



IOCH
Immunization and Other Child Health Project

**Vaccination Coverage Survey of the
Sylhet City Corporation
(Ward 1 – 5)**

November 2002

Survey Report No. 88

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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 routine EPI program in the city corporations/municipalities is carried out by a variety of private and public providers at fixed (hospitals, clinics, dispensaries, etc.) and at outreach sites. NGOs and private practitioners also provide immunization services in many places. The city corporation/municipal authorities are primarily responsible for providing and/or coordinating primary health care including routine EPI services in municipal areas. However, in the absence of an effective management information system and reliable service statistics at city corporation/municipal level, it is often difficult to assess the level of immunization coverage of the municipalities. In view of this situation, the IOCH decided to conduct a series of coverage evaluation surveys in the selected city corporation/municipal areas to assess the level of immunization coverage in these areas. As a part of this effort, the IOCH conducted two coverage evaluation surveys in the Sylhet City Corporation- one for the Ward 1 – 5 and the other for the Ward 6 – 13, in November 2003. This report presents the results of the coverage evaluation survey conducted in Ward 1 – 5, where city corporation health authority is responsible for providing primary health care including immunization services.

Objectives

The overall objective of the survey was to assess the level of immunization coverage in the Sylhet City Corporation (Ward 1 – 5). 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; and
- c) assess the coverage levels of OPV and Vitamin A administered during the SNID campaign- 2002.

Methodology

The survey employed the WHO recommended 30-cluster survey methodology that has been widely used in many developing countries to assess immunization coverage. In all, 30 clusters were randomly selected from the Ward 1 – 5 of the Sylhet City Corporation following PPS sampling procedures. A list of the selected clusters is provided in Annex- A and their locations are shown on the maps in page10. From each cluster, 7 children 12 – 23 months and 7 women of reproductive age (15 – 49 years) irrespective of their marital status were selected following 30 cluster survey methodology to ascertain their routine immunization coverage. Also, 7 children < 5 years (0 – 59 months) were selected to assess the immunization coverage of the SNID Campaign- 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 NIDs and reasons for non-immunization and dropouts. 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.

Coverage levels for the routine immunization of children

Access to child immunization: Based on crude data (card plus history), 93% children received at least one dose of antigen (DPT 1st dose in this case) from routine immunization sessions. 7% children did not receive a dose of any antigen.

Crude coverage of 12-23 months age group: 93% children received BCG, 82% children received three doses of OPV, 84% received three doses of DPT and 76% received measles vaccine. 75% children were fully immunized.

Valid coverage of 12-23 months age group: 93% children received BCG, 79% children received three doses of OPV, 78% received three doses of DPT and 73% received measles vaccine. 67% children were fully immunized.

Valid coverage by 12 months: 93% children received BCG, 78% children received three doses of OPV, 78% received three doses of DPT and 66% received measles vaccine. 61% children were fully immunized.

Routine immunization coverage by sex: There was no significant sex difference in accessing routine child immunization services. Boys' access to immunization, as measured by the crude coverage of DPT1, was almost similar to that of the girls (92% for boys vs. 94% for girls). The crude coverage for different antigens and full immunization for boys were almost similar to those for girls (crude FIC for both boys and girls was 75%). However, the proportion of invalid doses for DPT/OPV for the boys were higher than those for girls, resulting in lower valid FIC for boys than that for girls (63% valid FIC for boys vs. 71% valid FIC for girls).

Dropout rates: Although access to child immunization was high (93% for DPT1), the dropout rates for different antigens were also high. There was 9% dropout from DPT1 to DPT3 and 19% from DPT1 to measles.

Invalid doses: 5% of the DPT1 doses were administered before 6 weeks and 3% of the measles cases before 38 weeks of age of the children. In addition, 2% of the DPT2 were invalid as they were given before 4 weeks interval between the doses.

Missed opportunities: Total missed opportunities (uncorrected plus corrected) for different antigens ranged from 1% to 5%. The prevalence of uncorrected missed opportunities for different antigens was low (1% - 2%). The composite index for total missed opportunities was as high as 49, reflecting poor quality of screening during vaccination sessions.

EPI card retention: 93% of the children interviewed were ever given EPI cards; however, EPI cards were available with 53% of the respondents at the time of interview. EPI card retention rate was 57% only, as 43% of the EPI cards were lost.

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

Knowledge about required visit to immunization center for full immunization: 40% 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 21% had wrong idea about it. Only 39% 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.

Source of immunization services and distance of vaccination centers: Childhood immunization in this area was provided mostly by the NGO clinics (46%), followed by the municipal outreach centers (41%). GOB outreach centers and hospitals provided EPI services to 9% and 3% of the cases respectively. Almost all the EPI outreach centers (97%) were located within 15 minutes walking distance from homes of the children.

Reasons for non-immunization and partial immunization or dropout of children: The primary reasons for non-immunization of children cited by the parents were lack of awareness of need and importance of immunization (57%) and lack of faith in immunization (14%). The reasons for partial immunization or dropout included sickness of the children (28%), lack of knowledge about the need of subsequent doses to get fully immunized (21%) or parents did not know about the need of measles vaccination (21%).

Coverage levels for the routine TT immunization of women

TT immunization coverage: Access to TT immunization for the women 15 – 49 years was fairly good. 86% of the women received TT1. The corresponding figures for TT2, TT3 and TT4 were 80%, 60% and 45% respectively. Only 27% of the women received TT5, which provide lifelong protection against tetanus. 14% of the women never received any TT vaccine.

Age distribution of women never receiving TT immunization: The younger, as well as older women are less likely to receive TT vaccine. 19% of the women under 20 years and 33% of the women over 30 years of age had never received any dose of TT vaccine; while the corresponding figures ranged from 8% to 12% for the women of other age-groups.

TT immunization dropout rates: TT immunization dropout rates were high. The dropout rate for TT2 to TT3 was 25%. The corresponding rates for TT3 to TT4 and TT4 to TT5 were 25% and 40% respectively. The dropout rate for TT1 to TT5 was as high as 69%, indicating that 69% of the women who received first dose of TT did not complete 5 doses TT immunization schedule.

Invalid TT doses: A significant proportion of TT doses were invalid as they were administered before the minimum required interval between the doses. 25% of the TT3 doses were given before 6 months interval between TT2 and TT3, and as such were invalid. 43% of the TT4 doses were invalid, since they were given before one year interval between TT3 and TT4; similarly, 35% of the TT5 doses were invalid for the same reason.

Protection against tetanus at birth: 83% of the newborn babies were found protected against tetanus, indicating that 17% newborn babies were still not protected against tetanus at birth.

Knowledge about full TT immunization: 90% of the women did not have correct knowledge about the number of TT doses required for a woman for full immunization. Only 10% 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: 84% of the women were ever given TT cards; however, TT cards were available with 22% 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: Majority of the women received TT vaccine from the municipal outreach centers (38%), followed by the NGO clinics (34%). GOB outreach centers and hospitals provided TT immunization to 12% of the cases each.

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 (80%). The primary reasons for partial immunization or dropout were that the women were not aware of the need of subsequent doses to get fully immunized against tetanus (53%), the health workers did not specify the next dose (17%), , or the women were told by the health workers that 2 or 3 doses of TT were enough for them for their pregnancies, and they were not advised (by health worker) for full immunization (14%).

Coverage levels for the SNIDs- 2002

OPV and Vitamin A coverage: 98% of the children <5 years received OPV in both the rounds of the SNIDs. The coverage for OPV in each of the rounds was 99%. Vitamin A capsules were given to 96% of the eligible children (12 – 59 months of age). Besides, 4 ineligible children (out of 210) were wrongly administered vitamin A, as they were under one year on the 1st round SNID day.

Sources of OPV during the SNIDs- 2002: Most of the children received OPV from the SNID sites (96% in the 1st round and 93% in 2nd round). Only 2% children received OPV during child-to-child search in the 1st round and 6% in the 2nd round.

Distance of SNID sites and mode of transportation used: All the SNID sites were located within 20 minutes walking distance form the home of the children.

Households visited during child-to-child search in the 2nd round of the SNIDs: 89% of the households were visited by the health workers/volunteers during child-to-child search in the 2nd round, as reported by the parents/respondents. However, only 37% households were found with date of visitation (by the workers/volunteers during child-to-child search) written on the door or wall, and the family members of those households reported that their households were actually visited by the health workers/volunteers during child–to-child search.

Sources of information of the SNIDs- 2002: Majority of the parents learned about the SNIDs-2002 from municipal workers (56%), followed by miking (25%) and relatives/neighbors (25%). Television as a source of information were cited by 22% of the parents. 14% of the parents came to know about the SNIDs from NGO workers.

Reasons for not receiving vaccines from the SNID sites: The primary reasons for not receiving OPV from the SNID sites were: parents were busy with household work (13% in the 1st round and 22% in the 2nd round), parents did not know about SNID (13% in the 1st round and 14% in the 2nd round) and child was traveling on the SNID day (13% in the 1st round and 14% in the 2nd round).

Conclusions and recommendations

Access to child immunization in the slums of Khulna City Corporation was good (93% for DPT1); but this high access dropped to 75% for fully immunized children because of high dropout rates of different antigens. (Dropout rate for DPT1 to DPT3 was 9% and DPT1 to measles was 19%). Such high dropout rates imply inability of the EPI program to follow-up and protect the cohort of children initially reached out.

Similarly, access to TT immunization for the women 15 – 49 years (irrespective of their marital status) was also good. 86% of the women received the first dose of TT; but TT dropout rate was very high (69% for TT1 to TT5), resulting in very low coverage of TT5 (27%), which provides lifelong protection against tetanus.

- ***Programmatic strategies 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 interval***
- ***The service providers should be given refresher training to improve their technical skills on counseling of mothers/women on immunization***

There were also too many invalid doses in child immunization (5% for DPT1, 2% for DPT2, and 3% for measles), which further reduced the crude full immunization coverage of 75% to 67% when validity of doses was taken into account. Total missed opportunities for different antigens ranged from 1% to 5%. Like child immunization, a very high proportion of TT doses were

invalid (25% for TT3, 43% for TT4 and 35% 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);*
 - *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.***

A large number of newborn babies (17% of the total new born babies) were found unprotected against tetanus at birth.

- ***The pregnant mothers should be motivated to receive the required number of TT doses necessary to protect their newborn babies.***

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, 57% 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 full immunization. 61% of the mothers could not mention how many times a child was required to be taken to EPI center to get fully immunized. Similarly, 90% 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 mothers/women and the service providers and/or at the first contact, the mothers/women 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 as a reason for not receiving child and TT vaccine was reported by majority of the women; while lack of knowledge about the need

of subsequent doses to get fully immunized and/or lack of knowledge as to when to return for next doses 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.*

2% of the children 0 –59 months did not receive OPV in both the rounds of the SNIDs. 11% of the households were not visited by the health workers/volunteers during child-to-child search in the 2nd round of the SNIDs, and 63% households were found not marked with visitation date of the workers during child-to-child search on the door or wall of the house.

- *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 NID/SNID 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*

Lack of information of SNIDs as a primary reason for not receiving OPV from the SNID sites was cited by 13% of the parents in the 1st round and 14% in the 2nd round. Also, a number of children (13% in the 1st round and 14% in the 2nd round) were not vaccinated as they were traveling on the day of NID.

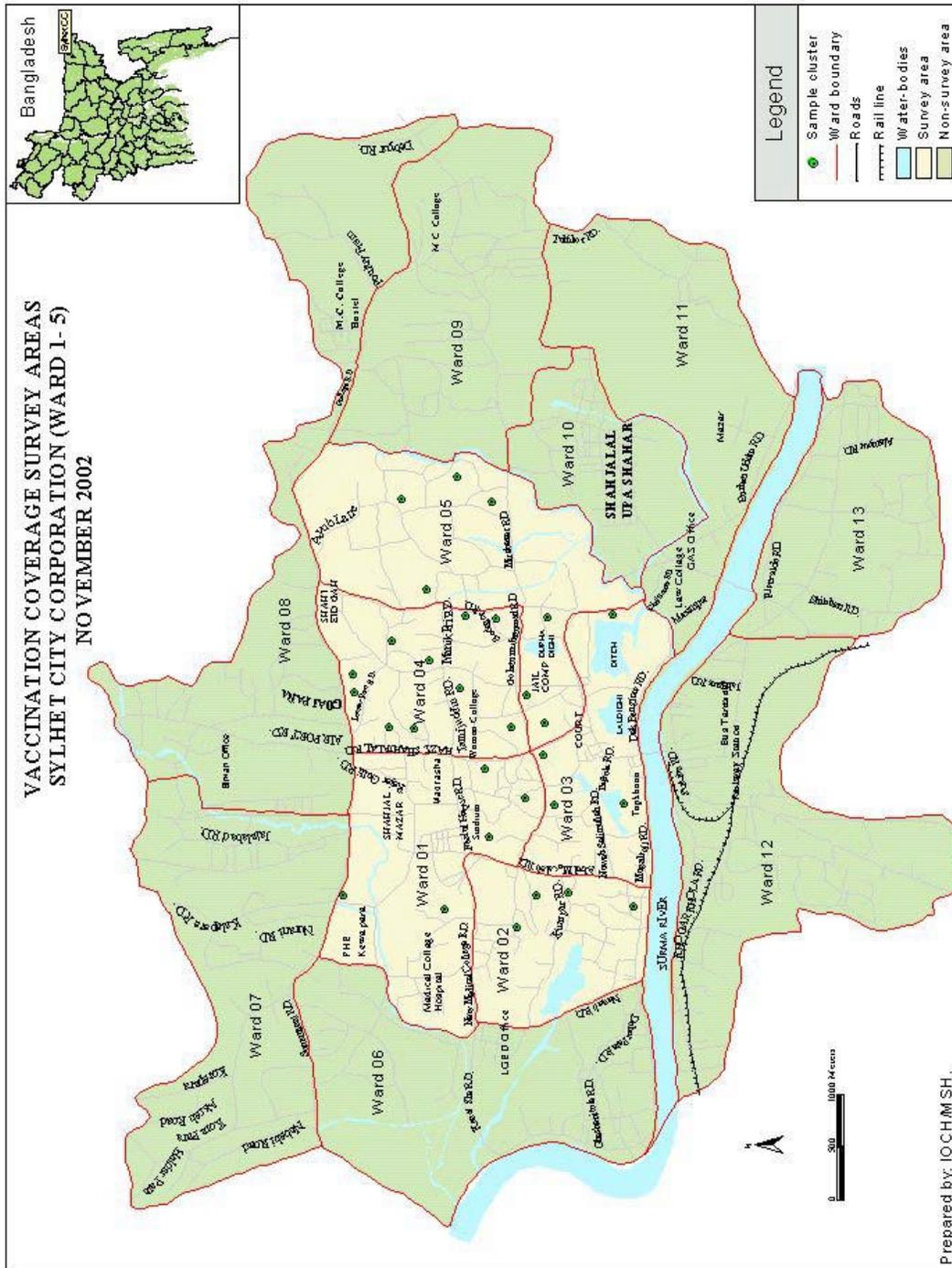
- *Communication activities need to be strengthened through mass media, such as television and radio, as well as through IPC by the health workers and volunteers during next SNIDs/NIDs*
- *Vaccination site/team for traveling children should be organized at bus/train stations and ferry ghats to vaccinate the traveling population*

4% of the children did not receive Vitamin A during the 1st round of the SNIDs- 2002. Besides, Vitamin A capsules were administered wrongly to 4 ineligible children (out of 210) who were <1 year of age on the day of 1st round SNID.

- *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.



TABLES AND FIGURES

Table 1: Routine immunization coverage levels of the children

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	93	93	93
OPV1	93	89	89
OPV2	88	83	81
OPV3	82	76	74
DPT1	93	89	89
DPT2	88	83	81
DPT3	82	76	74
Measles	73	72	64
Fully immunized	73	69	62
Zero Dose	7	-	-

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 (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)
BCG	95	92	95	92	95	92
OPV1	95	92	90	88	90	88
OPV2	90	85	86	80	83	80
OPV3	86	78	80	73	75	73
DPT1	95	92	90	88	90	88
DPT2	90	85	86	80	83	80
DPT3	86	78	80	73	75	73
Measles	78	67	78	65	67	62
Fully immunized	78	67	74	63	64	60
Zero dose	6	8	-	-	-	-

Figure 1: Drop-out rate for child immunization

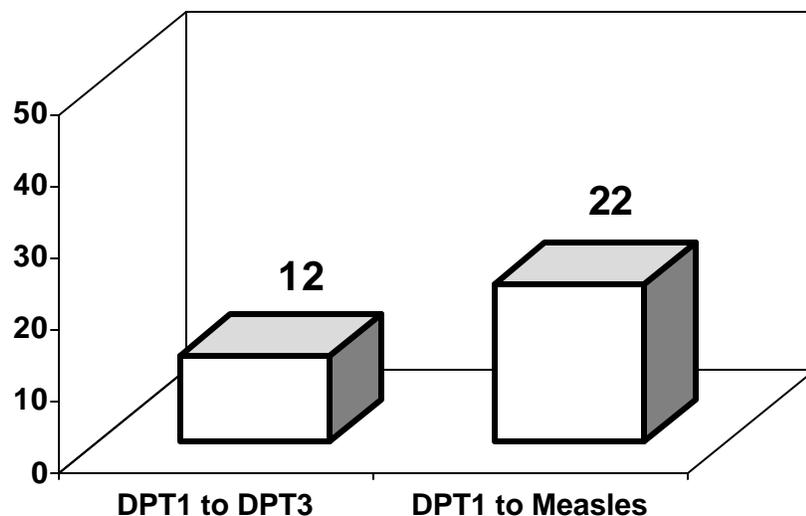


Table 3: Invalid doses of immunization provided to the children

Antigen	Percent
DPT1	5
Measles	1

Table 4: Missed opportunities by antigens

Name of the vaccine	Uncorrected		Corrected		Total		
	Number	Percent	Number	Percent	Number	Percent	
BCG	2	1	4	2	6	3	
DPT1	2	1	1	1	3	2	
DTP2	0	0	0	0	0	0	
DPT3	0	0	0	0	0	0	
OPV1	2	1	1	1	3	2	
OPV2	0	0	0	0	0	0	
OPV3	0	0	0	0	0	0	
Measles	4	2	9	4	13	6	
*Index						25	

** The idea is to propose one composite index reflecting the quality of screening during vaccination sessions.*

Table 5: EPI cards availability and retention

Card Status	Number	Percent
EPI card available	113	54
EPI card ever given	196	93
EPI card retention	113	58

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

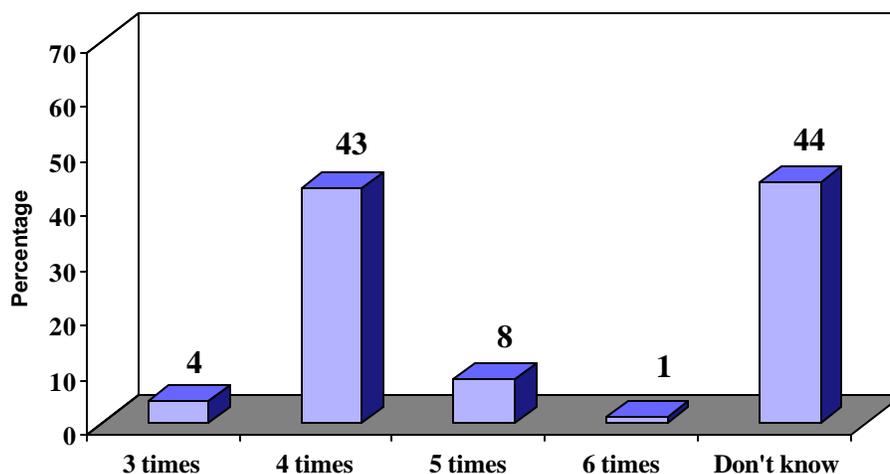


Figure 3: Sources of child immunization services

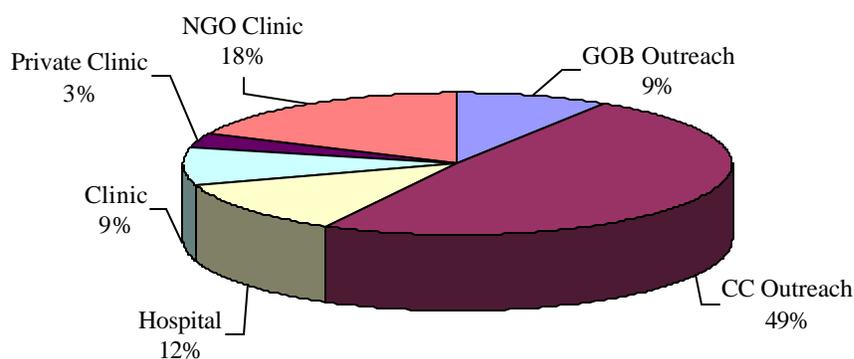


Table 6: Time required to reach the EPI center by mode of transportation

Time required	Mode of transport					
	Walking		Rickshaw		Total	
	#	%	#	%	#	%
1-5 Min.	90	43	44	21	134	64
6-10 Min.	66	31	4	2	70	33
11-15 Min.	6	3	-	-	6	3
Total	162	77	48	23	210	100

Table 7: Reasons for non-immunization and partial immunization of the children

Reasons for non-immunization or partial immunization	Non-immunized (%) (N=14)	Partially immunized (%) (N=44)
Did not know about need of immunization	57	-
Did not know about need of next dose	-	21
Did not know when to return for 2 nd /3 rd dose	-	2
Did not know about importance of measles vaccine	-	21
Did not know when to return for Measles.	-	2
Did not know about place and time of immunization	15	-
Child was sick and not taken to immunization center	7	34
Child was sick, and was taken to immunization center but not given by vaccinator	7	5
Family problem/mother sick	-	2
Painful for the children	7	11
Others	7	2

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

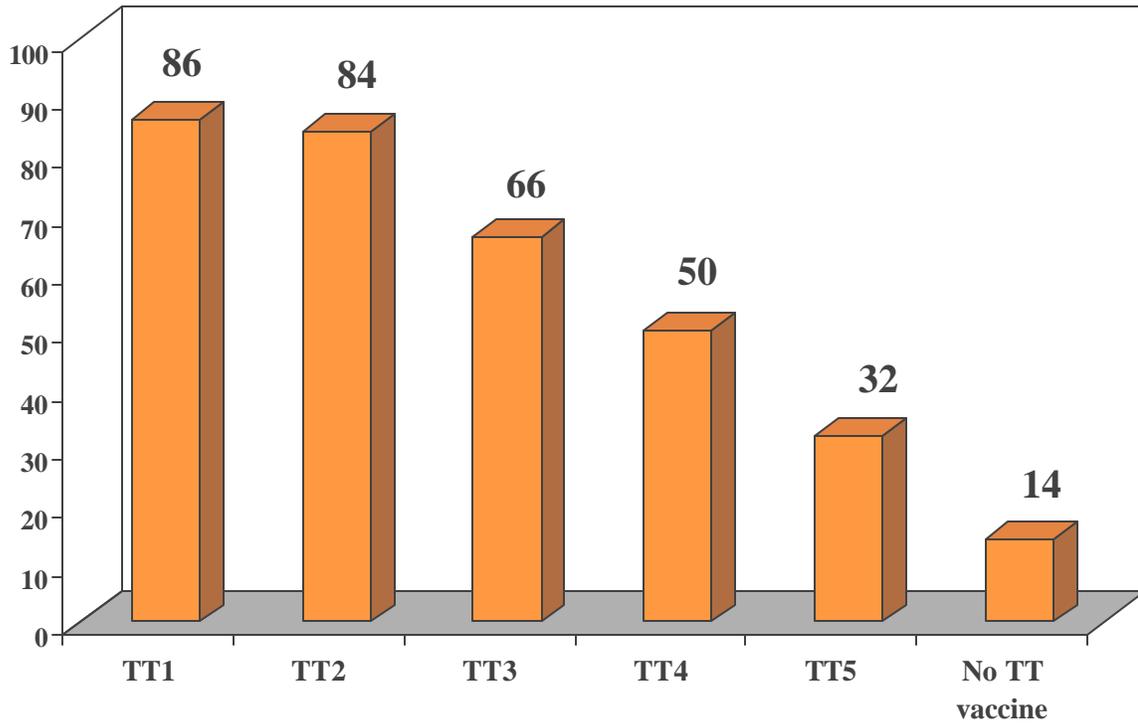


Figure 5: TT Immunization drop-out rate among women 15-49 years

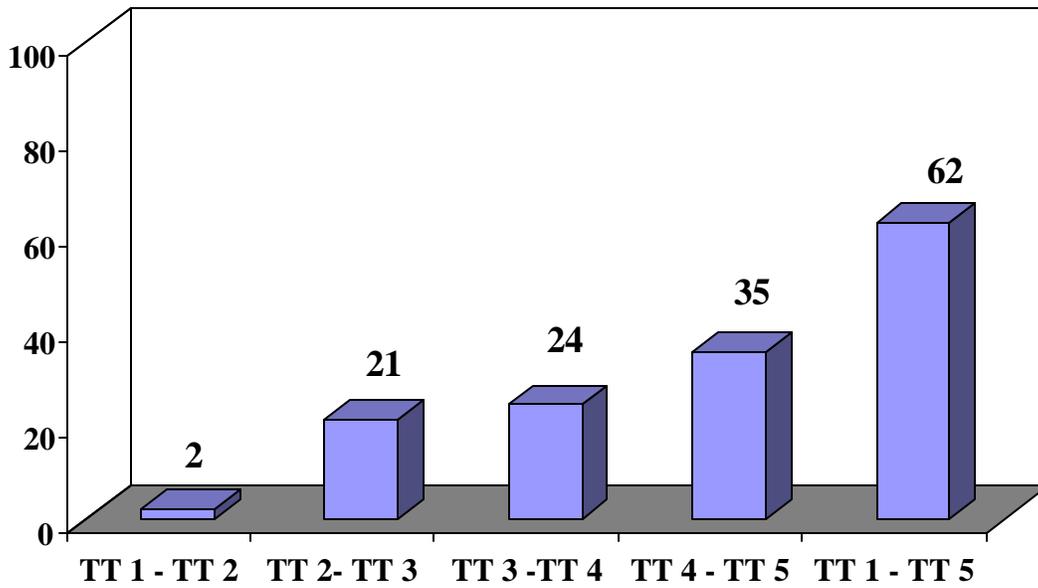


Table 8: Age distribution of women who never received TT vaccine

Age group	Received		Not received		Total	
	#	%	#	%	#	%
15-19	10	53	9	47	19	100
20-25	42	86	7	14	49	100
26-30	66	92	6	8	72	100
31-35	44	98	1	2	45	100
36-45	19	76	6	24	25	100
Total	181	86	29	14	210	100

Table 9: 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	3	136	97	-	-	-	-	-	-	-	-	140	100
TT2-TT3	-	-	-	-	25	27	68	73	-	-	-	-	93	100
TT3-TT4	-	-	-	-	-	-	-	-	28	42	38	58	66	100
TT4-TT5	-	-	-	-	-	-	-	-	19	47	21	53	40	100

Table 10: Children born protected against tetanus

Status of children born protected	Number	Percentage
Protected	190	91
Not Protected	20	9

Table 11: Knowledge about number of TT doses required for life time protection against tetanus

Answers	Number	Percentage
5 doses	22	10
Don't know/ no idea	188	90

Table 12: TT cards availability and retention

Card Status	Number	Percentage
TT card available	43	20
TT card ever given	169	80
TT card retention	43	25

Figure 6: Providers of TT immunization

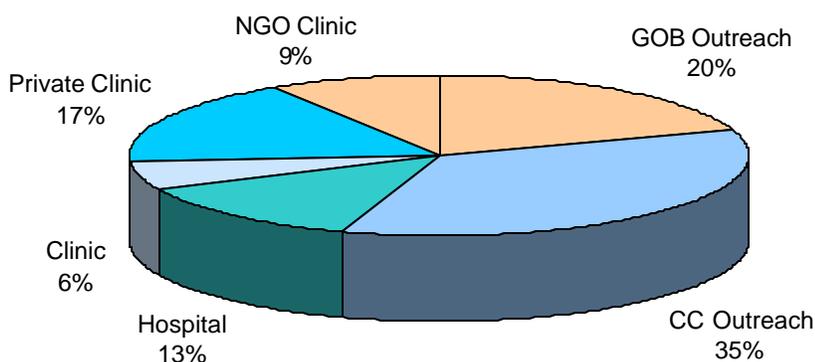


Table 13: Reasons for non-immunization and partial immunization for TT of the women

Reasons	Non-immunization (%) (N=29)	Partially immunization (%) (N=113)
Next dose is not yet due	-	22
Don't feel need for immunization	52	-
Health worker did not specify the next dose	-	17
As per HW advice 2/3 TT is enough during the pregnancy	-	28
Unaware of need of next dose	-	27
In our times TT immunization was not in practice	10	-
Fear of injection	38	1
Postponed until another time	-	3
Busy with homework	-	1
Others	-	1

Table 14: OPV and Vitamin A Coverage during the SNIDs-2002
N=210

Round	OPV (%)	Vitamin A (%)
1 st round	99	97
2 nd round	99	-
Both rounds	99	-
Any round	100	-

Table 15: Sources of OPV during the SNIDs-2002

Sources of OPV	1 st Round		2 nd Round	
	#	%	#	%
NID site	204	97	201	96
Child to child search	5	2	7	3
Mobile Team	-	-	-	-
Not received	1	1	2	1
Total	210	100	210	100

Table 16: Time required to reach the SNID sites by mode of transportation

Time required	Mode of transport			
	Walking		Total	
	#	%	#	%
1-5 Min.	171	81	171	81
6-10 Min.	39	19	39	19
Total	210	100	210	100

Table 17: Households visited during the child-to-child search of the 2nd round of the SNIDs-2002

Variable	Number	Percents
Households visited	198	94
Households not visited	12	6
Total	210	100

Table 18: Date of child-to-child search for 2nd round was written on the door or wall of the house

Status	Number	Percents
Written	183	87
Not written	27	13
Total	210	100

Table 19: Actual visitation status of the households with the date of child-to-child search written on the door or wall of the house

Actual Visitation status	Number	Percents
Visited	183	100
Not visited	-	-
Total	183	100

Figure 7: Sources of information about the SNID campaign

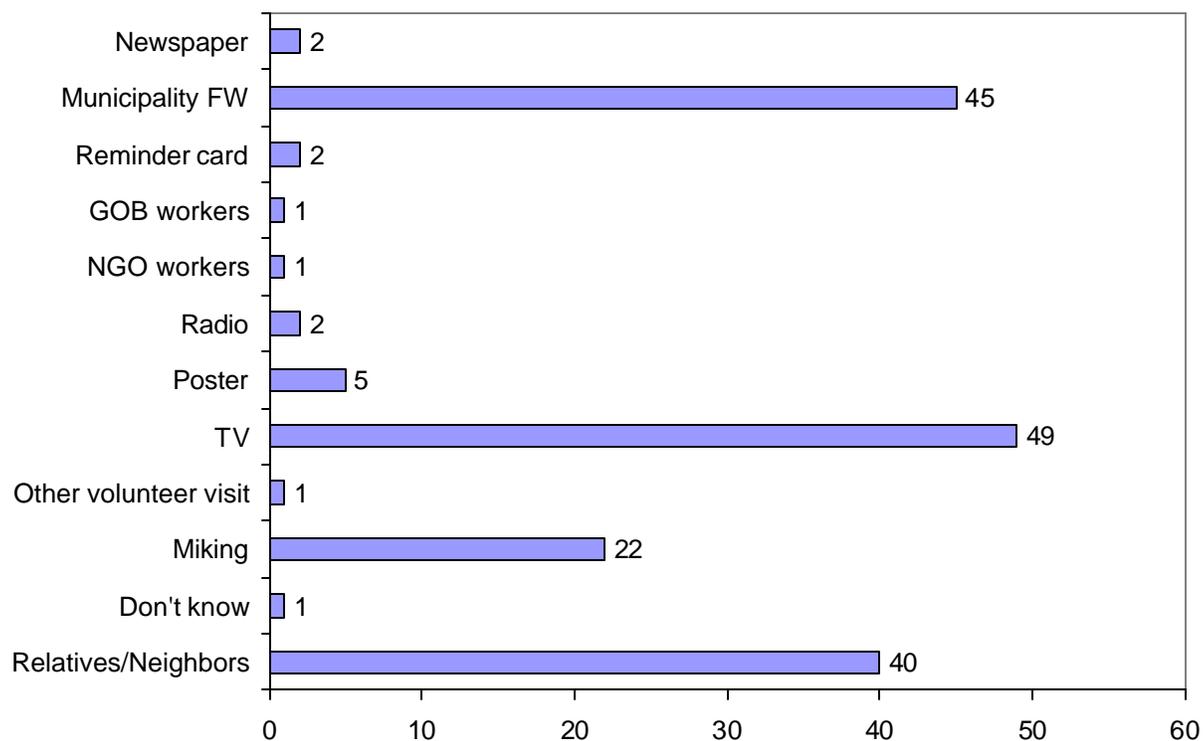


Table 20: Reasons for not receiving of OPV from SNID sites

Reasons	1st Round (%) (N=6)	2nd Round (%) (N=9)
Forgot the date	-	11
Too busy	50	34
Waited for house visit	17	11
Child was sick, and not taken to immunization center	17	11
Religious/social barrier	-	22
Others	16	11

List of Selected Clusters for the Survey

Word no.	Mouza name	Mahalla name	Total HH	Total Pop.	Cluster No.
1	Daria Para	Daria Para	182	954	1
	Kazi Elias	Kazi Elias	250	1591	2
	Mirza Jangal (Part)	Mirza Jangal (Part)	170	1064	3
	Munshi Para	Munshi Para	321	2036	4
	Subid Bazar	Subid Bazar	182	1226	5
2	Bhatalia	Bhatalia	175	2047	6
	Kuarpar	Kuarpar	319	2072	7
	Saudagartala	Saudagartala	252	1441	8
	Sekhghat	Sekhghat	681	4293	9
3	Chararpar	Chararpar	279	1734	10
	Kamalgargh	Kamalgargh	325	2068	11
	Mirza Jangal (Part)	Mirza Jangal (Part)	97	811	12
	Purba Kazi Bazar (Topkhan)	Purba Kazi Bazar (Topkhan)	368	2311	13
4	Ambarkhana	Ambarkhana	892	6087	14,15
	Abdullah Mahallah	Abdullah Mahallah	68	475	16
	Chauhatta	Chauhatta	113	978	17
	Topkhana	Topkhana	98	698	18
	Kazitala	Kazitala	606	3572	19
	Kumar Para	Kumar Para	152	989	20
	Mission Compound	Mission Compound	66	408	21
	Saudagartala	Saudagartala	505	2789	22
	Tati Para	Tati Para	134	761	23
5	Baruthkhana	Baruthkhana	75	536	24
	Daptari Para	Daptari para	109	740	25
	Jharnarpar	Jharnarpar	365	2404	26
	Jherjheri Para	Jherjheri Para	267	1811	27
	Sonar Para	Sonar Para	466	3027	28
	Suphanighat	Suphanighat	279	1776	29
	Zinda Bazar (Bandar Bazar)	Zinda Bazar (Bandar Bazar)	196	1742	30

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