

A Study to Evaluate Immunization Coverage During a Round of Intensified Mission Indradhanush Among Children (0-3 Years) In Urban Blocks Of District Patna, Bihar, India.

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Background: India's immunisation programme is the largest in the world, with annual cohorts of around 26.7 million infants and 30 million pregnant women. However an estimated 38% of children failed to receive all basic vaccines in the first year of life in 2016. Intensified Mission Indradhanush (IMI) was launched to accelerate progress with the aimed to reach 90% full immunisation coverage in districts and urban areas with persistently low levels of coverage. This study finds the coverage in one of the rounds of IMI in Patna city of Bihar, India.

Methodology: Monitoring was done on all 5 Days of IMI Activity in one of the rounds covering 10 session sites and 8 HTH activities covering 5 children each in one HTH session. Simple random sampling was done to monitor session sites & HTH surveys

Results: 100% of new born monitored children received BCG. 75% of children due for measles vaccine did not receive it. 75% of session sites had poor IEC display while 42% of sessions did not run as per the micro plan.

Conclusion: The Immunization coverage showed improvements through intensive campaign but higher drop out percentages, lack of implementation micro plan and poor IEC still hampers the Immunization activities.

Keywords: Intensified Mission Indradhanush, Immunization, Monitoring.

Date of Submission: 22-07-2019

Date of Acceptance: 07-08-2019

I. Introduction

Vaccination is the most important preventive and cost-effective intervention to decrease morbidity and mortality rates in children(1). Every year, vaccination averts an estimated 2-3 million deaths from from 5 vaccine preventable diseases yet 1.5 million children die annually from diseases which can be prevented by vaccination(2). Millions of children world over routinely get vaccines for protection against many killer diseases and many of these diseases are at their lowest level in history and disease like polio is on the verge of eradication globally(3).

India's immunisation programme is the largest in the world, with annual cohorts of around 26.7 million infants and 30 million pregnant women(4). The Union Ministry of Health and Family Welfare has launched Intensified Mission Indradhanush (IMI) on 8th October 2017, to accelerate full immunization coverage to more than 90% by December 2018. Through this programme, Government aimed to reach each and every child less than two years of age and all those pregnant women who have been left uncovered under the routine immunisation programme. However, vaccination on demand to children up to 5 years of age will be provided during IMI rounds. (5). Thus landscape of routine child immunization in India is changing rapidly (6). This study evaluates one of the rounds of IMI which will help to overcome the lacunae and improve Immunization coverage routinely or through special campaign.

II. Methods

Monitoring was done from 11th to 18th December 2018 except on Routine Immunization days and Sunday when IMI activity did not take place during the second round of IMI in Patna city of Bihar State in India. In 5 Days of IMI Activity, 2 session sites were monitored on each day (10 session total) and 8 HTH activities done in total (on 1st day HTH activity was not done), taking 5 children in each area (40 in total). Sessions for monitoring were randomly chosen from sessions listed prepared for each day by District health Authorities. Areas for HTH activity were chosen randomly in areas where session was held on previous day. All monitoring activity was done in different areas of Patna city. Areas where more than 3 children were found

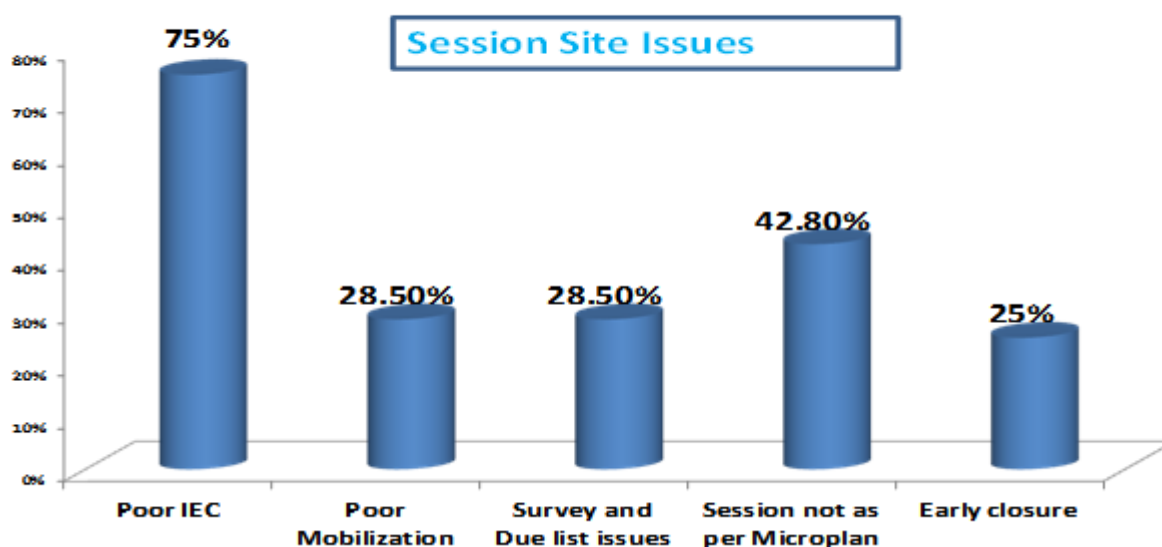
to be unimmunised out of 5 children monitored were considered as Missed Areas. Data was entered in Monitoring WHO formats for Session sites and House to House activities. Epiinfo 3.5.3 was used for deriving descriptive analysis.

III. Results

75% of session sites had poor IEC material. 28.5% of sessions had poor mobilisation. 43% of sessions did not function as per the micro plan whereas 25% of session sites had closed early. 66% of session sites had functional hub cutter.

Out of 40 children monitored-24(60%) received vaccines and 16(40%) dint. 37% of the areas were found to be Missed areas. 100% of children who were due for BCG vaccine were vaccinated which fulfils the aim of vaccinating new born children. 75% of the children did not receive measles vaccine out of those who were due for it. Not being contacted for receiving the vaccine was the commonest reason for missing the dose. 60% of the children were brought by their mothers for vaccination.

Monitoring summery



Age group	Percentage
1-2	2.5(1)
3-8	30(12)
9-15	50(20)
16-36	17.5(7)

Vaccine	Children Due each vaccine()	Received(%)	Missed(%)
BCG	4	100	0
Pentavalent	42	87.5	12.5
Measles	33	25	75
Booster	21	87	12.5

Reason for not receiving	
Not aware of need	11
No one contacted	47
Session Inconvenient	5.8
Unfriendly vaccinator	11.7
Sick child- Caregiver dint Opt	23.5
Availability of Hub cutter at sessions	
Yes	66.6
No	44.4
Source of Information for vaccination under IMI	
ASHA	11.1
AWW	77.7
CMC	11.1
Pooster Banner	11.1
Who bought child for vaccination	
Mother	60

IV. Discussion

The reasons for drop-outs for IMI in children was found to be unawareness regarding IMI as no one had contacted them (47%) followed by sick child (23.5%). Odomani et al also observed in their study that most frequently reported reason for non-vaccination was unawareness for the need of immunization(38.46%)(7). A study in Haryana by Goyal et al showed 44% of children due to be immunized were unimmunised as there was no awareness done regarding Immunization (8). ANM/ASHA were the main source of information about immunization in our study. The sources of information from ANM or AWW regarding immunization among the respondents 34.19% in a study for routine immunization(9). This difference could be due to difference in programme implementation as IMI had ASHA/AWW as community mobilisers.

V. Conclusion

It can be concluded from the observations made by the present study towards a pressing need to accelerate efforts in improving the immunization coverage in the area. This study highlights the need to have proper micro plan, updated due list availability at immunization session site with proper IEC material display. There is also scope for improvement of routine immunization as special programmes to take up drop outs is not easy.

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Dr. Sameena Yousuf. “A Study to Evaluate Immunization Coverage During a Round of Intensified Mission Indradhanush Among Children (0-3 Years) In Urban Blocks Of District Patna, Bihar, India.” *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, vol. 18, no. 8, 2019, pp 49-51.