

# Immunization Services In Rural Population -Campaign vs Clinical Approach

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## Introduction

In the world today, most of our problems can be prevented at community level through change in social behaviour and at a reasonable low cost. To achieve this, we will have to transform available knowledge and technology into action. In 24 hours, app 40000 under-five children die, and out of this, 80% can easily be saved through preventive measures (UNICEF, 1989). Immunization, which can alone save 3 million children out of 14 million who die every year, is the most cost-effective programme. During this decade, through determined efforts, the developing countries have been able to increase the proportion of immunized children from 10% to 50% and are now saving the lives of nearly 1.5 million children annually (UNICEF, 1989).

In our rural areas, scattered population and difficult terrain limits the access to the health institutions thus contributing to the

low immunization coverage in most parts of our country (Bhargava and Sokhey, 1985). It has been recommended that till such time our primary health care system becomes capable of achieving near universal immunization coverage, a strategy of campaign approach involving different agencies should be adopted (John and Steinhoff, 1981).

To prove the value of such programme, an immunization coverage assessment was undertaken in a Rural block in Himachal Pradesh.

## Materials and Methods

The survey was conducted in Lad-Bhrol, a Rural block of district Mandi in Himachal Pradesh. Immunization services in this block is provided through under-5 clinics and various immunization camps conducted in the areas by a team from block headquarters. A WHO recommended cluster sampling technique was used (Hendersen and Sunderesan 1982). and 210 children between the age,

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group of 12-23 months were identified. The immunization status was confirmed from the relevant registers maintained at the respective local health institution and also from the records available at the block headquarters. A child who had three doses each of DPT and OPV, and had undergone BCG and measles immunization was considered as fully immunized. A child having no vaccination at all was termed as un-immunized. All other children were taken as partially immunized. Parents were inquired regarding the source of immunization. Reason for not availing these services were also inquired from the parents of the children.

#### Observations

Out of 210 children identified in this study, 94 (44.76%) were found fully immunized. 88 (41.91%) were partially immunized whereas 28 (13.33%) were un-immunized. Out of 94 fully immunized children, only 18 (19.1%) were immunized at clinics and as many as 76 (80.9%) had received immunization in various camps organised in the area.

Vaccines wise Coverage for BCG was highest (69.05%). It was 47.14% for measles. As many as 59.05% and 6.67% children received three doses of DPT and OPV respectively. Drop out rate from I-III dose was 21.52% for DPT and 20.13% for OPV.

Table-I. Coverage with different vaccines.

Vaccines	No.	Percent
Measles	99	47.14
B C G	145	69.05
D P T I	158	75.24
II	142	67.62
III	124	59.05
Drop out I-III		21.52
O P V I	149	70.95
II	131	62.38
III	119	56.67
Drop out I-III		20.13

The majority of children received vaccination during various camps. As compared to 71.7% only 28.3% children

received measles vaccine in Under-5 clinics organised in PHC/Sub-centres/ civil dispensary. Same was the case with other vaccines also.

Table-II Source of Immunization.

Vaccine	Source in Percentage	
	Clinics	Camps
Measles	28.3	71.1
BCG	24.9	75.1
DPT I	29.8	70.2
II	27.5	72.5
III	18.5	81.5
OPV I	32.2	67.8
II	39.7	60.3
III	16.8	83.2

Ignorance of the complete schedule (13.8%) and need of immunization (12.1%), illness of the child at the due date of vaccination and busy parents, 11.2% each and no

information of the camp date (12.1%) were the main reasons for partial immunization and non-immunization.

Table-III. Reasons for non-immunization and partial immunization. (N=116)

Reasons	No.	Percent
1. Information of the camp not received	14	12.1
2. Un-aware of the complete schedule of vaccination	16	13.8
3. Out of station on camp date	8	6.9
4. Child ill on the due date	13	11.2
5. Parents busy	13	11.2
6. Forgot about the date of the camp	8	6.9
7. No faith in Immunization	10	8.6
8. Unaware of the need of vaccination	14	12.1
9. Afraid of side reactions	12	10.3
10. No definite reason	8	6.9

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### Discussion

It has been observed in this study that of completely immunized children about four fifth were immunized during various Camps organised in the area. Higher coverage by camp services clearly shows that coverage can be increased impressively in the Rural areas. Similar findings have also been observed by other workers in India (John et al., 1983, and Balraj and John, 1986). Success of this type of approach has also been emphasised by workers from other countries (Risi, 1984).

The efficacy of immunization services depends on information which should reach the parents, their compliance, and delivery of vaccine. In camps, public has to be informed in advance and a day is fixed. As many as 12.1% did not receive the information in this study and another 6.9% forgot about the date. So the involvement of media has its role here. Wide publicity utilising popular channel of communication should be undertaken before initiating such campaign.

Social mobilization which is an important component of immunization programme can be speeded through campaign approach in one sitting. Still many people have misconceptions regarding immunization as revealed in this study.

As mass campaigns involve more than one agencies, increased cooperation and coordination can be achieved and sustained amongst these agencies for other health activities as well. Backlog of un-immunized under-5 children can also be covered

as health workers in camps can seek out their potential clients with the help and active participation of community leaders, teachers and other village level functionaries. But this type of approach can prove to be expansive, but other field activities can also be combined with these services and it can act as a common platform for all health educational activities. It can therefore be concluded that in Rural areas where access to health institutions is limited, mobile teams campaigns are required till another efficient vaccine delivery system is evolved.

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