



IOCH
Immunization and Other Child Health Project

**Vaccination Coverage Survey
of the Chhitmahals (enclaves)
in Bhurungamari Upazila**

February 2003

Survey Report No. 105

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Acronyms

BCC	Behavior Change Communication
BCG	Bacillus of Calmette and Guerin
CES	Coverage Evaluation Survey
COSAS	Coverage Survey Analysis System
DPT	Diphtheria, Pertussis and Tetanus
EPI	Expanded Program on Immunization
FWC	Family Welfare Center
IOCH	Immunization and Other Child Health
Mahallah	Smaller localities (smaller than a village)
MOHFW	Ministry of Health and Family Welfare
Mouza	Smallest administrative locality in an Upazila
MSH	Management Sciences for Health
NGO	Non Governmental Organization
NID	National Immunization Day
OPV	Oral Polio Vaccine
SNID	Sub-national Immunization Day
TT	Tetanus Toxoid
WHO	World Health Organization

Terminology

This provides the meaning of some of the more technical terms used in this report and a brief explanation of their use.

By card: An immunization given to a child is termed as by card if the date of the dose is entered on an immunization card. Only doses recorded by card are treated as valid data in this survey.

By history: Immunization history collected from a parent's recall is termed as by history. Often no date will be mentioned. This information is only included in crude data.

Crude coverage rate is calculated from the doses recorded by card and/or by history. It is not ascertained whether the doses were given at the correct age and/or following the correct interval (where applicable). Crude data however, helps us to understand how much additional coverage could be achieved if all vaccines were given at the optimum age for the child and following the optimum interval. It also provides useful information on access to the EPI program and on the operational aspects of the provision of health services.

Valid coverage rate is calculated from the vaccinations recorded by card plus history. In the calculation process, first the rate of validity is calculated based on cards only, then this rate is applied to history cases too. Valid data includes only the doses of vaccines that were given after the minimum date of eligibility and/or after the minimum interval necessary to be effective and to protect the child. There is no maximum interval for a dose and therefore a dose administered after 52 weeks is still regarded as valid. By comparing crude coverage with valid coverage data of any particular antigen, one can determine how much coverage was lost due to the inability to give vaccine at the appropriate time.

Invalid doses are those administered at the wrong age and/or at the wrong interval. Doses administered before the minimum age in the case of DPT/Polio 1st doses and Measles vaccine or with less than four weeks interval in the case of DPT or Polio vaccines are classified as "invalid" doses.

The **criteria for a valid dose** used in this survey is the criteria recognized by the Bangladesh EPI program: minimum age for DPT/Polio 1st dose - 6 weeks old; minimum DPT/Polio interval - 4 weeks; minimum age for Measles vaccine - 38 weeks old.

Dropout cases refer to the children/women who have initially received at least one dose of any antigen and then failed to receive the subsequent doses to get fully immunized. Dropout rate implies the inability of the EPI to follow-up and protect the cohort of children initially reached out.

Program access is measured by the percentage of children surveyed who received DPT 1st dose (crude data – by card and history) in the routine immunization session.

Fully immunized means the child has received all the doses it requires (BCG, OPV 1-3, DPT 1-3 and measles).

Missed opportunity refers to a visit of a child to a vaccination center for a dose that he received. However at that time he was also eligible for another dose of antigen that he did not receive. If the missed dose was provided at a later date, it is a *corrected missed opportunity*. If not, it is an *uncorrected missed opportunity*.

SUMMARY RESULTS

Background

The recent increase of identification and reporting of wild polio virus in West Bengal, India, increases the risk of transportation of wild polio virus from India to Bangladesh, and the risk is relatively higher in the border areas of Bangladesh because of frequent cross border visitation. There are a number of Indian chhitmahals into Bangladesh territory, and the people living in the chhitmahals frequently visit the people in the border areas of both Bangladesh and India on different occasions. The levels of immunization coverage in these areas are not known. In view of this situation, IOCH conducted a coverage evaluation survey in the Indian chhitmahals (enclaves) in Bhurungamari Upazila of Kurigram district in February 2003.

Objectives

The overall objective of the survey was to assess the level of immunization coverage in the Indian chhitmahals (enclaves) in Bhurungamari Upazila of Kurigram district to get a better sense of risk of circulation of wild polio virus in these areas. The specific objectives were to:

- a) assess the level of routine immunization coverage of the children (12-23 months) and find out the reasons for non-immunization and partial immunization;
- b) assess the level of TT immunization coverage among women of 15-49 years of age, irrespective of their marital status, and find out the reasons for non-immunization and partial immunization;
- c) assess the coverage levels of OPV and Vitamin A administered during the SNID Campaign- 2002; and
- d) assess the degree of cross border visitation.

Methodology

A coverage evaluation survey was conducted in six Indian chhitmahals in three unions of Bhurungamari Upazila, Kurigram District. The parents/guardians of all the children 12 – 23 months and all the women of reproductive age (15 – 49 years) irrespective of their marital status living in these chhitmahals were interviewed to ascertain their routine immunization coverage. Also, all the children < 5 years (0 – 59 months) were interviewed to assess the immunization coverage of the SNIDs- 2002

The WHO standard questionnaires were used for documenting the routine immunization status of the children and women. Also, separate questionnaires were used to collect data on SNIDs- 2002 and reasons for non-immunization and dropouts. Additional information was collected to know if the selected households (selected for interview) were visited by Indians or any members of the selected households visited India during last 12 months. The data were collected by the experienced Field Investigators of the Survey Team of the IOCH. Data processing and analysis were done by the Monitoring & Evaluation Unit of the IOCH using COSAS 4.41¹ and EpiInfo.

¹ COSAS (Coverage Survey Analysis System) is a dedicated software for analyzing coverage evaluation survey data.

Coverage levels for the routine immunization of children

Access to child immunization: Based on crude data (card plus history), 94% children received at least one dose of antigen (DPT 1st dose in this case) from routine immunization sessions. 6% children did not receive a dose of any antigen.

Crude coverage of 12-23 months age group: 94% children received BCG, 81% children received three doses of OPV, 81% received three doses of DPT and 81% received measles vaccine. 81% children were fully immunized.

Valid coverage of 12-23 months age group: 94% children received BCG, 72% children received three doses of OPV, 72% received three doses of DPT and 81% received measles vaccine. 72% children were fully immunized.

Valid coverage by 12 months: 94% children received BCG, 72% children received three doses of OPV, 72% received three doses of DPT and 72% received measles vaccine. 72% children were fully immunized.

Routine immunization coverage by sex: Boys' access to immunization, as measured by the crude coverage of DPT1, was 14 percentage points higher than that of the girls (100% for boys vs. 86% for girls). But, the coverage of DPT3 and measles for the boys was 8 percentage points lower to that of the girls, resulting in lower crude FIC for the boys than the girls (78% crude FIC for boys vs. 86% crude FIC for girls). Proportions of invalid doses for DPT3 among the girls was higher than that for the boys, resulting in 14 percentage points higher valid FIC for boys than the girls (78% valid FIC for boys vs. 64% valid FIC for girls). A similar trend was also observed regarding valid coverage by 12 months.

Dropout rates: Although access to child immunization was good (94% for DPT1), the dropout rates for different antigens were high too. There were 13% dropouts from DPT1 to DPT3 and 13% from DPT1 to measles.

Invalid doses: 20% of the DPT1 doses were administered before 6 weeks of age of the children, and as such they were invalid.

EPI card retention: 81% of the children interviewed were ever given EPI cards; however, EPI cards were available with 63% of the respondents at the time of interview. EPI card retention rate was 77% only, as 23% of the EPI cards were lost.

Knowledge about required visit to immunization center for full immunization: 63% of the mothers interviewed did not have any idea about how many times a child was required to be taken to an immunization center to get fully immunized; while 31% had wrong idea about it. Only 6% of the mothers could mention correctly the number of times (i.e. 4 times) a child is required to visit immunization center to get fully immunized.

Sources of immunization services and distance of vaccination centers: Childhood immunization in this area was provided solely by the GOB EPI outreach centers (100%). No other source of EPI services was reported. All the EPI outreach centers were located within 10 minutes walking distance from the homes of the children.

Reasons for non-immunization and partial immunization or dropout of children: Only 1 child out of 16 were found never vaccinated, and the primary reason for his/her non-immunization was parents' lack of awareness of need and importance of immunization. Two children dropped out, because their parents did not know that their children were required to take subsequent doses to get fully immunized.

Coverage levels for the routine TT immunization of women

TT immunization coverage: Access to TT immunization for the women 15 – 49 years was not good. 78% of the women received TT1. The corresponding figures for TT2, TT3 and TT4 were 75%, 50% and 35% respectively. Only 28% of the women received TT5, which provide lifelong protection against tetanus. 22% of the women never received any TT vaccine.

Age distribution of women never receiving TT immunization: The older women were less likely to receive TT vaccine. 11% to 13% of the women aged 15 years to 30 years had never received any dose of TT vaccine; while the corresponding figures ranged from 33% to 67% for the women in the age-groups over 30 years.

TT immunization dropout rates: TT immunization dropout rates were high. The dropout rate for TT2 to TT3 was 33%. The corresponding rates for TT3 to TT4 and TT4 to TT5 were 29% and 19% respectively. The dropout rate for TT1 to TT5 was as high as 64%, indicating that 64% of the women who received first dose of TT did not complete 5 doses TT immunization schedule.

Invalid TT doses: In the context of a 5 dose strategy, a significant proportion of TT doses have to be considered invalid as they were administered before the minimum required interval between the doses. 40% of the TT3 doses were given before 6 months interval between TT2 and TT3, and as such were invalid. 35% of the TT4 doses were invalid, since they were given before one year interval between TT3 and TT4; similarly, 69% of the TT5 doses were invalid for the same reason.

Protection against tetanus at birth: 94% of the newborn babies were found protected against tetanus, indicating that 6% newborn babies were still not protected against tetanus at birth.

Knowledge about full TT immunization: 97% of the women did not have correct knowledge about the number of TT doses required for a woman for full immunization. Only 3% women could correctly mention that a woman was required to receive 5 doses of TT vaccine for full immunization for lifelong protection against tetanus.

TT card retention: 71% of the women were ever given TT cards; however, TT cards were available with 19% of the women only at the time of interview. TT card retention rate was 26% only, as 74% of the TT cards were lost.

Sources of TT immunization: Most of the women received TT vaccine from the GOB EPI outreach centers (94%). Only 6% women received TT vaccine from GOB hospitals and clinics.

Reasons for non-immunization and partial immunization of women: The primary reason for non-immunization of TT cited by majority of the women was lack of awareness of need and importance of TT immunization (68%) The primary reasons for partial TT immunization or

dropout were that the women were not aware of the need of subsequent doses to get fully immunized against tetanus (49%), the health workers did not advise for 5 dose TT schedule for full TT immunization for lifelong protection (23%) or the vaccinator did not specify the date of next dose (8%).

Coverage levels for the SNIDs- 2002

OPV and Vitamin A coverage: 92% of the children <5 years received OPV in both the rounds of the SNIDs- 2002. The coverage for OPV was 95% in the 1st round; while it was 92% in the 2nd round. Vitamin A capsules were given to 94% of the eligible children (12 – 59 months of age).

Sources of OPV during the SNIDs: Most of the children received OPV from the SNID sites (94% in the 1st round and 91% in the 2nd round). One percent of the children received OPV during child-to-child search in each round.

Distance of SNID sites and mode of transportation used: All the SNID sites were located within 15 minutes walking distance from the homes of the children.

Households visited during child-to-child search: 65% of the households were visited by the health workers/volunteers during child-to-child search in the 2nd round of the SNIDs, as reported by the parents/respondents.

Sources of information of the SNID: Majority of the parents learned about the SNIDs from GOB health workers (78%), followed by miking (38%). Nine percent of the parents came to know about the NIDs from their relatives and neighbors.

Reasons for not receiving vaccines from the SNID sites: The primary reason for not receiving OPV from the SNID sites included: a) parents were busy on NID day (25% in the 1st round and 33% in the 2nd round); b) children were away from home on NID day (25% in the 1st round and 50% in the 2nd round); and c) vaccinator was not available at the NID site (25% in the 1st round).

Cross border visitation

The survey was conducted in 6 Indian chhitmahals in three unions of Bhurungamari Upazila bordering West Bengal, India. People living in these areas frequently visit the people in the border areas of both Bangladesh and India on different occasions. In order to assess the degree of cross border interaction, we interviewed 102 women in these chhitmahals to know if any member of their families went to India during past 12 months or their families were visited by some one from India during the same period. It was reported that some one from 29 families (out of 102) visited India during the last 12 months, and over half of them went there within last two months. 5 families out of 102 interviewed were also visited by some one from India during the same period, and over half of them were visited within last 6 months. This cross border interaction represents some risk of transmission of wild poliovirus from India to the border areas of Bangladesh as wild polioviruses are still in circulation in some states of India, particularly in West Bengal.

Conclusions and recommendations

Access to child immunization was good (94% for DPT1), but this high access dropped to 81% for fully immunized children because of dropouts of different antigens. (Dropout rate for DPT1 to DPT3 was 13% and DPT1 to measles was 13%). Access to TT immunization for the women 15 – 49 years (irrespective of their marital status) was not good. 78% of the women received the first dose of TT, and TT dropout rate was very high (64% for TT1 to TT5), resulting in very low coverage of TT5 (28%), which provides lifelong protection against tetanus. Such high dropout rates imply inability of the EPI program to follow-up and protect the cohort of children and women initially reached out.

- ***Efforts must be undertaken to reduce the existing high dropout rates in both child immunization and TT immunization. The program should focus on quality of counseling of mothers/women (on immunization) by the health workers. The health worker at the first contact must counsel the mother/woman properly to motivate her to return and to get herself and/or her child fully immunized. He/she must:***
 - *explain to mother/woman the importance of full immunization, and concept of 8 doses and 4 visits required for full immunization of a child;*
 - *tell mother/woman of reproductive age the benefit and importance of full TT immunization and the concept of 5 dose TT schedule for lifelong protection against tetanus;*
 - *issue an EPI card/TT card dully filled out and explain the mother/woman the importance of keeping the EPI card/TT card in safe and bringing it on the next due date;*
 - *tell the mother/woman clearly when she should come back for next doses, and inform her that the date is written in the EPI card/ TT card so that she can check it if forgets the date;*
 - *inform the mother/woman of possible side effects of injection and how it should be handled;*
 - *pay attention to the hospitality at the clinic/EPI center, and to supportive environment.*
- ***Program managers and field supervisors should ensure that EPI sessions are held as per plan, and at a regular and adequate minimum interval***
- ***The service providers should be given refresher training to improve their technical skills on counseling of mothers/women on immunization***

There were also many invalid doses in child immunization (20% for DPT1), which further reduced the crude full immunization coverage of 81% to 72% when validity of doses was taken into account. Like child immunization, a very high proportion of TT doses were invalid (40% for TT3, 35% for TT4 and 69% for TT5). These high rates of invalid doses and missed opportunities reflect service providers' inability to screen the clients properly.

- ***Emphasis should be given on screening of clients for immunization to avoid or reduce invalid doses and missed opportunities. The service providers must:***
 - *screen properly each and every child/ woman to decide his/her eligibility for a specific dose of specific antigen;*
 - *check EPI card/ EPI register/ TT card or any other record to decide on the eligibility of a particular dose of specific antigen(s); provide a new one if needed;*

- *if a child/woman is found not eligible for a dose today, ask him/her to return at a specified date and explain the reason to her/mother clearly and patiently;*
- *check if there is any missed opportunity for other antigens.*
- *The service providers should be given refresher training to improve their technical skills on screening of clients for immunization.*

EPI card (child immunization card) and TT card play an important role in ensuring good quality of immunization services. It helps the mothers to adhere to immunization schedule, as well as assists the service providers to screen the children for specific doses of specific antigens. Unfortunately, the retention rates of both the EPI card and TT card were very low, 77% and 26% respectively.

- *Mothers/women should be explained the benefits and importance of EPI cards/ TT cards for immunization of themselves and their children.*
- *Mothers should be asked to preserve the EPI card safely until the child is 5 years old, and to bring the card with them whenever they come to the clinic/ EPI center for immunization.*
- *Women should also be asked to carefully preserve their TT cards, and to bring their TT cards with them whenever they come to clinic/ EPI center for TT immunization.*
- *In the case of loss of EPI card/TT card, it should be provided over and over, and the history of the earlier vaccinations accurately recorded again and again, if necessary.*

Mothers have a poor understanding of the concept of full immunization. 94% of the mothers could not mention how many times a child was required to be taken to EPI center to get fully immunized. Similarly, 97% of the women 15 – 49 years did not know how many TT doses were required for a woman for lifelong protection against tetanus.

- *During IPC between the mother/woman and the service provider and/or at the first contact, the mother/woman should be clearly explained the importance of full immunization of children and women, and of the immunization schedule of full immunization for both children and women.*

Lack of awareness of need and importance of immunization was cited as primary reason for non-immunization of child and women; while lack of knowledge about the need and importance of subsequent doses to get fully immunized resulted in high drop out rates for child and TT immunization.

- *The program should strengthen BCC activities to inform the community of importance and benefits of immunization in general, and to motivate the mothers/women to get themselves and their children fully immunized in particular. Very selective and focused mass media campaign, in addition to IPC by health workers, may also be conducted to achieve this end.*

8% of the children 0 –59 months did not receive OPV in both the rounds of the SNIDs- 2002. 35% of the households were not visited by the health workers/volunteers during child-to-child search in the 2nd round of the SNIDs.

- *Area specific innovative strategies suitable to local situation have to be undertaken during the next SNIDs/NIDs to reach to the left out children. These may include, but not limited to, the following:*

- *detailed microplanning for each activity;*
 - *use of updated map in microplanning and child-to-child search;*
 - *adequate orientation training of volunteers and workers;*
 - *adequate number of SNID/NID sites with required number of health workers and volunteers;*
 - *using masque miking, as well as Imam of the masque during Jumma Pray;*
 - *special team at railway station, bus stand, ferry-ghat etc. for traveling children*
 - *evening SNID/NID sites for working mothers; and*
 - *special mobile teams at night to vaccinate homeless and floating children.*
- *Supervision of field workers during child-to-child search needs to be further strengthened to ensure that each and every household is visited and properly marked by the workers*
 - *More attention should be given to high risk areas and traveling/homeless/floating population*

Parents' preoccupation on the day on SNID as a primary reason for not receiving OPV from the SNID sites was cited by 25% of the parents of the children who did not receive OPV in the 1st round and 33% in the 2nd round. Also, a number of children (25% in the 1st round and 50% in the 2nd round) were away from home on the SNID day.

- *Communication activities need to be strengthened through mass media, such as television and radio, as well as through IPC by the health workers and volunteers during next SNIDs/NIDs focusing the importance of getting each and every children vaccinated on SNID/NID day*
- *Special teams should be organized at railway station, bus stand, ferry-ghat etc. for traveling children*

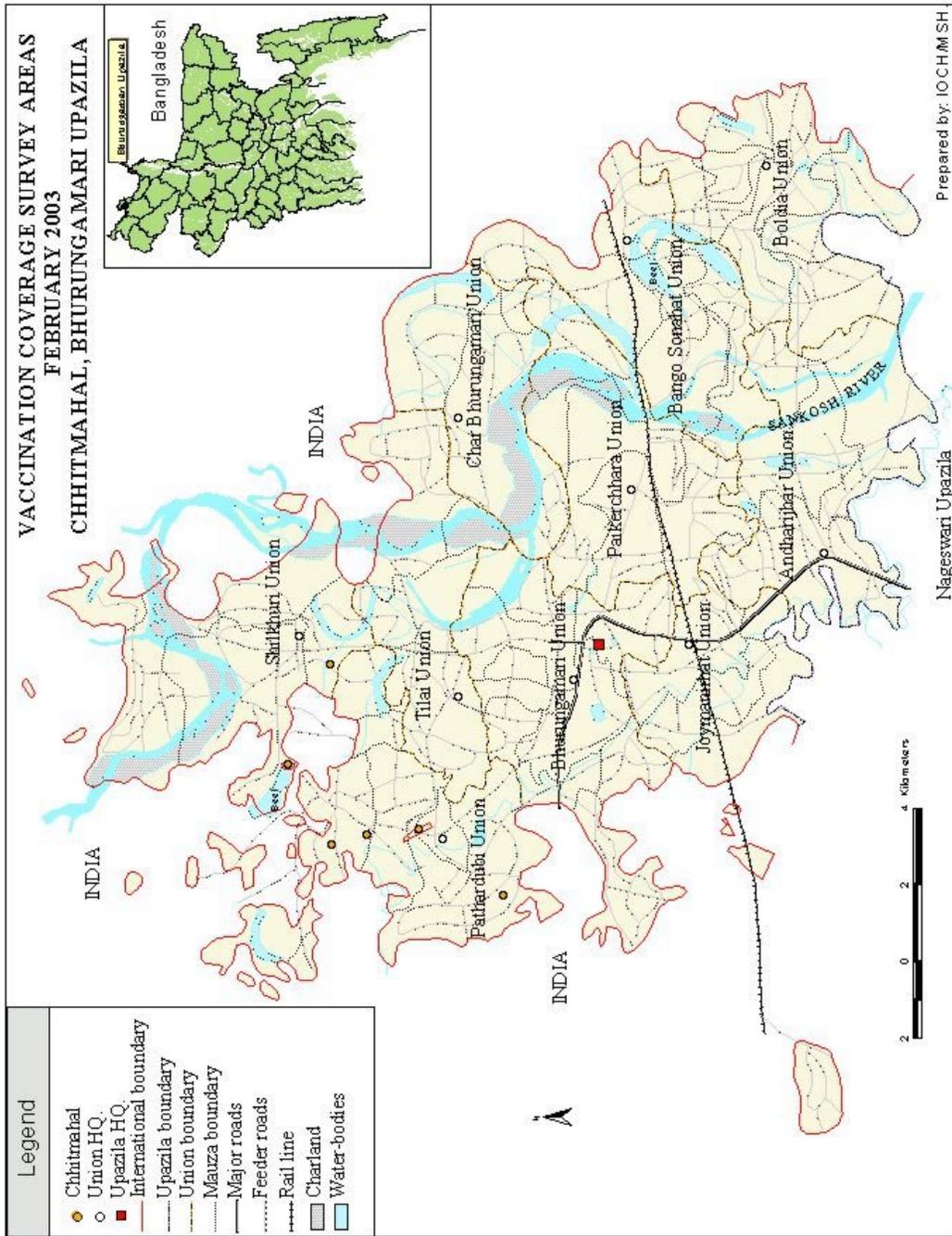
6% of the eligible children (12 – 59 months) did not receive Vitamin A during the 1st round of the SNIDs- 2002.

- *Special attention should be given to:*
 - *ensure that each and every eligible child 12–59 months receives Vitamin A;*
 - *the exact age group to limit shortage (better screening for age); and*
 - *no Vitamin A capsules should be given to the parents to administer them to their children either at NID site or in their homes.*

Cross Border Interaction

There is a considerable degree of cross border interaction between the people living in the Indian chhitmahals in Bangladesh and those living in the border areas of India. 29 families (out of 102) visited India during the last 12 months, and over half of them went there within last two months. 5 families out of 102 interviewed were also visited by some one from India during the same period, and over half of them were visited within last 6 months. This cross border interaction represents some risk of transmission of wild poliovirus from India to the border areas of Bangladesh as wild polioviruses are still in circulation in some states of India, particularly in West Bengal.

- ❑ *Special attention should be given to improve valid routine immunization coverage, particularly the coverage of OPV3, of the children in the border areas of Bangladesh*
- ❑ *AFP and EPI disease surveillance needs to be strengthened in the border areas*
- ❑ *First Line Health Care Providers (FLHCP) in the border areas needs to be oriented on identification and reporting of AFP cases, so that any AFP case is reported to the proper person/place in time.*



TABLES AND FIGURES

Table 1: Routine immunization coverage levels of the children

N=16

Name of the Vaccine	Coverage (%) Immunization of 12-23 months age group		Coverage (%) Immunized by 12 months of age
	Crude data (Access)	Valid data	Valid data
BCG	94	94	94
OPV1	94	75	75
OPV2	94	75	75
OPV3	81	72	72
DPT1	94	75	75
DPT2	94	75	75
DPT3	81	72	72
Measles	81	81	72
Fully immunized	81	72	72
Zero Dose	6	-	-

Table 2: Routine immunization coverage levels by gender

Name of the vaccine	Coverage % Immunization of 12-23 months age group				Coverage % Immunized by 12 months	
	Crude data (Access)		Valid data		Valid data	
	Male N=9 (%)	Female N=7 (%)	Male N=9 (%)	Female N=7 (%)	Male N=9 (%)	Female N=7 (%)
BCG	100	86	100	86	100	86
OPV1	100	86	83	64	83	64
OPV2	100	86	83	64	83	64
OPV3	78	86	78	64	78	64
DPT1	100	86	83	64	83	64
DPT2	100	86	83	64	83	64
DPT3	78	86	78	64	78	64
Measles	78	86	78	86	78	64
Fully immunized	78	86	78	64	78	64
Zero dose	0	14	-	-	-	-

Figure 1: Drop-out rate for child immunization

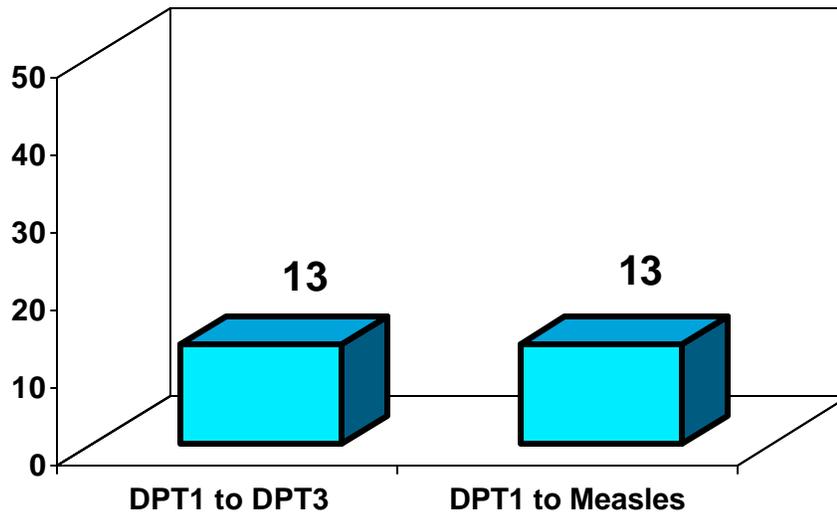


Table 3: Invalid doses of immunization provided to the children

Antigens	Percents
DPT1	20
DPT2	-
DPT3	-
Measles	-

Table 4: EPI cards availability and retention

Card Status	Number	Percentage
EPI card available	10	63
EPI card ever given	13	81
EPI card retention	10	77

Figure 2: Knowledge about required visits to immunization centers for full immunization

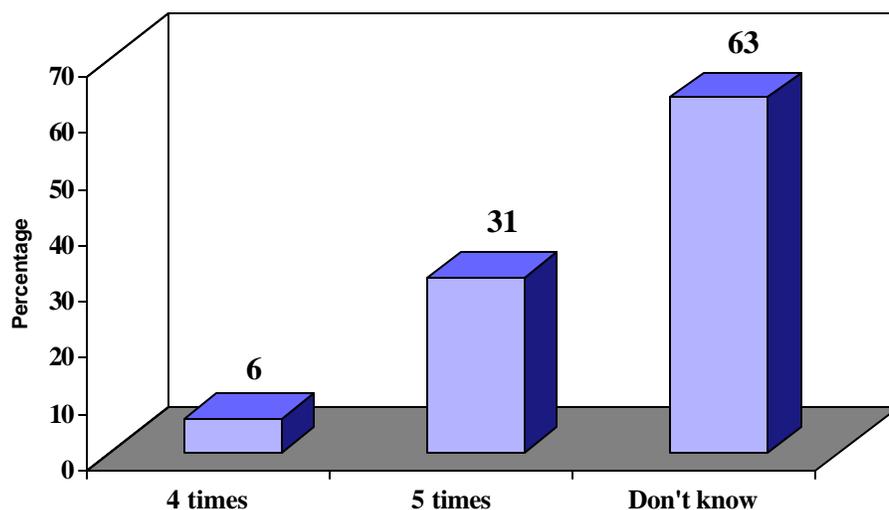


Figure 3: Sources of child immunization services

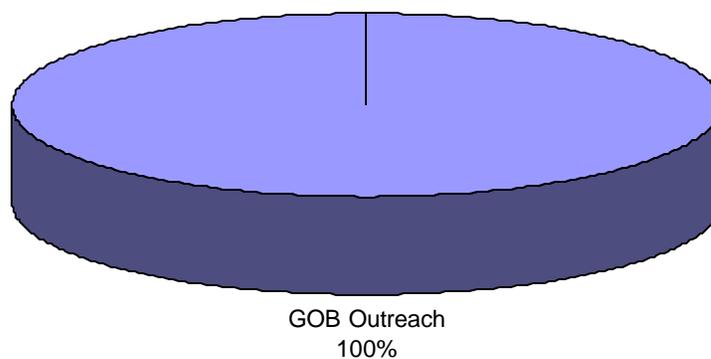


Table 5: Time required to reach the EPI center by mode of transportation

Time required	Mode of transportation	
	Walking	
	#	%
1 – 5 minutes	15	94
6 – 10 minutes	1	6
Total	16	100

Table 6: Reasons for non-immunization and partial immunization of the children

Reasons for non-immunization or partial immunization	Non-immunized (%) (N=1)	Partially immunized (%) (N=2)
Did not know about need of immunization	100	-
Did not know about need of next dose	-	100

Figure 4: Routine immunization coverage levels for TT among women 15-49 years
N=102

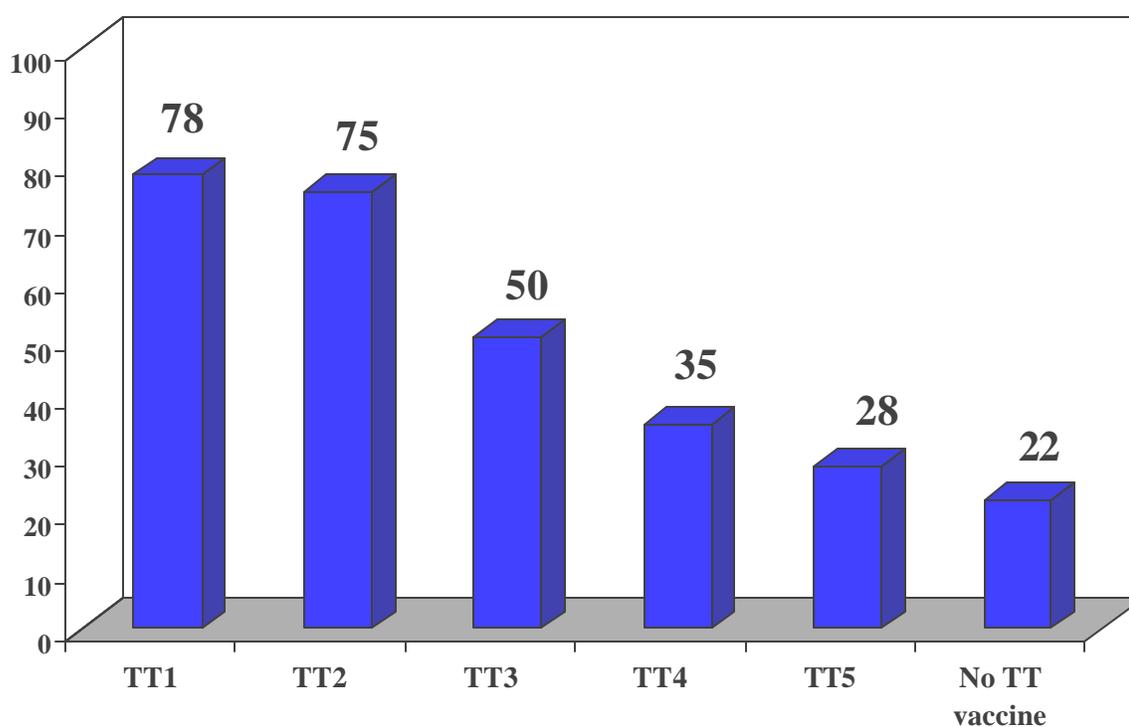


Table 7: Age distribution of women who never received TT vaccine

Age group	Received		Not received		Total	
	#	%	#	%	#	%
15-19	7	87	1	13	8	100
20-25	31	89	4	11	35	100
26-30	23	88	3	12	26	100
31-35	6	67	3	33	9	100
36-40	11	61	7	39	18	100
41-49	2	33	4	67	6	100
Total	80	78	22	22	102	100

Figure 5: TT Immunization drop-out rate among women 15-49 years

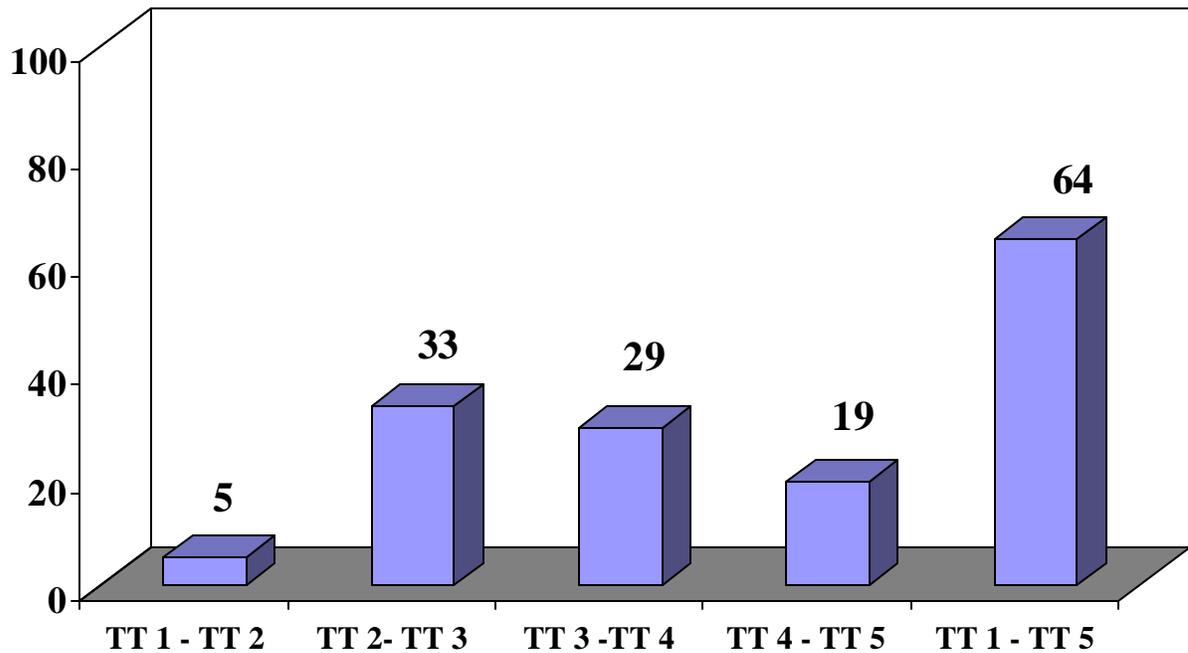


Table 8: Interval between TT1 and TT2, TT2 and TT3, TT3 and TT4, TT4 and TT5 doses

Interval between dose	<1 months		1 months+		<6 months		6 months+		<1 year		1 year +		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
TT1-TT2	4	7	52	93	-	-	-	-	-	-	-	-	56	100
TT2-TT3	-	-	-	-	12	40	18	60	-	-	-	-	30	100
TT3-TT4	-	-	-	-	-	-	-	-	7	35	13	65	20	100
TT4-TT5	-	-	-	-	-	-	-	-	11	69	5	31	16	100

Table 9: Children born protected against tetanus

Status of children born protected	Number	Percentage
Protected	15	94
Not Protected	1	6

Table 10: Knowledge about number of TT doses required for life time protection against tetanus

Answers	Number	Percentage
5 doses	3	3
Don't know/ no idea	99	97

Table 11: TT cards availability and retention

Card Status	Number	Percentage
TT card available	19	19
TT card ever given	72	71
TT card retention	19	26

Figure 6: Providers of TT immunization

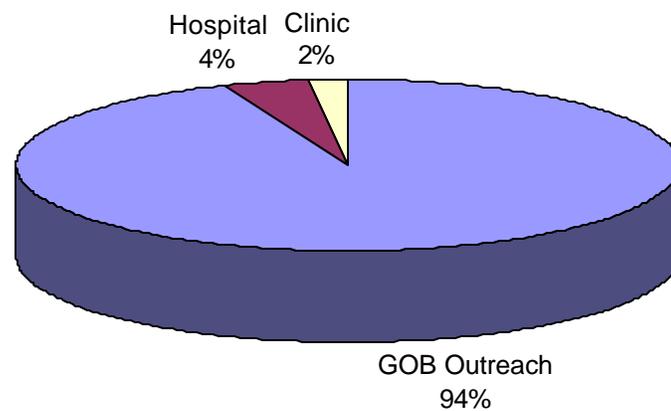


Table 12: Reasons for non-immunization and partial immunization for TT of the women

Reasons	Non-immunization (%) (N=22)	Partially immunization (%) (N=51)
Next dose is not yet due	-	12
Don't feel need for immunization	68	-
Health worker did not specify the next dose	-	8
As per HW advice, 2/3 TT is enough during the pregnancy	-	23
Unaware of need of next dose	-	49
Did not know about place and time of immunization	-	-
In our times, TT immunization was not introduced	32	-
Fear of injection	-	2
Vaccine not available	-	6

Table 13: OPV and Vitamin A Coverage during the SNIDs-2002

N=65

Round	OPV (%)	Vitamin A (%)
1 st round	95	94
2 nd round	92	-
Both rounds	92	-
Any round	95	-

Table 14: Sources of OPV during the SNIDs-2002

Sources of OPV	1st Round		2nd Round	
	#	%	#	%
NID site	61	94	59	91
Child to child search	1	1	1	1
Mobile Team	-	-	-	-
Not received	3	5	5	8
Total	65	100	65	100

Table 15: Time required to reach the SNID sites by mode of transportation

Time required	Mode of transportation	
	Walking	
	#	%
1 – 5 minutes	54	83
6 – 10 minutes	6	9
11 – 15 minutes	5	8
Total	65	100

Table 16: Households visited during the child-to-child search of the 2nd round of the SNIDs-2002

Variable	Number	Percents
Households visited	42	65
Households not visited	23	35
Total	65	100

Figure 7: Sources of information about the SNID campaign

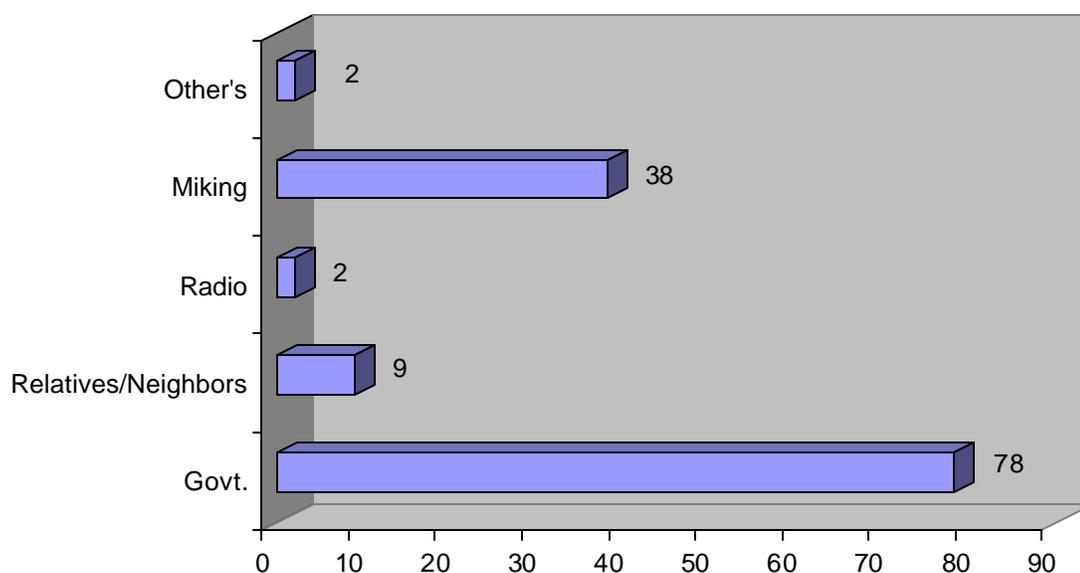


Table 17: Reasons for not receiving of OPV from SNID sites

Reasons	1st Round (%) (N=4)	2nd Round (%) (N=6)
Did not know about SNID	-	17
Forgot the date	-	-
Traveling	-	-
Too busy	25	33
Doesn't believe in vaccine	25	-
Child was sick, and not taken to immunization center	-	-
No vaccine available	25	-
Child was away from home	25	50
Others	-	-

Table 18: Family members who visited India by time of visit during last 1 year

N=102

Visitation time	Number #	Percents %	Cum. Percents %
>1 months	5	5	5
1-2 months	12	12	17
3-4 months	3	3	20
5-6 months	5	5	25
7-10 months	2	2	27
11-12 months	2	2	29
Total	29	29	

Table 19: Family which were visited by any person from India during last 1 year by time of visit

N=102

Visitation time	Number #	Percents %	Cum. Percents %
>1 month	1	1	1
1-6 months	1	1	2
7-9 months	1	1	3
10-12 months	2	2	5
Total	5	5	

List of Selected Clusters for the Survey

Sln #	Name of the Chitmahal	Total Pop.	Cluster No.
1	Bashjani Digholtary Chitmahal		1
2	Digholtary Chitmahal		2
3	Gaowchulka Chitmahal		3
4	Sewte Kursha Chitmahal		4
5	Sahebganj Chitmahal		5
6	Garoljor Chitmahal		6

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