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Access to childhood immunisation services and its determinants among recent and settled migrants in Delhi, India

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ABSTRACT

Objectives: Childhood immunisation is one of the important public health interventions, and poor migrants are vulnerable to forego these services. The objective of the study is to understand the access of childhood immunisation services to the socio-economically disadvantaged migrants and the determinants of full immunisation uptake up to the age of 1 year.

Methods: In a cross-sectional survey, 458 migrant households with a child aged up to 2 years were identified. Data on sociodemographics, migration history, receipt of various vaccines and maternal healthcare services were collected through interviewer-administered pre-tested questionnaires. Multiple logistic regression analysis was performed to identify the determinants of full immunisation status.

Results: Childhood immunisation coverage rates were low as only 31% of recent-migrant children and 53% of settled-migrant children were fully immunised against seven vaccine-preventable diseases (VPDs) by 12 months of age. Lack of awareness of the immunisation schedule and location of health facilities, mobility, illness of the child, fear of vaccines and side-effects were the main reasons for incomplete or no immunisation. Mother's educational attainment, TV viewership, hospital birth and receipt of information on childhood immunisation from the health workers during postnatal visits increased chances of getting the child fully immunised against seven VPDs by 1 year of age.

Conclusion: The migrants, particularly the recent migrants, are at the risk of foregoing immunisation services because of livelihood insecurity, mobility and non-familiarity of services in the new urban environment. There is a need to deliver services with a focus on recent migrants. Investing in education and socio-economic development and providing secured livelihoods and equitable services are important to improve and sustain access to healthcare services in the long run.

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Introduction

Immunisation is one of the important interventions to protect children against preventable morbidity and mortality. An analysis based on demographic health surveys from 62 developing countries revealed that childhood vaccination is associated with substantial reductions in childhood mortality, and it was estimated that 100% coverage of all vaccination was associated with a decrease of under-five mortality at cluster level by 24%.¹ India's immunisation programme, launched in 1985, is one of the largest health programmes of its kind in the world and provides vaccination against seven life-threatening diseases (diphtheria, whooping cough, tetanus, polio, tuberculosis, measles and hepatitis B) in the entire country.² Despite high childhood mortality rates due to vaccine-preventable diseases (VPDs), 30% of Indian children miss the benefits of full immunisation every year.³ The fourth National Family Health Survey of India showed that compared with rural areas (61.3%), a high number of children in urban areas (63.9%) were fully immunised.⁴ However, this coverage may not be true for all urban communities; inequalities exist, and vulnerable people such as poor migrants may not receive coverage on par with the general population.⁵ Migrants may not be covered in the routine surveys; hence, it is important to have disaggregated data to know the coverage of immunisation services among vulnerable groups such as poor migrants.

Existence of disparities in health conditions and healthcare utilisation are evident between the natives and migrants.^{5–11} This situation is to be examined in the background of marginalisation and vulnerability context of migrants. The degree of access depends on the interplay between the health services and the status of the community in the context of vulnerability.¹² The vulnerability of migrants, particularly the recent migrants, is obvious in terms of livelihood insecurity, neglect and alienation in the new socio-cultural environment and leads to less control over available resources that are meant for all communities, including migrants. We hypothesise that the poor migrants, particularly the recent migrants, are at the risk of forgoing health care compared with the general population and settled migrants. With this background, we carried out this study with an objective of understanding the access to immunisation services by poor labour migrants living in Delhi and the determinants of full immunisation uptake during the first year of life of the migrant children.

Methods

Study design and population

The data were collected as a part of a major interventional study to improve healthcare access for labour migrants in Delhi. Methodological details of this study are available elsewhere.¹³ Migrant households in urban slums, slum-like pockets, dwellings at construction work sites and open spaces were identified and considered for inclusion after obtaining informed consent. A total of 4773 recent-migrant (those who have migrated to the city of Delhi from other states of India within the last 10 years) and 1389 settled-

migrant (those who have migrated from other states of India and living in Delhi at least for 10 years) households participated in the study. Among these households, 242 recent-migrant and 222 settled-migrant households had a mother with a child up to the age of 2 years. Complete data for analysis were available from 458 households (236 recent migrants and 222 settled migrants). Ethical approval was given by the institutional ethics committee.

As mentioned, the migrants were categorised into two groups, namely, recent migrants and settled migrants, taking 10 years as a cut-off to classify. In earlier studies, those who have migrated and been staying in Delhi for at least 10 years were considered as settled migrants.¹⁴ People of these communities perceived those who have migrated within the last 5 years as very recent and those between 5 and 10 years as neither old nor very recent,¹⁵ and still are in the process of settling in the city.¹⁶ Hence, we took 10 years as an arbitrary cut-off to classify into recent migrants and settled migrants. Both the groups are mainly from northern Indian states, particularly Uttar Pradesh and Bihar. Their distribution in terms of place of origin, ethnicity, social class and religion was similar and comparable. Health services in National Capital Territory of Delhi adopted the universal immunisation programme of India which stipulates that infants should be vaccinated with the following vaccines: a dose of Bacillus Calmette–Guerin (BCG) at birth or as soon as possible i.e. within a month; hepatitis B vaccines and oral polio vaccine (OPV) within 48 h; three doses each of Diphtheria, Pertussis and Tetanus (DPT) vaccine, OPV and hepatitis B vaccines at 6, 10 and 14 weeks of life and one dose of measles vaccine between 9 and 12 months.¹⁷

Data

Data pertaining to demographic and socio-economic details, migration history, immunisation details and mother's use of healthcare services were collected through interviewer-administered pretested questionnaires. The immunisation status of the child was determined from the immunisation card, and in the absence of the immunisation card, mothers were asked to recall whether the child had received different vaccines (including number of doses for each) and vitamin A supplement. Separate questions were posed to extract information on each age-appropriate vaccine to be received.

Measures

Outcome variables

The outcome measure was the likelihood of a child aged 1 year or older having received full immunisation against seven VPDs (BCG within one month of age, three doses each of DPT, OPV and Hepatitis B vaccines at 6, 10 and 14 weeks of age, and measles vaccine between 9 and 12 months of age), here onwards referred to as full immunisation against seven VPDs.

Independent variables

The individual-level variable of interest was gender of the child. The household-level characteristics were mother's age, educational status, household income per month (in Indian

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