

**Summer Training at
Urban Health Resource Centre,
Indore**

Study on Immunization Status of Migrant Brick Kiln Workers

**By
Yogesh Kumar Lahari**

**Under the guidance of
Dr. Neetu Purohit**

**MBA Hospital and Health Management
2015-2017**



**The IIHMR University, Jaipur
2016**

CERTIFICATE

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Dr. Yogesh kumar Lahari** student of **MBA Hospital and Health Management** from the IIHMR University; Jaipur has undergone summer training at **Urban Health Resource Centre, Indore** from 1st April to 31st May, 2016.

The candidate has successfully carried out the study designated to him during summer training and his approach to the study has been sincere, scientific & analytical.

The internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.



Col. (Dr.) Ashok Kaushik
Dean (Academics & Student Affairs)
IIHMR University, Jaipur



Dr. Neetu Purohit
Associate Professor
IIHMR University, Jaipur

Certificate of Internship

This is to certify that Dr. Yogesh Lahari, interned with Urban Health Resource Centre (UHRC), Indore from 1st April, 2016 to 1st June, 2016. His work involved primary data collection from migrant workers on brick kiln through field visits and documentation of basti children's groups' sports day event report.

His work was satisfactory.

UHRC wishes him all the best for a bright future.



Dr. Siddharth Agarwal

(Executive Director, UHRC New Delhi).



Mr. Neeraj Verma



Ms. Shabnam Verma

(City Program Coordinator UHRC, Indore) (Capacity building coordinator, UHRC, Indore)

ACKNOWLEDGEMENT

The success of any task would be incomplete without the expression of gratitude to the people who made it possible. I express sincere gratitude towards everyone who helped directly or indirectly in completion of my Summer Training from UHRC (INDORE).

At the onset of my report, I would like to acknowledge my sincere thanks to our institute, Institute of Health Management and Research, Jaipur for providing us platform to gain enough knowledge and skills in different aspects of health management.

I express my gratitude and regards to my mentor Prof. Neetu Purohit for her able guidance and useful suggestions which helped me in completing the project work.

Special thanks to our organisation director Dr.Siddharth Aggrawal and project coordinator Shabnam Verma for the faith shown upon me and guidance given without which the assignment would not have been possible.

I would like to thank to supervisors and coordinators for their help at various stages of my project.

I would also like to thank my faculty members without whom this project would have been a distant reality. My seniors and colleagues Dr.Ajmal Khan and Dr.Kavya Shrivastava who also hold a special mention here for believing in me and supporting me throughout summer training.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents for their blessings and my friends for their help and wishes for the successful completion of this training.

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LIST OF ABBREVIATIONS

ACRONYM	FULL FORM
UHRC	Urban Health Resource Centre
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
USAID	United States Agency for International Development
IPV	Injectable Polio Vaccine
RI	Routine Immunization
DPT	Diphtheria + Pertussis + Tetanus
JE	Japanese Encephalitis
VPD	Vaccine Preventable Disease
MOHFW	Ministry of Health and Family Welfare
IMR	Infant Mortality Rate
NMR	Neonatal Mortality Rate
UIP	Universal Immunization Programme
EPI	Expanded Programme of Immunization
NFHS	National Family Health Survey
OPV	Oral Polio Vaccine
ASHA	Accredited Social Health Activist
UP	Uttar Pradesh
MP	Madhya Pradesh
BCG	Bacillus calmette-guerin
Hib	Haemophilus Influenza b
CES	Coverage Evaluation Survey

PURPOSE OF SUMMER INTERNSHIP:

Practical exposure is an integral part of MBA in Health and Hospital management programme. As a part of the curriculum, I had the privilege to “get hands” on experience in URBAN HEALTH RESOURCE CENTRE where I learnt the functioning of the organization and various health projects and training. During my internship, I visited different brick kiln and construction sites for collection of data.

Objectives of internship study:

- To understand functioning of the Organisation
- To understand the on-going activities and my responsibility so as to contribute in the best possible manner to the Organization and project given to me.
- Develop skills in collection of primary data, operations & managing the tasks and to handle managerial issues of the program.
- The above objective required extensive reading and interaction with the staff to get a brief idea of functioning of the Organization.

DESCRIPTION OF ORGANISATION-

UHRC-An overview

Urban Health Resource Centre is a nongovernmental organization that addresses health, nutrition and wellbeing of the disadvantaged urban dwellers through demonstration programmes, technical support to government and non-government sector, research, advocacy and knowledge dissemination through a consultative and partnership based approach.

The Urban Health Resource Centre is functioning towards addressing Health issues of the urban poor in partnership with the government and civil society.

It provides technical assistance and generates and disseminates urban health information to address understanding gaps on the health of people in underprivileged slum settlements. Demonstration and research activities conducted by UHRC in diverse cities provide evidence-based inputs for strengthening programming efforts of government and non-government agencies.

UHRC advocates, at various platforms, for enhanced attention to the health of the urban poor. UHRC's focus is on improving life in the slums and addressing gender inequity. This is done through empowering women's groups and their federations, developing community-based health and development funds, and empowering women to take charge of their health, nutrition and well-being. Through strengthened community groups, coordination with providers, programs facilitate access of services to the vulnerable, socially "lost" sections of society.

UHRC was established in 2005 as a registered non-profit company under India's Companies Act, 1956 with the aim of working towards socio-economic empowerment, improved quality of life, health, nutrition, and general well-being for urban disadvantaged families. Its start up was supported by USAID between 2004 and 2005, but as of 2009, the UHRC no longer receives USAID financial support.

UHRC is broadening beyond health, utilizing its capacity in community organizing and building community capital to address needs beyond health and nutrition; as well as its capacity for knowledge sharing and advocacy. UHRC acknowledges that learning by doing is the core building capacity. Hence, this broadening its scope would lead to the organization's own capacity building in areas that it has so far not focused and make the organization better equipped to address the health and wellbeing of urban slum dwellers of different cities.

MISSION STATEMENT-

The mission of UHRC is to bring about sustainable improvement in the health as well as living condition of urban poor by influencing policies, programmes and empowering the community

VISION

Our vision in urban India, every resident enjoy optimal health, nutrition and well-being, realizes his/her full potential and contribute to the nation growth and development

MAIN OBJECTIVE OF ORGANISATION

1. Develop innovative urban health programmes in cities of different sizes that can be adapted by the government and non-government agencies
2. Strengthen urban health programme approaches and capacities at different level among the government and non-government partners
3. Increase availability of urban poor specific health information and programme experiences among various stakeholders through research, documentation and various dissemination.
4. Advocate enhanced attention on urban health, targeted policies and increased allocation of resources for slum dwellers
5. Demonstrate and advocate for empowerment of slum communities, especially women and children as a means to achieve and sustain improvement in healthcare

OBSERVATIONAL LEARNINGS

Urban health resource centre implements demonstration programmes in diverse cities (Indore, Agra, Meerut and Delhi) such that they may be adapted, replicated, and up scaled by other agencies.

- **Team work enhancing activities-**

UHRC has always been unique in its celebration of events. They organised Sports Day for the underprivileged children at Nandbagh slum in Indore. This activity was supported by Blue Dart, under these activity five types of sports played by children who included General Race, Sack Race, Lemon Race, Passing the Ball and 3 leg races. The play was witnessed by around 50 children the idea of organising Sports event help children gaining lifelong skills and positive peer relationship are also encouraged through sports. They can gain self-esteem when they are enjoying the experience of taking part in sports. These types of activities are very helpful for children overall growth. Through taking up the role of arranging the activities and then playing games help those to learn team work.

- **Awareness rally on clean drinking water organised by UHRC**

An awareness rally on the significance of consuming safe drinking water was carried out in the city by slum youth, children and women organised by UHRC Indore. Over 600 group member marched in rally which aimed at promoting simple low cost methods of keeping drinking water clean. The rally also sought to highlight the diseases that spread due to consumption of unhygienic water. The motive of this rally was to aware people for using safe drinking water and importance of safe water. Water treatment methods include boiling, filtration and disinfection with chemicals like chlorine methods are presented through banners and pamphlet. Combining the provision of safe water with educational, behavioural and promotional aspects will have a positive impact on the conditions of the community.

- **Stimulating education activities for disadvantaged children.**

Four sessions of general knowledge quiz organised in different children-youth groups in slums in Indore for 100 children-youth group members, UHRC team members organised the quiz sessions in four locations.

- **Strengthening mobile library and encouraging use of library.**

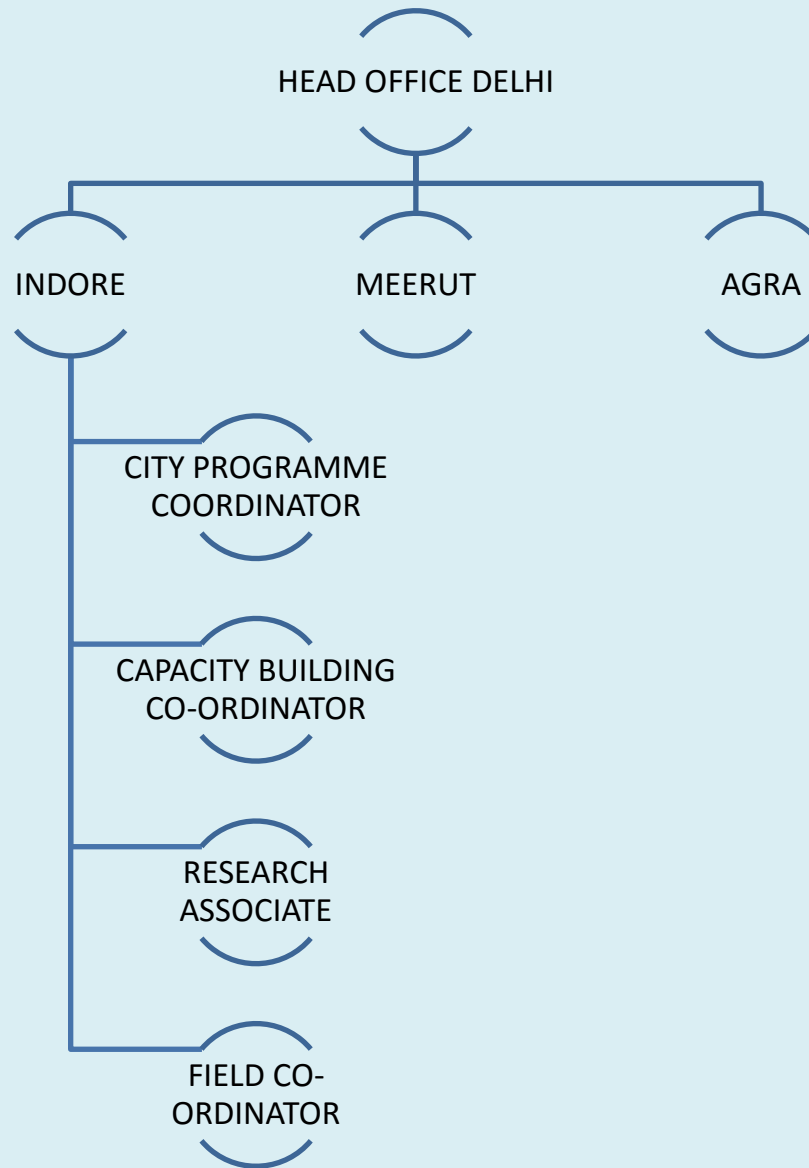
The mobile library presently operates among slum children-youth groups and managed by the children's group leaders, women's group leaders in the respective slum clusters with support from UHRC social facilitator. UHRC Indore team members will focus on motivating children youth group members during their monthly meeting to use the library material and gain knowledge.

- **Hygiene and hand washing**

UHRC Volunteer teaches hygiene and hand washing through proper demonstration with water and soap to reduce the risk of the transmission and spread of bacteria, pathogen and virus that causes the disease and infections. As after the heavy rainfall in slum drains in the slum get blocked in turn garbage and waste accumulates in the street therefore risk of infection through dirty hands get increase. Hand washing promoted to women and children in slum area for better spread of practice of proper hand washing.

ORGANOGRAM

HEAD OFFICE DELHI



DEFINITION

Immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease.

Under the Universal Immunization Programme, Government of India is providing vaccination to prevent eight vaccine preventable diseases nationally, i.e. Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B and meningitis & pneumonia caused by Haemophilus influenza type B, and against Japanese Encephalitis in selected districts.

Polio: India reported its last case of polio on 13th January 2011. South East Asia Region (SEAR) has been certified Polio free on 27th March, 2014. As a part of Polio end game strategy, Injectable Polio Vaccine (IPV) vaccine has been introduced in 6 states from 30th November 2015 in Phase 1. In 2016, IPV will be introduced in the remaining states.

Measles: Nationwide coverage of Measles first dose was started in 1985 in Routine immunization (RI). 2nd dose of Measles was introduced in 2010; in 22 states immediately in RI and in remaining 14 states in RI after campaign (Measles Supplementary Immunization Activity) covering ~12 crore children. As on date, the entire country is providing two dose measles vaccine schedule under routine immunization.

Hepatitis B: Hepatitis B vaccine was piloted in 2002-03 and then scaled up in entire country in 2010 to protect children from liver diseases such as Jaundice and Cancer.

Pentavalent vaccine: Pentavalent vaccine contains five antigens i.e. Hepatitis B, Diphtheria + Pertussis + Tetanus (DPT – current trivalent vaccine) and Haemophilus influenza b (Hib) vaccine. Pentavalent vaccination is provided to the children at the age of 6, 10 and 14 weeks as primary dose. The vaccine has replaced DPT and Hep B vaccine in the immunization schedule. However, birth dose of Hep B and two booster doses of DTP (at 16-24 month and 5 years of age) will continue to be given. India introduced pentavalent vaccine initially in two states viz. Kerala and Tamil Nadu in December 2011. At present, pentavalent vaccine has been expanded to all 36 States/UTs.

Rotavirus Vaccine: to be given under UIP as a 3 dose vaccine along with DPT 1st, 2nd and 3rd dose in a phased manner, initially in four states i.e. Andhra Pradesh, Odisha, Haryana and Himachal Pradesh in first quarter of 2016. Subsequently, the vaccine will be scaled up in entire country.

Japanese encephalitis: Japanese Encephalitis (JE) is an acute viral illness with high case fatality and long term complications. JE vaccination program started in 2006 in JE endemic areas with strategy to cover all children of 1-15 years of age in mass vaccination drive (campaign mode) and subsequent integration into routine immunization. Out of total 204 identified JE endemic districts across 21 states, campaign activity has been completed in 182

districts and JE vaccine has been introduced as a part of RI in those districts (two doses, first at 9-12 months and second at 16-24 months). In addition, there is a plan to cover remaining districts in subsequent years

Operational definitions

Fully vaccinated child

Any child who had received one dose of BCG, three doses of DPT, three doses of OPV, and one dose of measles by 1 year of age was considered fully vaccinated.

Dropouts or partially vaccinated child

Any child who received at least one dose of vaccination by 1 year of life, but did not complete all doses.

Left outs or unvaccinated child

If child had never received any of the vaccines by 1st year of life.

Overall dropout rate

The percentage difference between the vaccines of maximum and minimum antigen received expressed as a percentage of the maximum antigen.

Migrant site/colony

The sites included brick kilns, slums, construction sites, or temporary settlements having more than 10 households with families coming from other states and residing within Indore for more than 1 month prior to the date of interview.

Resident district

The district of residence where migrants resided prior to migrating to current location

Overall dropout rate

The percentage difference between the vaccines of maximum and minimum antigen received expressed as a percentage of the maximum antigen.

TOPIC OF RESEARCH-

A STUDY IMMUNIZATION ON IMMUNIZATION STATUS OF CHILDREN OF MIGRANT BRICK KILN WORKERS

INTRODUCTION

Globally, 19.3 million infants did not receive diphtheria, pertussis, and tetanus (DPT) vaccine in 2010. Nearly 70% of these children live in 10 developing countries of Africa and Asia including India. India achieved 61% immunization coverage in 2011. However, the dropout rate from Bacillus Calmette-Guérin (BCG) to measles and BCG and DPT3 is 14.7 and 17.7%, respectively in India (Coverage Evaluation Survey (CES) 2009 UNICEF report). The dropout rates are higher among migrants who have poor service utilization. Floating population, overcrowding poor sanitation, and personal hygiene lead to higher transmission of vaccine preventable diseases (VPD). Studies on determinants of immunization have shown that nearly one in three migrant children is unable to complete their course of vaccination. Government of India declared 2012 as “the year of intensification of routine immunization” a campaign-like strategy to reach all children including migrants in remote inaccessible backward areas and urban slums.

In an era of globalization, migration is a burning topic of interest to almost all countries and Communities.

The term ‘migrants’ includes the categories of migrant workers and their families, long-term and Short-term immigrants, refugees and asylum seekers, victims of human trafficking amongst others. According to present estimates, there are an approximate 214 million international migrants, 740 million internal migrants and an unknown number of migrants in an irregular situation throughout the globe.

Immunization Programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. It is one of the largest immunization programmes in the world and a major public health intervention in the country.

Immunization Programme in India was introduced in 1978 as Expanded Programme of Immunization (EPI). The programme gained momentum in 1985 and was expanded as Universal Immunization Programme (UIP) to be implemented in phased manner to cover all districts in the country by 1989-90. Under the Universal Immunization Programme, Government of India is providing vaccination to prevent eight vaccine preventable diseases nationally, i.e. Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood

Tuberculosis and Hepatitis B and meningitis & pneumonia caused by Haemophilus influenza type B, and against Japanese Encephalitis in selected districts. Immunization coverage refers to information on the proportion of children who have received specific vaccines or are up to date with the recommended vaccine schedule. This information is essential for planning immunization programmes, identifying vulnerable groups or areas that require targeting of increased resources, assessing the acceptability of a programme, and predicting likely vaccine-preventable disease epidemics.

Children are considered fully immunized if they receive one dose of BCG, three doses of DPT and polio vaccine each, and one measles vaccine. In India, only 44% of children aged 12–23 months are fully vaccinated and about 5% have not received any vaccination at all [3].

In spite of 20 years of efforts and millions of dollars poured into Universal Immunisation programme (UIP), our coverage rate has still not crossed the 50% mark. Immunization coverage showed improvement since National Family Health Survey-1 (NFHS-1), when only 36% of children were fully vaccinated and 30% had not been vaccinated at all. But there was very little change in immunization coverage between NFHS-2 (42%) and NFHS-3 (44%) .

Migration is a common phenomenon to almost all countries and communities including India. Brick kiln industry with 50000 kilns is one of the major sectors that employs large number of low caste and tribal seasonal migrants. Children with high morbidity and mortality are the most vulnerable group among migrants and need special care.

In spite of significant reductions in child mortality in developing countries in recent decades, more than 10 million children younger than 5 years continue to die yearly. Vaccine-preventable diseases (VPDs) constitute major causes of morbidity and mortality in India. About 95 per cent of the estimated 14 million deaths of children below 5 years of age worldwide occur in developing countries; approximately 70 per cent of these deaths are due to vaccine-preventable diseases

The rich geographical, cultural, ethnic, and socio-economic diversity of India implies that immunization uptake varies between and within geographical regions. These variations may subsequently lead to clusters of children that are under-vaccinated, thereby increasing the vulnerability of the rest of the population to major outbreaks of vaccine-preventable diseases.

Migration has been implicated as one of the behavioural processes influencing low immunization uptake. Population migration is a choice process that is influenced by socio-economic, demographic and cultural factors]. Socio-economic factors, such as the expectation of better earnings and employment opportunities, access to modern amenities, seem to a greater extent instrumental in the motives of the rural residents to migrate into cities

Three perspectives of migration could be used to explain the disparities in child immunization uptake among migrant groups. These include: i) disruption; ii) selection; and iii) adaptation. Migrant disruption posits that the process of migration disrupts the natural progression of demographic events in the lives of the migrants, such as break in mothers'

network of social- and financial support, as well as social & cultural practices This disruption may interfere with child immunization uptake and consequently necessitate a significant period of adaptation, and is associated with the migration process itself. Migrant status variable was used to test the migrant disruption perspective in this study.

The present study showed that only 28% of the children amongst the migrant families were totally timely immunized. A study by MOHFW 2008 shows that 60% of the migrant children are partially immunized in India.

Even if national immunization coverage levels are sufficiently high to block disease transmission, pockets of susceptibility may act as potential reservoirs of infection. It is therefore essential to know if under-vaccination is a problem in specific population group, which involves determining inequalities in coverage level. Thus, the present cross-sectional study was undertaken to assess the immunization coverage and various socio-demographic factors affecting the same in an urban slum population of INDORE, India.

NATIONAL IMMUNIZATION SCHEDULE

National Immunization Schedule for Infants, Children and Pregnant Women				
Vaccine	When to give	Dose	Route	Site
For Pregnant Women				
TT-1	Early in pregnancy	0.5 ml	Intra-muscular	Upper Arm
TT-2	4 weeks after TT-1*	0.5 ml	Intra-muscular	Upper Arm
TT- Booster	If received 2 TT doses in a pregnancy within last 3 yrs*	0.5 ml	Intra-muscular	Upper Arm
For Infants				
BCG	At birth or as early as possible till one year of age	0.1ml (0.05ml till 1mth age)	Intra-dermal	Left Upper Arm
Hepatitis B	At birth or as early as possible within 24 hours	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral
OPV 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	2 drops	Oral	Oral
DPT 1,2 & 3	At 6 weeks 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Hep B 1, 2 & 3	At 6 weeks 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Measles	9 completed months-12 months.	0.5 ml	Sub-cutaneous	Right upper Arm
Vitamin-A (1stdose)	At 9 months with measles	1 ml (1 lakh IU)	Oral	Oral
For Children				
DPT booster	16-24 months	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Measles 2nd dose	16-24 months	0.5 ml	Sub-cutaneous	Right upper Arm
OPV Booster	16-24 months	2 drops	Oral	Oral
Japanese Encephalitis**	16-24 months	0.5 ml	Sub-cutaneous	Left Upper Arm
Vitamin-A***				
(2nd to 9th dose)	16 months. Then, one dose every 6 months up to the age of 5 years.	2ml (2 lakh IU)	Oral	Oral
DPT Booster	5-6 years	0.5 ml.	Intra-muscular	Upper Arm
TT	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

*Give TT-2 or Booster doses before 36 weeks of pregnancy. However, give these even if more than 36 weeks have passed. Give TT to a woman in labour, if she has not previously received TT.

** JE Vaccine, in select endemic districts after the campaign.

*** The 2nd to 9th doses of Vitamin A can be administered to children 1-5 years old during biannual rounds, in collaboration with ICDS.

Mission Indradhanush

The result is the 'Mission Indradhanush' launched on 25th December, 2014 with an aim to cover all those children who are partially vaccinated or unvaccinated. 'Mission Indradhanush' is a nationwide initiative with a special focus on 201 high focus districts. These districts account for nearly 50% of the total partially vaccinated or unvaccinated children in the country. Mission Indradhanush will provide protection against seven life-threatening diseases (Diphtheria, Whooping Cough, Tetanus, Polio, Tuberculosis, Measles and Hepatitis B). In addition, vaccination against Japanese Encephalitis and Haemophilus influenza type B will be provided in selected districts of the country. Vaccination against tetanus will be provided to the pregnant women.

Between 2009-2013 immunisation coverage has increased from 61% to 65%, indicating only 1% increase in coverage every year. To accelerate the process of immunization by covering 5% and more children every year, the Mission Mode has been adopted to achieve target of full coverage by 2020. High-focus 201 districts will be taken up for implementation in the first phase. Of these, 82 districts are in just four states of UP, Bihar, Madhya Pradesh and Rajasthan and nearly 25% of the unvaccinated or partially vaccinated children of India are in these 82 districts of four states. .

The Government of India has launched Mission Indradhanush on 25 December 2014 as a special drive to vaccinate all unvaccinated and partially vaccinated children and pregnant women by 2020 under the Universal Immunization Programme.

Since the launch of Universal Immunization Programme in 1985, full immunization coverage in India has not surpassed 65% despite all efforts. Mission Indradhanush focuses on interventions to expand to more this coverage to more than 90% children.

Under Mission Indradhanush, the Government has identified 201 high focus districts (list annexed) across the country. These districts have been identified based on a composite indicator, considering full immunization coverage, number of partially vaccinated and unvaccinated children and whether the district is an identified HPD or EPRP HR district. Nearly 50% of all unvaccinated or partially vaccinated children in India are in these 201 districts. Intensified routine immunization campaigns in these districts will help reduce morbidity and mortality due to vaccine preventable diseases. This will be done through special catch-up campaigns to rapidly increase full immunization coverage

NEED FOR RESEARCH

We wanted to understand current state of immunization in migrant brick kiln workers. . Migrants carry with them a health risk and public health implication due to their epidemiological profile, their exposure to infectious agents, their genetic and life style related risk factors, and culture based health beliefs. Migrants often have to deal with poverty, marginality, stigmatization and unequal access to social benefits including healthcare services. Disparities in the access to health care and denial of the migrants' right to health are the major issues at hand.

OBJECTIVE

- To assess immunization status of under 10 years children of Bhangarh brick kiln migrant workers.
- To identify reasons behind incomplete immunization.

RESEARCH METHODOLOGY

The present community based descriptive study was conducted at Bhangarh brick kiln urban slum from 1 April to 30 may 2016. . .

The study population comprised children aged 0-10 YEARS. Age was confirmed by birth certificate or immunization card or, when it was not available, by asking the mothers (using a standardized Indian calendar and major holidays as reference points).

Complete Immunisation- Children have received BCG, measles, and three doses of DPT, hepatitis B, and OPV each (excluding OPV-0).

Partial/Incomplete Immunization- Children who have received at least one of the above-mentioned vaccines.

Unimmunised Children-Children have not received any vaccine.

Preformed, pretested, semi structured questionnaire was used to collect information from mothers regarding socio-demographic parameters, status of immunization of their child, and reasons for noncompliance (if applicable). To maintain privacy, information was collected maintaining utmost privacy as per the convenience of respondents. Time required to complete

one interview was 30-35 minutes. The collected data was numerically coded and entered in Microsoft Excel

Study Design:

Descriptive Research Study Area: The study area was bhangarh brick kiln, Indore

Indore was chosen as study area because Indore is the economic capital of Madhya Pradesh and the state's most populous city, with a population of 1.8 million. Being an economic hub, it attracts migrants from adjoining hinterlands. Latest released data of Annual health survey shows the shocking results in context of Infant Mortality Rate (IMR), Child Mortality Rate (CMR/U5MR) and Neo Natal Mortality Rate (NMR). In all EAG (Empowered Action Group) states Madhya Pradesh stated first or second among all. The situation of Madhya Pradesh is very grim. This survey also revealed that female infants experience higher mortality than males. Also in List of top 100 districts in order of IMR Madhya Pradesh contributed 30 districts in this list..

Study Population: Parents of children age below 10 years.

Study Period: The was carried out for 2 Months (1st April to 31st May, 2015)

Data Collection: Interview method

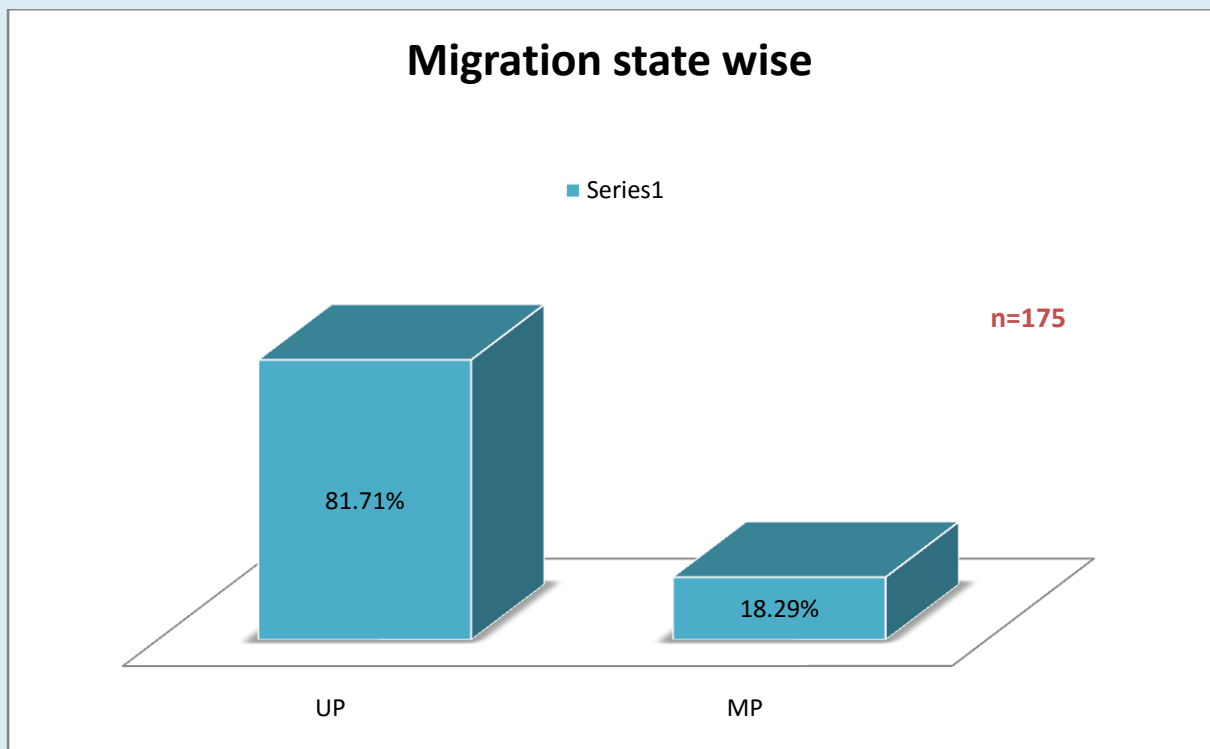
- ☐ Face to Face interview – All the parents were interviewed by Door to Door visit.
- ☐ Semi-structured Questionnaire – A questionnaire of close ended questions was made to get specific and relevant information from parent regarding the immunization status of their child.

Data Preparation:

Data Entry - All the responses were entered into Microsoft excel.

Coding of data - Different responses from the respondent were coded numerically for the closed ended questions and entered in MS excel. ☐ cleaning of data ☐ Missing values were removed from the dataset.

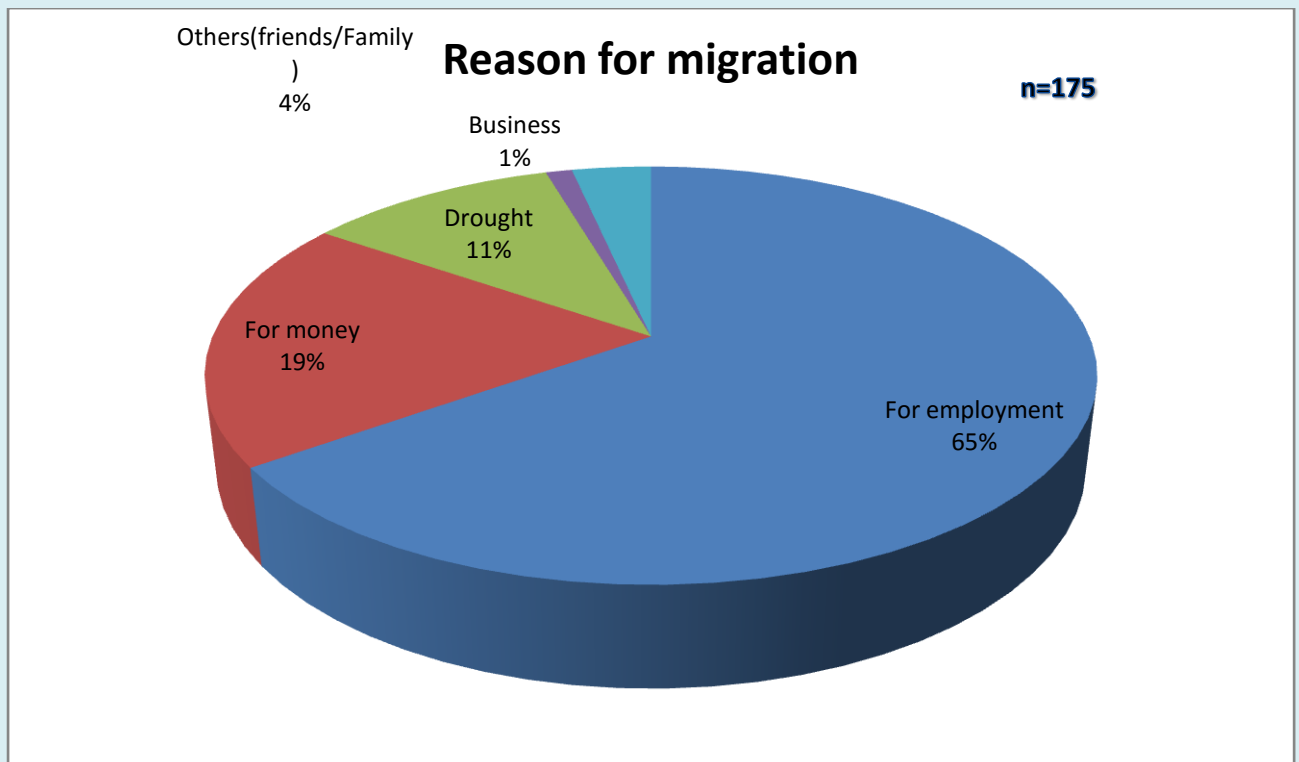
FINDINGS AND RESULT-



Graph-1

MIGRATION FROM-STATE WISE

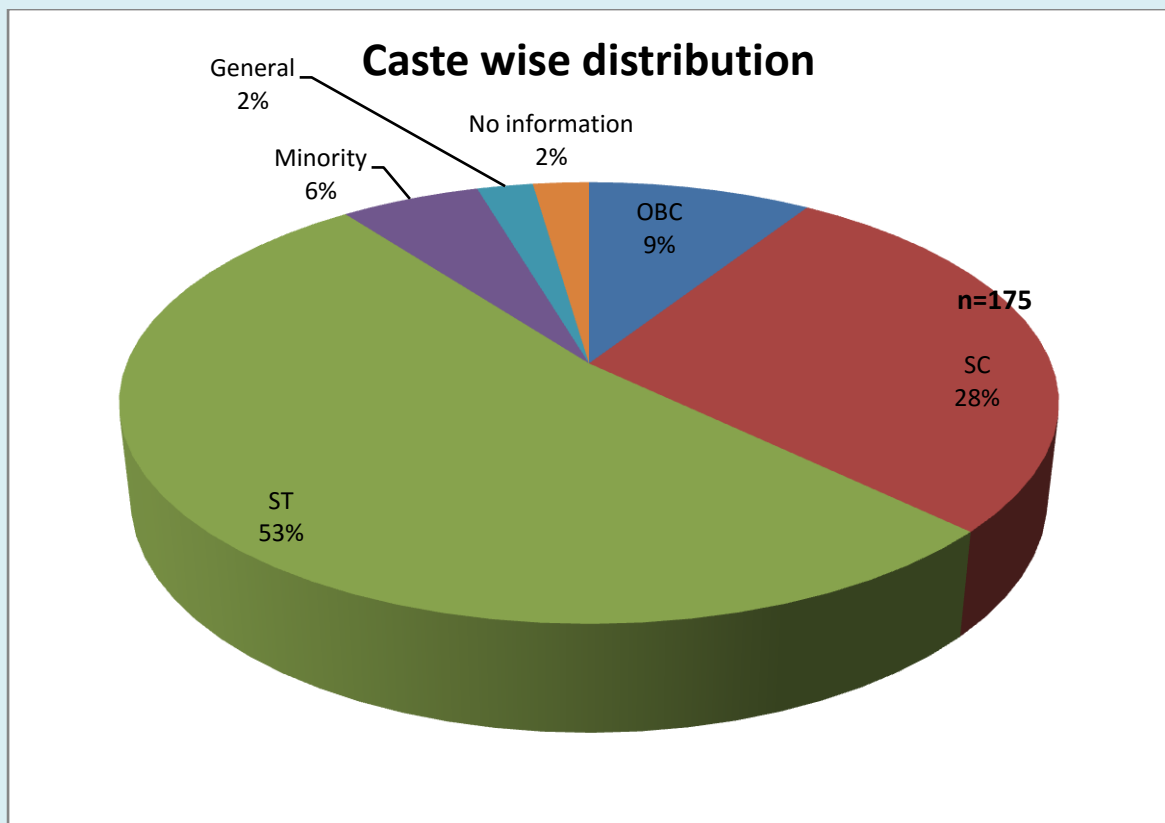
Out of 175 families, 143 families migrated from Uttar Pradesh (up) and 32 families migrated from Madhya Pradesh (MP) Around 81% of families migrated from up to brick kiln.



Graph-2

Reason for migration

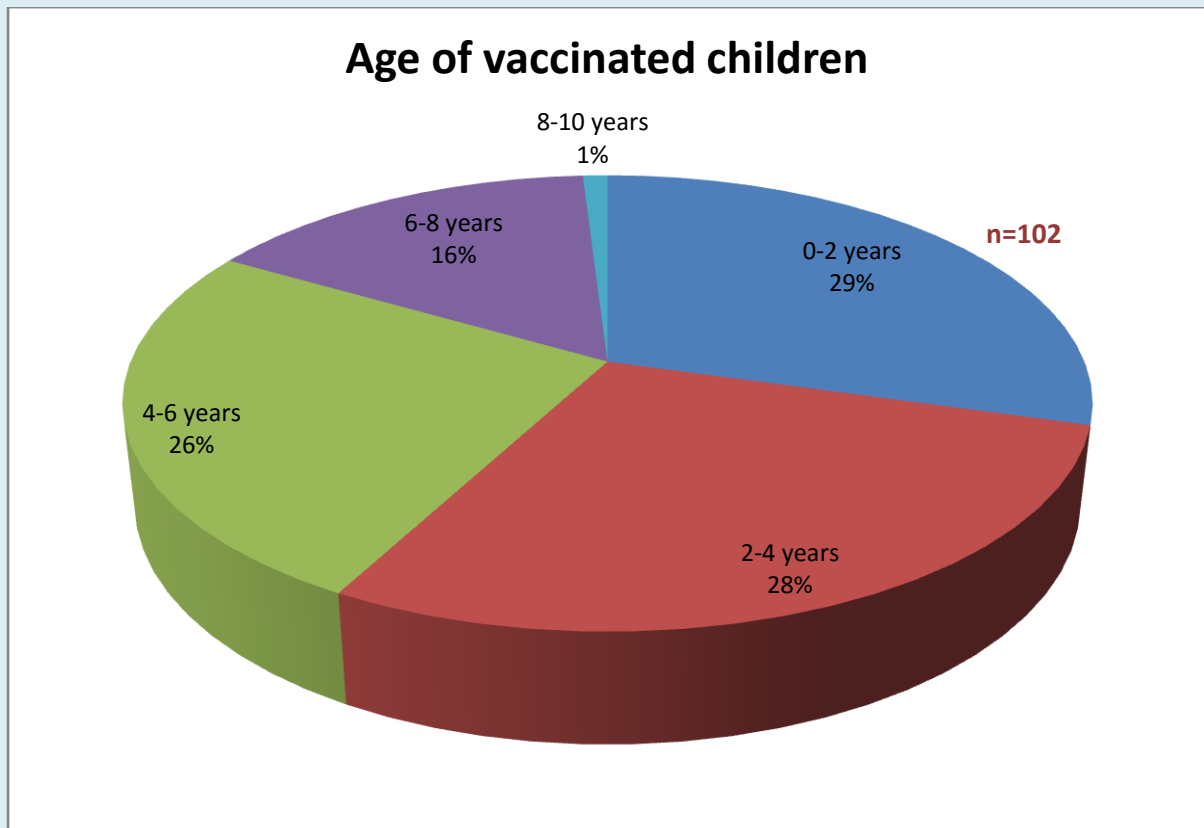
Out of 175 families, 114 families reason of migration was unemployment, 34 families reason of migration was money issues, 19 families reason of migration was drought in their village, 2 families reason of migration was business in Indore, 6 families reason of migration was other (because of friends and family). Over 65% families migrated due to geographical constraints having limited economic activities. Limited economic activities also restrict employment opportunities. Unemployment is the biggest reason for rural to urban migration.



Graph-3

CASTE WISE DISTRIBUTION

Out of 175 families, 92 families from scheduled tribe which comprises 53% of total. 49 families from scheduled caste which comprises 28% of total. 16 families from backward caste which comprises 9% of total. Out of 175 families, 4 families from general which comprises 2% of total. Out of 175 families, 10 families from minority which comprises 6% of total.

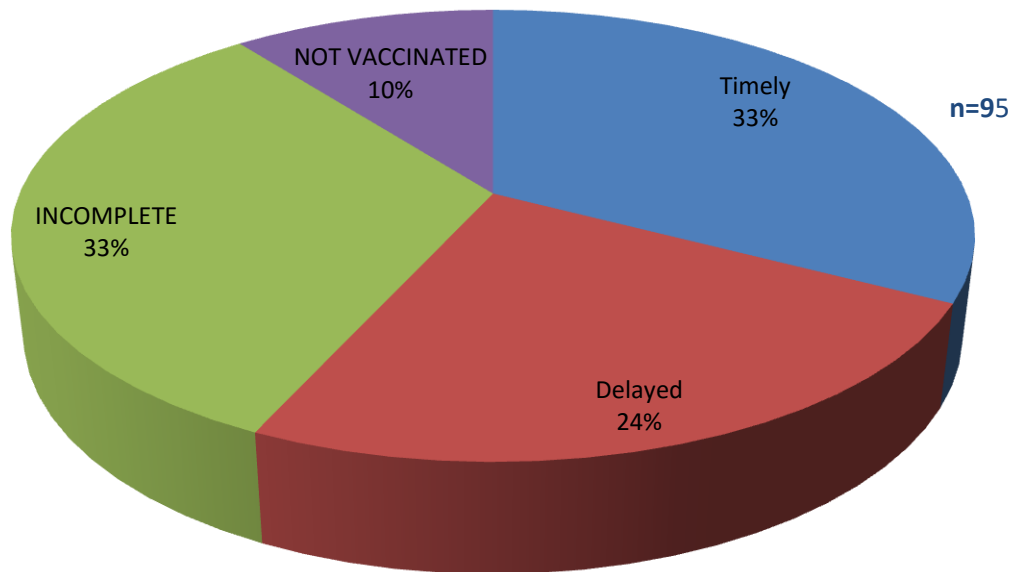


Graph-4

Age distribution of vaccinated children

Out of total 175 families, 102 families have children in which 30 children age was between 0-2 years. 29 children age was between 2-4 years. 26 children age was between 4-6 years. 16 children age was between 6-8 years. 1 children age was between 8-10 years

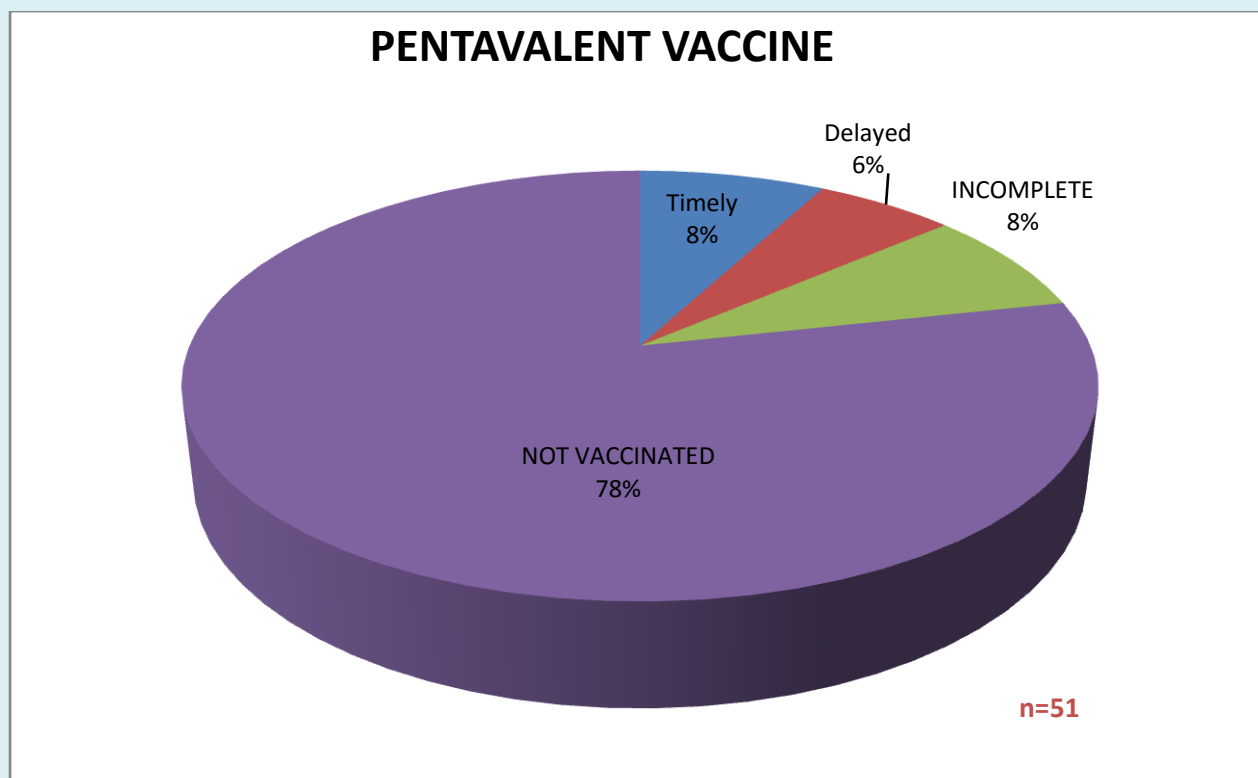
DPT AND POLIO VACCINE



Graph-5

DPT AND POLIO VACCINE INTERPRETATION

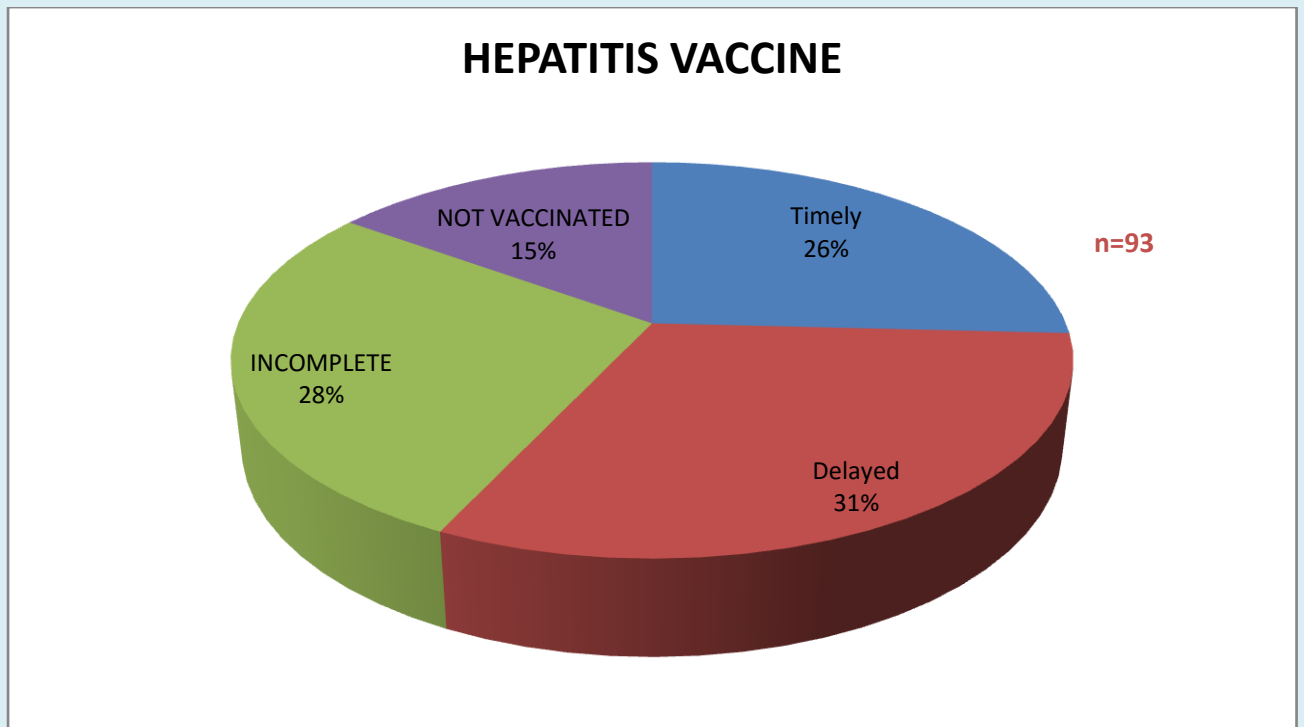
Out of total 95 children, 31 children were timely immunized. , 23 children were delayed immunized, 31 children were incomplete immunized, 10 children were not immunized



Graph-6

PENTAVALENT VACCINE

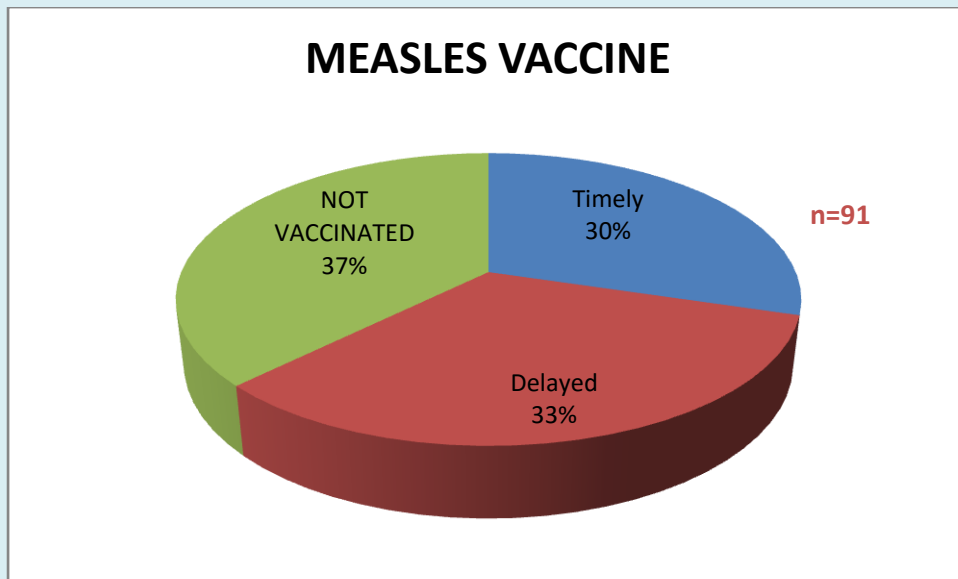
Out of total 51 children, timely immunized were 4 which comprises 8% of total, delayed immunized were 3 which comprises 6% of total, incomplete immunized were 4 which comprises 8% of total, not immunized were 40 which comprises 78% of total.



Graph-7

HEPATITIS VACCINE

Out of total 93 children, timely immunized were 24 which comprises 26% of total, delayed immunized were 29 which comprises 31% of total, incomplete immunized were 26 which comprises 28% of total, not immunized were 14 which comprises 15% of total.

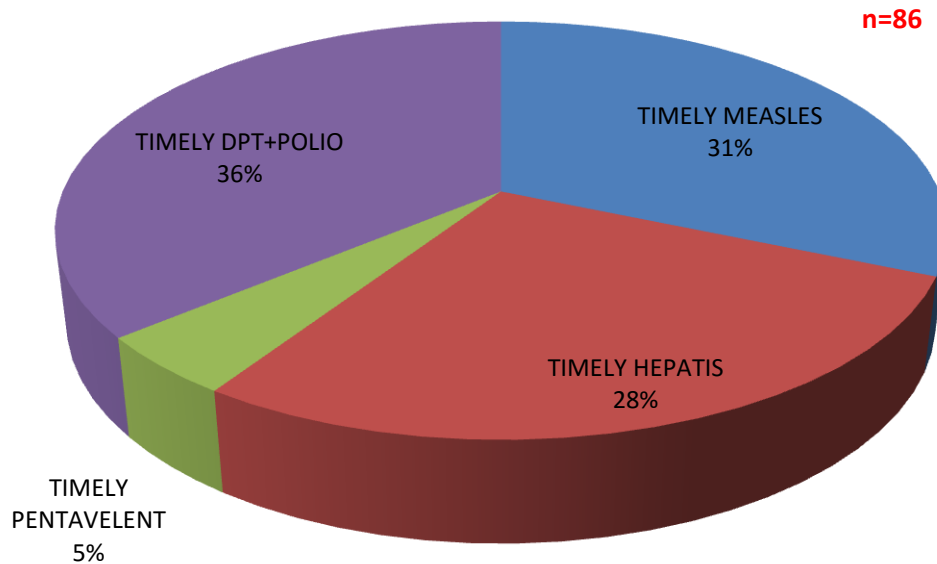


Graph-8

MEASLE VACCINE

- Out of total 91 children, timely immunized are 27 which comprises 30% of total, delayed immunized are 30 which comprises 33% of total, not immunized are 34 which comprises 37% of total

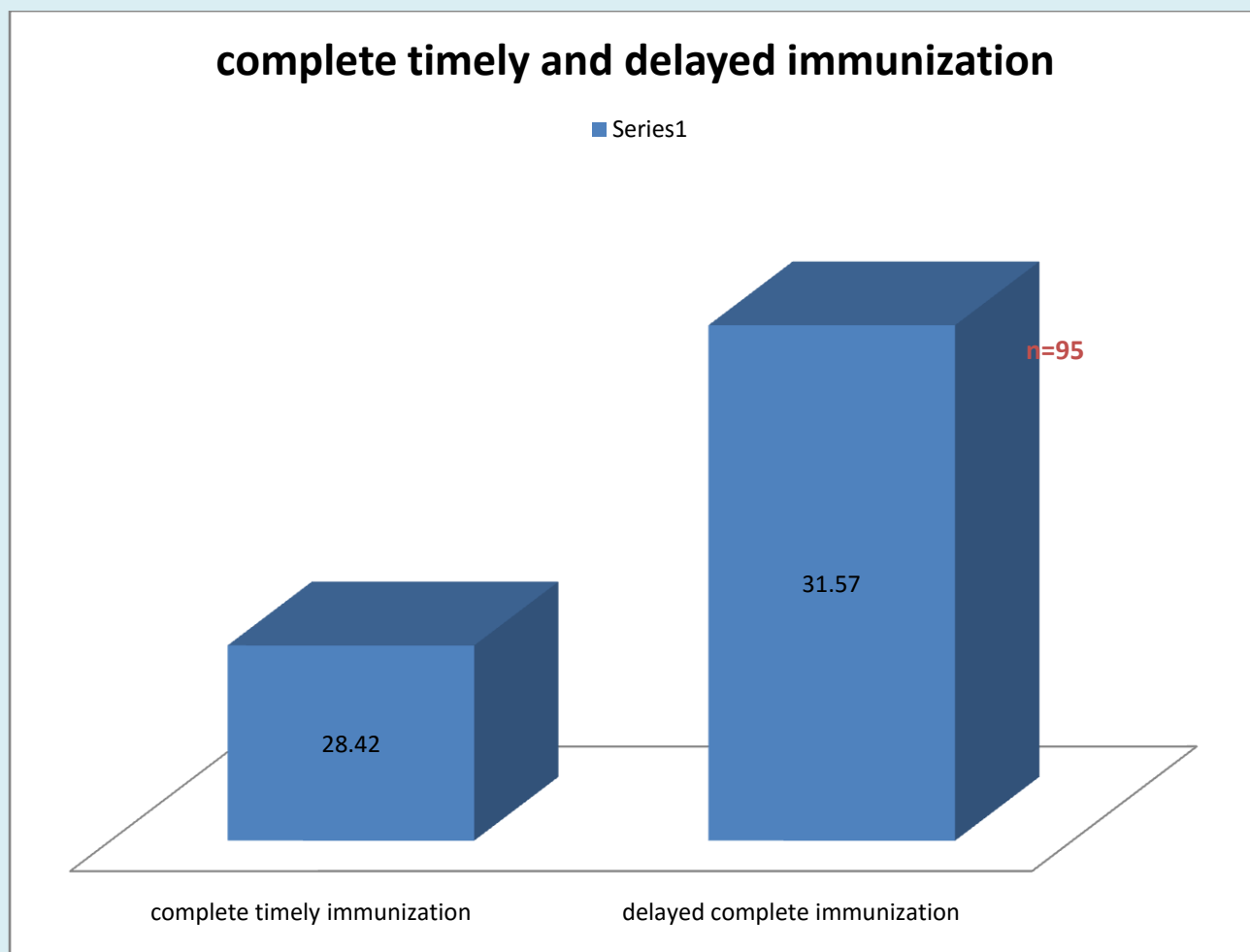
Timely vaccination of vaccines



Graph-9

TIMELY VACCINATION

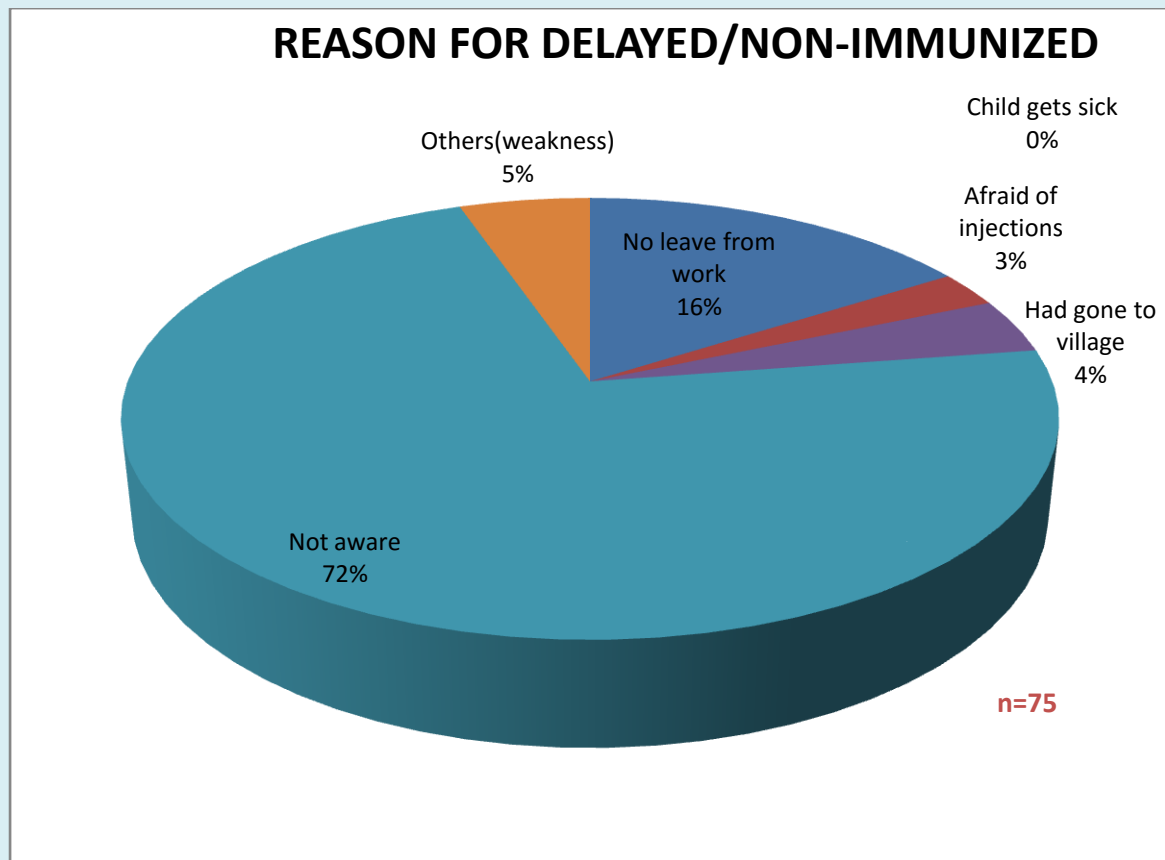
- Out of total 86 children, timely immunized for DPT are 33 which comprises 36% of total, timely immunized for pentavalent are 4 which comprises 5% of total, timely immunized for hepatitis 24 which comprises 28% of total, timely immunized for measles 27 which comprises 31% of total



Graph-10

COMPLETE TIMELY AND DELAYED IMMUNIZATION

Out of total 95 children, 27 children are complete timely immunized. 30 children are delayed immunized

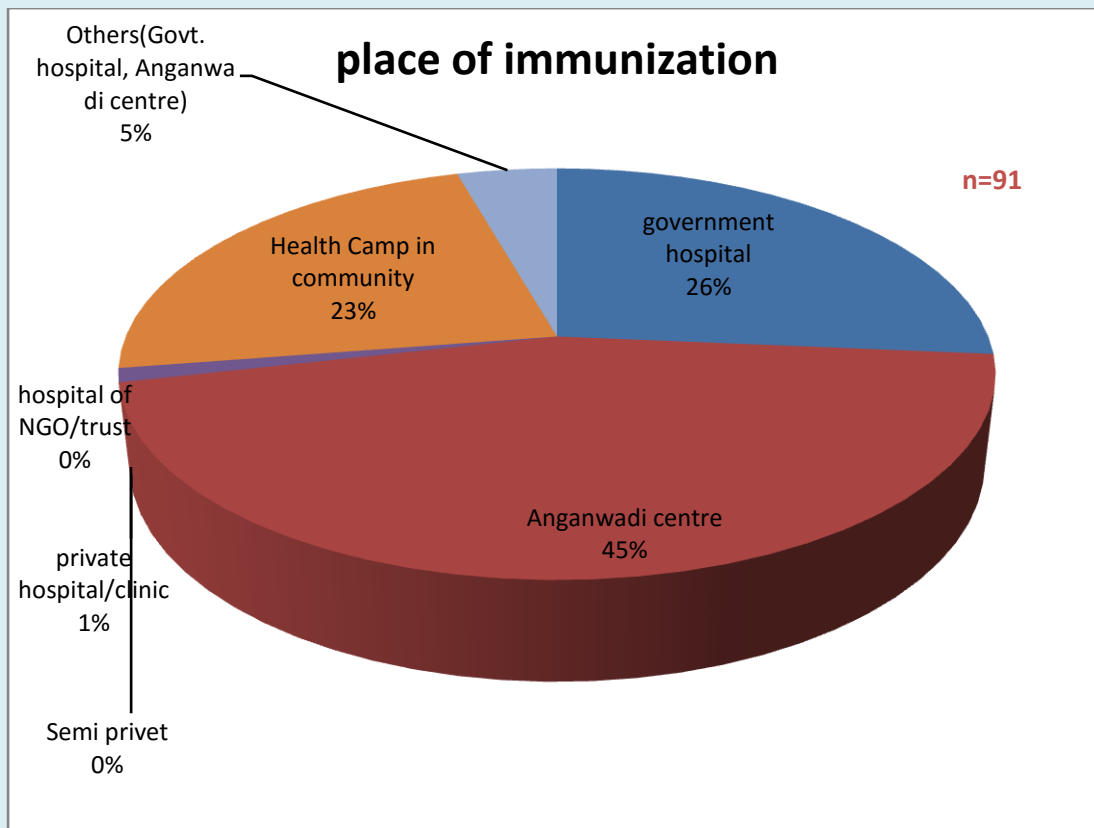


Graph-11

REASON FOR DELAYED OR NO IMMUNIZATION

Out of total 175 families, 75 families have children who are delayed or non-immunized in which 54 families reason for delayed immunization is lack of awareness about immunization, 12 families reason for delayed immunization is no leave from work, 3 families reason for delayed immunization is had gone to village, 2 families reason for delayed immunization is afraid of injection, 4 families reason for delayed immunization is other(weakness of children).

PLACE OF IMMUNIZATION



Graph-12

PLACE OF IMMUNIZATION-

Out of 175 families, 91 families told place of immunization, 41 immunised their child in anganwadi centre, 24 immunised their child in government hospital, 21 immunised their child in health camp in community, 4 immunised their child in other place, 1 immunised their child in private hospital

The evaluation indicated low immunization coverage with reasons behind low immunization. The community did not adequately utilize the services due to lack of counselling from the health staff, lack of awareness, and social determinants such as low literacy level.

Migration is an important determinant of child immunization. Mothers despite long stay preferred vaccination in their resident district as the awareness and utilization of local health facilities was poor. Complete timely immunization coverage in our study 28% was lower than studies done in slums of Delhi and Lucknow, which showed 64 and 44%, respectively; Low awareness was one of the reasons in Lucknow study as well as our study. This is in contrast to a study done in Delhi slums which showed that health services were better utilized by settled migrants in contrast to recent migrants due to their better adaptability to the sociocultural environment and better social networking.

Reasons for partial immunization were missing of the dose due to the visit to the migration (3%) compared to (14.7%) in the study done in Lucknow slums, and lack of knowledge 53% compare to Lucknow slum study (10.4%)

Place of immunization for brick kiln workers are anganwadi centre which comprises 45% of total, after this government hospital and health camps. Only 1% children immunized in private hospitals

DPT vaccine is maximum 36% timely administered in comparison to other vaccines

The health system was not adequately adapted to the needs of this special population of migrants. ANM/ASHAs who are the key personnel in ensuring immunization did not have adequate interaction with the mothers. Similar studies from Surat (India), Dhaka, and Nairobi showed that in spite of illiteracy amongst mothers, frequent contacts with community health workers with effective interpersonal communication can improve utilization of immunization services.

The limitation of the study was the no availability of vaccination cards in the community. Vaccination had to be mostly verbally confirmed by mothers leading to recall bias.

RECOMMENDATIONS/SUGGESTIONS

We recommended mobile immunization teams comprising ANMs and ASHAs to cover widespread brick kiln migrant clusters. Interventions such as counselling of parents, prelisting of migrant children with the help of local brick kiln managers/contractors at construction sites, and incentivizing ASHAs for these activities could be

considered..Mechanisms to track dropouts and supervision needed to be strengthened to improve the coverage.

CHALLENGES FACED DURING SURVEY

Brick kiln workers was very busy-The average working day of workers consists of 12-14 hours. The whole family has to work long hours in the kilns to meet the targets. During survey it is difficult for them to give answers for so many questions.

Language problem- peoples of brick kiln are illiterate. Most of them are villagers ,solanguage was difficult to understand sometimes. Sometime they don't understand what we are asking

Hot weather -Bricks are prepared in open field and burnt in the area known as dock which is also uncovered area. Survey conducted in April-May which is peak time of summer it was difficult to stand in open ground for hours and asking questions

They don't have enough knowledge-Kiln workers have little or no knowledge of their basic rights, entitlements and bonded labour prohibitions. Being from the most vulnerable segments of society, most of them are illiterate so it was difficult to understand some questions.

CONCLUSION

The goal of achieving universal immunization, especially in the disadvantaged, vulnerable urban slum population with poor health infrastructure, needs a coordinated effort and a multi-pronged strategy to deal with both lack of access and dropout. The measures to be taken would include reaching out effectively to people to generate demand for the services through interpersonal communication, which can be translated into a change in behaviour, and then maintaining the demand consistently. Involvement of private agencies and other stakeholders

may lead to the much-needed political, civil-society and media pressure and periodic uproar on the issue.

This emphasizes the need for enhanced community-level measures in urban communities that would enhance improved full immunization uptake, such as increased female education, increased community health campaigns targeting mothers who deliver at home, and a general improvement of the socio-economic situation of people in urban communities. There is also a need for improvement in the quality and equitable spatial distribution of maternal and child health services. The fact that high birth order, home delivery and low proportion of mothers who delivered in hospital were independent predictors of reduced likelihood of full immunization uptake stresses the need to broaden child survival measures to include mothers at pre-pregnancy and pregnancy stages.

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ANNEXURE