9% at the VHND session site, 10.8% at Other Govt. Hospital, 5.40% at PHC and 3.4% at other places.

Table 3

PHC/CHC	No. of Children	Place of Immunization											
		SC		VHND / Out Reach Session		PHC		Other Govt. Hospital		Pvt. Doctor / Pvt. hospital		Other	
		No.	PC	No.	PC	No.	PC	No.	PC	No.	PC	No.	PC
AMPURA PHC	10	2	20.0	5	50.0	3	30.0						
BAIJALBARI PHC	20			17	85.0	3	15.0						
CHEBRI PHC	20	1	5.0	10	50.0	9	45.0						
HD SMRITI PHC	10	10	100.0										
KALYANPUR CHC	50	31	62.0	15	30.0							4	8.0
KHOWAI SDH	50	22	44.0	9	18.0	1	2.0	18	36.0				
MUNGIAKAMI PHC	27	23	85.2									4	14.8
RATANPUR PHC	10	5	50.0	4	40.0							1	10.0
TELIAMURA CHC	80	55	68.8	9	11.3			14	17.5	1	1.3	1	1.3
TULASIKHAR PHC	20	15	75.0	5	25.0				0.0				
District Total	297	164	55.2	74	24.9	16	5.4	32	10.8	1	0.3	10	3.4

Source of information for vaccination

Awareness amongst the community plays a pivotal role in mobilizing the community to access health services. It has been observed in Table 4 that ASHAs have played important role in mobilizing the community to the extent of 92.6% in accessing the immunization service.

Table 4

PHC/CHC	No. of Children	Source of information for immunization of the children											
		Radio TV		Miking		Service Provider		ASHA		Relatives / Friends / Neighbors		Others	
		No.	PC	No.	PC	No	PC	No.	PC	No.	PC	No	PC
AMPURA PHC	10	1	10.0					8	80.0	1	10.0		
BAIJALBARI PHC	20							20	100.0				
CHEBRI PHC	20	2	10.0					16	80.0			2	10.0
HD SMRITI PHC	10							10	100.0	3	30.0		
KALYANPUR CHC	50	2	4.0	1	2.0	2	4.0	46	92.0	3	6.0		
KHOWAI SDH	50	9	18.0	3	6.0	8	16.0	49	98.0	17	34.0	7	14.0
MUNGIAK AMI PHC	27	1	3.7			5	18.5	25	92.6	3	11.1		
RATANPUR PHC	10					4	40.0	10	100.0	4	40.0		
TELIAMURA CHC	80	10	12.5	4	5.0	11	13.8	75	93.8	12	15.0	2	2.5
TULASIKHARA PHC	20	1	5.0	2	10.0	6	30.0	16	80.0	7	35.0	5	25.0
District Total	297	25	8.4	10	3.4	36	12.1	275	92.6	50	16.8	15	5.1

Key messages from service provider

It's important for the service provider to provide some key messages to the mothers after their children are being immunized. Table 5 shows that the service providers have provided the messages to the mothers and in most of the cases it is above 95%.

Table 5

PHC/CHC	No. of Children	Key Messages given at the time of Immunization							
		What injections were given on that day		Side effects of the vaccination and their management		Time for next vaccination		Remember to bring card during the next visit	
		No.	PC	No.	PC	No.	PC	No.	PC
AMPURA PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
BAIJALBARI PHC	20	20	100.0	20	100.0	20	100.0	20	100.0
CHEBRI PHC	20	20	100.0	20	100.0	20	100.0	20	100.0
HD SMRITI PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
KALYANPUR CHC	50	50	100.0	50	100.0	50	100.0	50	100.0
KHOWAI SDH	50	45	90.0	50	100.0	50	100.0	46	92.0
MUNGIAKAMI PHC	27	24	88.9	26	96.3	25	92.6	23	85.2
RATANPUR PHC	10	10	100.0	10	100.0	10	100.0	10	100.0
TELIAMURA CHC	80	75	93.8	78	97.5	79	98.8	78	97.5
TULASIKHAR PHC	20	19	95.0	20	100.0	20	100.0	19	95.0
District Total	297	283	95.3	294	99.0	294	99.0	286	96.3

DISCUSSION

Khowai district of Tripura started a programme “Mission 100” to achieve 100% immunization of the infants (0 – 1 year) during the year 2012-13. Under the programme the district has adopted the following strategy: - (1) Identification of the low performing SC (2) Identification of the underserved population (3) Increase community awareness on benefits of routine immunization (4) Develop mechanism to bring the left out and drop out under RI coverage.

Regional Resource Centre for NE States conducted the coverage evaluation survey to find the full immunization coverage.

A 30 cluster survey was done and from each cluster 10 children in the age group of more than 12 months and less than 23 months were studied. Thus, all total 300 children were studied.

The full immunization coverage as per the survey is 93.3%. Full immunization coverage above 12 months is 3.7%. The survey revealed 6 (2%) children have received partial immunization and 3 (1%) did not receive any immunization. The children who did not receive any immunization is under Mungiakami PHC.

There has been only 1 drop out from BCG to Measles and it is under Khowai SDH.

Under NRHM, to bring the services close to the community, VHND sessions are held in every village every month where the beneficiaries get the service close to their home. The study revealed that 55.2% children received immunization in the SC, followed by 24.9% children who received immunization in the VHND. A total of 10.8% and 5.4% children received immunization in Govt. Hospitals and PHCs respectively.

The study revealed that ASHAs have played an important role in mobilizing the mothers and improving the immunization coverage in children. A total of 92.6% ASHAs were the source of information for the mothers for immunization. The other sources of information were relatives and neighbors 16.8%, service providers 12.1%, radio 8.4% and miking 3.4%.

It is important after immunizing the child, that the service providers must inform the mother about the type of vaccine, side effects and time for the next vaccine. The study revealed that 95.3% service providers informed the mothers about the type of vaccine given. The message regarding side effects of vaccine and time of next vaccination was given by 99% service providers.

Regular supervision, accountability and fixing of responsibility, monthly review meeting and regular use of MCTS for mapping, tracking and follow up has helped the district to improve immunization coverage from 86.9% to 93.3% under the programme “Mission 100” which is highly commendable in Khowai which is a new district with scattered tribal population.

CONCLUSION AND RECOMMENDATION

CONCLUSION

The “Mission 100” programme launched in Khowai district under the leadership of the Chairman, District Health Society aiming at 100% immunization of the children.

The evaluation done by Regional Resource Centre for NE states revealed 93.3% complete immunization below 1 year. However, there were 6 children who were partially immunized and 3 children who were not at all immunized.

One of the important factors that have come out from evaluation is good tracking of the children as there is only 1 drop out from BCG to Measles.

The ASHAs have been pivotal in providing the information to the mothers regarding immunization services as the study revealed that 92.6% ASHAs being involved.

RECOMMENDATION

The use of MCTS for complete tracking and follow up of children for vaccination along with supportive supervision and involvement of ASHAs for community mobilization is an excellent model as being shown by Khowai district. Similar model can be replicated in others districts of Tripura to improve the immunization coverage where there is no additional cost involvement.

ANNEXURE**Name of the Respondent:**

A) Relationship of the respondent with the child : Father – 1 / Mother – 2 / Other : 3

B) Type of House hold: Joint -1 / Nuclear – 2

C) How many members usually live in this household including yourself:

Male : Female :

D) How many children (12 – 23 Months) live in this household of family :

Male : Female :

G) What is the religion of the head of the household:

1) Hindu 2) Muslim 3) Christian 4) Others

H) What is the caste of the head of the household:

1) General 2) OBC 3) SC 4) ST 5) Others

Family Background :

1. Sex of the baby : Male / Female

2. What is the birth order of this baby :

3. What is the educational level of the Father

1) Illiterate 2) Below primary 3) Below 10th standards
4) Below 12th standards 5) Below Graduate 6) Graduate & above
7) Others 8) If not alive

4. What is the educational level of the Mother

1) Illiterate 2) Below primary 3) Below 10th standards
4) Below 12th standards 5) Below Graduate 6) Graduate & above
7) Others 8) If not alive

5. What is the main Occupation of the Father

- | | | |
|----------------------|----------------------|------------------------|
| 1) Govt. Service | 2) Retd. Service | 3) Pvt. Service |
| 4) Business | 5) Cultivation | 6) Agricultural Worker |
| 7) Industrial Worker | 8) Daily Wage Labour | 9) Father is no more |
| 10) Others | | |

6. What is the main Occupation of the Mother:

- | | | |
|----------------------|----------------------|------------------------|
| 1) Housewife | 2) Govt. Service | 3) Pvt. Service |
| 4) Business | 5) Cultivation | 6) Agricultural Worker |
| 7) Industrial Worker | 8) Daily Wage Labour | 9) Mother is no more |
| 10) Others | | |

Exposure to Media

7. Do you know that your child needs vaccines : Yes / No

8. Did this child receive Immunization: Yes / No

9. From where did the baby receive most of his/her vaccinations :

- | | | |
|-------------------------|--------------------------------|--------------------|
| 1) SC | 2) VHND / Out Reach Session | 3) PHC |
| 4) Other Govt. Hospital | 5) Pvt. Doctor / Pvt. hospital | 6) Other (Specify) |

10. If Yes, Which were the main influencing factor to go for immunization of your child :

- | | | |
|---------------------|-----------------------|------------------------------------|
| 1) News Paper | 2) Radio / TV | 3) Leaflets / Magazine |
| 4) Wall Paintings | 5) Banner / Hoardings | 6) Miking |
| 7) Service Provider | 8) ASHA | 9) Relatives / Friends / Neighbors |
| 10) Others | | |

11. If No, What are the reasons for not immunizing your baby :

Lack of Knowledge / Wrong information	Personal problem	Poor Services
Unaware about the need for	Mothers too busy	Place of immunization too

immunization		far
No faith in immunization	Family problem including illness of mother	Time of immunization is inconvenient
Place and time of immunization not known	Child ill- not brought to centre	Vaccinator absent in session site
Fear of side effects	Cannot afford the cost	Long waiting time
		Child ill- brought but not given immunization
		Other Reasons

12. During any of your visit did you receive message/advice on following at least once :

- 1) What injections were given on that day
- 2) Were the side effects of the vaccination and their management explained
- 3) When to come for next vaccination
- 4) Remember to bring card during the next visit

13. Do You have an immunization card/any document for recording immunization : Yes / No

a) Status of the card :

- | | |
|----------------------------|------------------------|
| 1) Completely filled | 2) Partially Filled |
| 3) Card is with ASHA / ANM | 4) Card was not issued |

14. Immunization status of the child :

- Copy dates from the card
- If card is not available but according to the parents the vaccines was given to the baby then contact ASHA / ANM for the details of the Immunization Status.

Name of the baby _____

SI	Vaccines	Date (DD/MM/YY)	Remarks
A	Date of Birth of the baby		
B	BCG		
C	DPT 1		
D	OPV1		
E	DPT2		
F	OPV2		
G	DPT3		
H	OPV3		
I	Measles		
K	Status of Immunization	No – 1 Partially – 2 Fully Immunized – 3 Fully Immunized within 12 months – 4	Row K needs to be filled up by the investigator & supervisor needs to verify it.

15. What are the three main reasons for partially immunizing the children :

- 1) Unaware about the need to return for subsequent doses
- 2) Place and time of immunization Unknown
- 3) Fear of side effects
- 4) Rumors
- 5) Place of immunization is too far
- 6) Time of immunization is inconvenient
- 7) Vaccinator absent
- 8) Postponed until another time
- 9) Mothers too busy

- 10) Family problem
- 11) Child ill- not brought
- 12) Cannot afford the cost
- 13) Other