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CHILD IMMUNIZATION AND IMPACT OF ICDS PROGRAMME AMONG THE HAJONGS AND KAIBARTTAS OF TINSUKIA DISTRICT IN ASSAM: A CASE STUDY

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ABSTRACT Immunization is one of the services provided by the Integrated Child Development Services (ICDS) scheme. It is one of the key interventions for protection of children from life threatening conditions, which are preventable. This paper attempts to understand the implementation and impact of immunization service among two socio-economically poor rural communities - the Hajong and the Kaibartta of Tinsukia district, Assam. Regular immunization of Hajong and Kaibartta children were recorded as 64% and 90.11% respectively. Socio-cultural and economic factors like low level of mother's education, poverty, traditional mindset, irregularly organized immunization camp, communication gap between the Anganwadi workers and the mothers, etc. are the key obstacles in immunization of children.

KEYWORDS : Immunization, ICDS, Hajong, Kaibartta, Assam.

INTRODUCTION

Immunization is one of the major strategies of human resource development of a nation. It is one of the most cost-effective interventions for protection of children from life threatening conditions, which are preventable. The benefits of immunization are not restricted to improvements in health and life expectancy but also have social and economic impact at both community and national levels [1]. The Integrated Child Development Services (ICDS) scheme is a flagship programme of the Government of India for the all-round development of children (0-6 years). Immunization is one of the significant services of the ICDS scheme. India's Universal Immunization Programme (UIP) is dynamic and over the years has made great progress in expanding Routine Immunization (RI) coverage across the country. However, the immunization coverage of children is still lagging behind especially in the Northeastern states having numerous small inaccessible tribal villages [2]. Besides, low socio-economic status, low parental educational level and lack of micro-planning makes the task complex [3-4]. Hence, further investigation into specific populations and the identification of barriers within subgroups is a priority [3]. The present study has been carried out among the Hajongs and the Kaibarttas of Tinsukia district in Assam. The study attempts (1) to find out how the immunization service under ICDS programme is being implemented among the two study communities; (2) to find how mother's education influences child immunization; and (3) to find out the barriers in immunization.

MATERIALS AND METHODS

For the present study, two socio-economically backward communities' viz. the Hajong (a Scheduled Tribe) and the Kaibartta (a Scheduled Caste) of Tinsukia district, Assam were selected. The micro-field includes 02 Hajong villages - Kuhiarbari and Katha Adarsha; and 02 Kaibartta villages - Dehing Poria and Kachujan where the ICDS programme has been functioning since 2001. The Hajong villages are located in remote areas with poor means of transportation and communication. Field work was carried out from December 2010 to December 2011. Standard anthropological methods - survey schedule, interview, observation and questionnaire were used for data collection. To obtain detail information on child immunization, the mothers having children of 0-5 years of age and Anganwadi Workers (AWWs) were interviewed intensively.

RESULTS AND DISCUSSION

The total number of Hajong and Kaibartta children (0-5 years) of the micro-field is 175 and 91 respectively.

Table 1: Immunization of Hajong and Kaibartta children (0-5 years)

Community		Never immunized	Immunization continued	Irregular immunization	Total
Hajong	No.	26	112	37	175
	%	14.86	64	21.14	100
Kaibartta	No.	-	82	9	91
	%	-	90.11	9.89	100

Table 1 shows that 14.86% of the Hajong children are not immunized. Notably no Kaibartta child has been found without immunization. A total 64% of Hajong children and 90.11% of Kaibartta children have been continuing their vaccination regularly. On the other hand, 21.14% of Hajong children and 9.89% of Kaibartta children have been incompletely immunized. Immunization of children is subjected to awareness and involvement of parents especially the mothers. Hence, mother's education is an influential factor in the process of child immunization. However, low educational level i.e. up to primary or middle elementary education does not have significant impact on the child care practices [5]. The Hajong mothers are mostly illiterate; only a few of them received education up to the lower primary level. Whereas, educational status of the Kaibartta mothers is slight better as majority of them studied up to high school level.

Table 2: Mothers' education and child immunization

Community		Literate mothers			Illiterate mothers			Total
		NI	IC	II	NI	IC	II	
Hajong	No.	11	62	17	15	50	20	175
	%	6.29	35.43	9.71	8.57	28.57	11.43	100
Kaibartta	No.	-	76	6	-	6	3	91
	%	-	83.52	6.59	-	6.59	3.3	100

Abbreviation: NI - Never immunized; IC - Immunization continued; II - Irregular immunization

Table 2 shows that 6.29% and 8.57% of Hajong children of literate and illiterate mothers respectively had no immunization at all; followed by 9.71% and 11.43% children who are irregularly immunized. On the other hand, majority of Hajong children (35.43%) who are continuing regular immunization belong to literate mothers. Compared to that 83.52% of Kaibartta children of literate mothers are continuing vaccination. Significantly, no child of either literate or illiterate Kaibartta mothers has remained beyond the coverage of vaccination. However, it is a matter of concern since a total of 9.89% children of literate and illiterate mothers taken together have not been regularly immunized.

From the analyses of the quantitative data it is seen that child immunization among the two study communities is still not impressive even after implementation of immunization service under ICDS programme since 2001. The key factors responsible for no/irregular immunization of children of the study population are as follows:

Irregular immunization: Immunization service under ICDS programme is organized by the AWWs once in a month (preferably on the 2nd or 3rd Wednesday) either at the Anganwadi centers (AWCs) or at the nearby Primary Health Centre (PHC). However, both the Hajong villages under study do not possess a PHC in the village. In addition, during the monsoon season immunization camps are not organized in the Hajong villages' as communication to the area gets suspended due to frequent rise in the water level of the Rivers Dehing and Tirap. As such, health personnel's are not able to cross the rivers and travel to the villages.

Poor awareness of mother's towards child immunization: Majority of the mothers who are literate informed that child immunization is necessary to fight against diseases which results in either death or disability of the children. But, a significant number of the illiterate Hajong mothers have shown total ignorance about the importance of child immunization as well as about the services provided at the AWC under ICDS programme on a fixed day of the month. A few mothers (mostly the illiterate or having low level of education) did not consider the matter of continued and complete immunization seriously and lost the vaccination card or forgot to immunize the child on the day.

Communication gap between AWWs and beneficiaries: The AWW is the key functionary of the ICDS programme. It was observed that the AWC which covers the beneficiaries of Katha Adarsa Hajong village is located in the neighboring village; and the AWW, who comes from a different village, fail to inform the mothers of Katha Adarsa village about the immunization programme regularly. Moreover, awareness meetings to motivate the mothers (mainly the illiterate and with low education level) to immunize their children are rarely organized by the AWWs of the micro-field. The missed opportunities and drop out cases are seldom followed up by the AWWs. The AWCs were found to lack in information, education and communication (IEC) materials viz. posters of immunization, nutrition, etc.

Inaccessibility of the health centre and economical constrains: The 04 villages under study do not possess any PHC in or within the vicinity of the village itself. Thus, it is hard for a mother to take her child to the health centre/s located at distant area if she missed the immunization camp arranged in the village or if required vaccine is not available at the camp. In fact, it was informed that a few Hajong children had discontinued immunization due to unavailability of required vaccines at the camp. Although vaccines are provided free of charge at the health centre, mothers cannot bring their children for vaccination because of economic hardship. Majority of the families of the micro-field belong to below poverty line; as such, child immunization is not a priority.

Other reasons: The elder's of the family, especially mother-in-laws make objection to immunize their grand children/s. Their observation was that they brought up all their children without any vaccination and there was no physical problem, while now-a-days many of the children after immunization often faced health problems and sometimes it leads to death. Besides, factors like inadequate training of the AWWs and the health staffs; limited capacities of the frontline health workers, particularly at the field level; weak vaccine-preventable disease (VPD) surveillance; poor monitoring and supervision at all levels; and gaps in key areas such as predicting demand, logistics, cold chain management, etc. result in high wastage rates.

The findings of the present study show that a considerable number of Hajong children are deprived from regular or complete immunization. The study revealed slightly better immunization coverage for the Kaibartta children. Lack of information and education among parents, especially maternal education was the main reason for non-immunization. Similar observation has also been made in other studies from India [6-7]. In order to improve the immunization coverage in the study area accelerated efforts should be made to increase IEC interventions to educate and motivate the mothers, especially the illiterates and the ones with low educational level. It must not be limited to a onetime event; it should be able to increase demand for vaccination. Counseling and motivational programmes for the parents, particularly mothers and female elders of the family are critical for increasing acceptability and coverage of immunization as well as modern health care practices. The immunization services provided to the four interior study villages having poor access to health facility can be improved by establishing health sub-centers or immunization booths in each of the villages. Observations from the present study point towards a pressing need to strengthen the micro planning process. Strong links at all levels between immunization system and ICDS functionaries, strengthening coordination and review meetings, strengthening surveillance, providing proper training, including basic minimum education on vaccines to all the service providers associated with the immunization programme and undertaking periodic impact assessments studies would help in overcoming all barriers (geographical, socio-cultural, economic and technical) and add to achieve higher coverage of RI among the children in the study area.

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