SOCIO-ECONOMIC AND CULTURAL FACTORS AFFECTING CHILD IMMUNIZATION IN DISTRICT BHAKKAR

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DEPEARTMENT OF SOCIOLOGY

FACULTY OF SOCIAL SCIENCES

INTERNATIONAL ISLAMIC UNIVERSITY

ISLAMABAD, PAKISTAN

2016

Vaccination of children.

Communicable diseases in children.

Traditional thoughts.

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A thesis submitted in partial fulfilment

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DEPARTMENT OF SOCIOLOGY

It is certified that thesis submitted by **Mr. Naeem Adil** Registration No. **168-FSS/MSCSOC/S14** titled ***"Socio-Economic and Cultural Factors Affecting Child Immunization in District Bhakkar "*** has been evaluated by the following viva voce committee and found that thesis has sufficient material and meets the prescribed standard for the award of **M.S** degree in the discipline of Sociology.

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DEDICATION

To my most caring and loving, parents, (my respectable supervisor) Dr. M. Babar Akram, my sweetest nephew Muhammad Abdullah Malik, Muhammad Abdul-ul-Ahad Malik and my brothers, whose encouragement toward my studies enabled me to accomplish this (research) work.

Abstract

The present research was conducted to examine the socio-economic and cultural factors affecting child immunization in district Bhakkar. The area (Bhakkar) was selected due to its low health development and miserable health condition of the people particularly children of local communities. The objective of the study was to check the child's immunization and to find out the role of health care centres in child immunization. From two tehsils (out of four Tehsils) in the district, 10 villages were randomly selected. A random sample of 405 households was selected with the help of voter lists. The respondent's children suffer the loss of incomplete immunization due to various reasons like, lack of awareness, education, low income, migration and traditional thoughts. Duc to low educational level and poverty, most of the people were engaged in agricultural activities. Due to the parental outdoor activities like agricultural work, most of the children remained to get proper vaccination. Immunization plays a vital role in the health of children less than the 60 months of age group. People, who lived in the rural areas, face a lot of difficulties regarding their children immunization. Unfortunately, the current situation of immunization in local areas is very miserable because of inadequate health facilities and careless of Government. The role of Basic Health Units regarding immunization was also not satisfactory. The polio and vaccination teams may not perform their role properly. The awareness program is required to be launched to create better awareness about the importance of immunization. Government, political and religious leaders of communities should take some steps to improve the current situation of immunization especially in local areas. The Government should built new health care centres in the rural arcas.

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Words cannot say the gratitude that I feel for my parents for their affectation and prayers have always been the key to my success.

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Last but not the least, I am thankful to my best friends *Muhammad Irfan, Muhammad Ishaq and Fiaz Anjum* who always supported me at every step during my research work and always wished best for me.

(Malik Naeem Adil)

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LIST OF ABBREVIATIONS

BHU	Basic Health Unit
UC	Union Council
DPT	Diphtheria, Pertussis and Tetanus
EDHS	Ethiopian Demographic and Health Survey
EPI	Expanded Program on Immunization
HepB	Hepatitis B
MCV	Measles Containing Vaccine
MDG	Millennium Development Goal
RI	Routine Immunization
OPV	Oral Polio Vaccine
BCG	Bacillus Calmette-Guerin vaccine
TT	Tetanus Toxoid
JE	Japanese Encephalitis
WHO	World Health Organization
LHW	Lady Health Worker
LHV	Lady Health Visitor
KM	Killo Meter
AJK	Azad Jammu and Kashmir
NRHM	National Rural Health Mission
RCH	Reproductive and Child Health
SA	Strongly Agree
D	Disagree
SD	Strongly Disagree
NA	No Opinion

CHAPTER ONE

1.1. Introduction

ALLAH Almighty has blessed us with a lot of blessings in this world. Children are also one of HIS blessings. But the loss of these blessings creates horrible problems for the parents, families, countries and also all over the world. Infant's death put dangerous effects on the people like psychological depression on the parents. The one of the core setback of the less developed and also developing countries is the lack of child health immunization. Infant's health is totally depended on the immunization but in spite of the different public health benefits, vaccination programs face the obstacle of public remark of the relative risks.

According to World Health Organization (WHO), "Immunization is a process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine."

Immunization plays a vital role for the health of an infant. An infant (from the Latin word *infans*, meaning "unable to speak" or "speechless") is the very young offspring of a human or other animal. The term *infant* is typically applied to young children between the ages of 1 to 12 months; however, definitions may vary between birth and 1 year of age, or even between birth and 2 years of age. A newborn is an infant who is only hours, days, or up to a few weeks old. A child is a young individual who is under the legal age of majority, or who is the natural offspring of another. "A human being below the *age* of 18 years unless under the law applicable to the *child*, majority is attained earlier". Biologically, a *child* is generally anyone between birth and puberty (Toumba, 2013).

1.2. Background of the Study

The purpose of the research was to investigate the public perception about vaccination and the socio-economic and cultural factors that influence these perceptions from the vaccinator's point of view. Vaccination/polio programs have a lot of return but it faced many difficulties. The major hurdle in the way of vaccination is the thoughts of people about the side effects of vaccination. Every person and their whole family have the chances of both reward and complications of vaccination that replicate the contribution of people in immunization process (Ali et al., 2010).

High rate child health immunization is one of the momentous symbols of health status of the entire world. Child's death rate in industrialized countries has regularly decreased. But unluckily, in less developed and developing countries, its rate is very high due to lack of health immunization like delay or missing of important vaccines and also other medical development, technologies and low rate of education. The main problem of immunization is storage of vaccine; transportation and management are already known to contribute in incompetence of child immunization. Factors such as awareness, feelings and tradition are also known to participate in the achievement or breakdown of child immunization (Ahmad, 2010). Now the child immunization becomes better than the past which decreased the deaths significantly.

Jonas and Salk invented vaccine for the first time in 1955. The vaccination has a vital part in the reduction of different diseases. Vaccination has more important than the medicines (WHO, 2014). Parents make an effort to save from harmful illness through vaccination. The proper immunization protects children from diseases and incomplete immunization creates dangerous effects on the children of all community. The vaccination starts from the birth of the child.

EPI schedule for RI in 2005 is consisted of nine rounds of vaccinations to be completed by the child's first birthday is as under:

1.1: Schedule of EPI Routine Immunization

Vaccine	Disease	Age
BCG	Tuberculosis	At Birth
DPT	Diphtheria, Pertussis, Tetanus	6, 10, 14 Weeks
OPV	Polio	At Birth, 6, 10, 14 Weeks
Measles	Measles	9 Months
TT	Tetanus	Pregnant Women
TT(School Immunization)	Tetanus	Grade 1 Students
JE	Mosquito Virus	12-23 Months Age
Hepatitis B	HepB	Birth to 18 months (after every 3 months)
Hepatitis A	HepA	12 months to 5 years
Influenza	Influenza Viruses	6 months to 6 years

Source: (Benn et al., 2008).

1.3. Factors Affecting Child Immunization

Due to different social, economic, cultural and religious factors, a lot of children cannot get proper immunization, that is why the health care centres remain to control the polio related diseases and unable to control the mortality rate. Different socio-cultural factors lead to the weakness or prevention of health immunization. The social factors that become the cause of prevention of child health immunization are lack of family support, lack of community support, socio-economic status of the mother and lack of health education. The social factors affecting immunization are lack of family and community support, socio-economic status of the parents and lack of knowledge etc. The children of

poor and less educated were less immunized than the rich and educated parents in all the communities (Smith, 2006). The people of local communities that have low level of education or illiterate, they become unaware from the advantages and the value of existing and new developed vaccines and immunization method (Bardenheier et al., 2004).

The cultural factors include gender inequality, birth order, migration, trust on vaccinator and lack of maternal education effect the child immunization. The road and transportation facilities also affect badly to the immunization coverage (Streefland, 2003).

The religious factors also considered very important for child immunization. The religious factors also play an important role in the child immunization. Religious has a great impact on the acceptance or rejection of the vaccination process in any community. Religion has a strong impact on the health related behaviour of community and Religious leaders also motivate the community about child immunization. Religion and religious leader plays a key role to accept or reject the vaccination especially in tradition areas. The religious leaders guide the people to admit or refuse immunization process (Ruijs et al., 2013).

The current research was conducted to examine social and cultural determinants that affect the immunization of children. During the survey, the researcher has examined if the infants received proper or not and why? For the better health condition, a child must get every necessary vaccine that prevented him from diseases.

The health condition of children's in less developed and developing countries is horrible and thus a large number of population especially children died every day due to lack of immunization. About 14000 children die every year in the world. In Pakistan, about 1100 children die every day (Kim, 1988).

In past the people of traditional thoughts avoided the female checkups from male doctors. There were no female doctors in the local communities and due to lack of hospitals, dispensaries, medical equipments, specialists and lack of lady health worker program put an unfavourable affect on mothers during pregnancy and also on the child before his birth. But now days, BHU's (Basic Health Units) in local communities provide basic health facilities to the people and with the development of medical technologies, and due to lady health worker program, the trend of health immunization developed and the rate of mortality is decreasing with the passage of time. With the passage of time, death rates are decreasing due to late marriages, proper checkups, use of family planning and frequently visits of lady health workers.

1.4. Role of Health Care Centres

Immunization coverage (age appropriate vaccination & up to date vaccination status) plays a key role in increasing the rate of immunization. Vaccination has its great significance to avert from diseases and deaths to almost each and every child.

Immunization coverage like age appropriate vaccination status and up to date vaccination status plays a key role in increasing the rate of immunization. Vaccination is very important for good health and to prevent from disability or death to each and every child. According to the Koenig et al. (1990) vaccination had highly impact on the child's health. They depict that vaccinated children mortality rate was 46% less than the non-vaccinated children. Health care centres give fundamental health facilities to the communities door by door. Now a day, the best examples of door to door health care services are Lady Health Workers and Community Health Worker. Pakistan started leady health worker program in 1994 to provide door to door health facilities especially to the local and traditional communities through definite females. The LHW program started with initial

recruitment but now it become a large network of female services. With the help and advised of LHW's, the mothers are able to birth a safe baby.

The objective of initiating this program was to raise defensive services at the community level especially for women and children in poor and less developed communities. LHW's considered the best tool to cover the child immunization in any area of the world. LHW's remains always on the frontline to minimized the infectious diseases of the children. LHW's play an important role to educate the patients, families and also communities about the immunization and told about to prevent from various disease (Arif, 2012).

Local married and educated women under the age group of 18-45 years are selected. Selected women were getting training as LHW at various health centres. The trainee gets 15 months training including 3 months class room and 12 months mix training, i.e. class room and field work (Hafeez, 2011).

The LHWs are normally posted in local areas to provide their services with respect to their residence. The LHWs provide the services for the children and their mothers. LHWs also give the contraceptive provisions for birth spacing. They also advised the women about the health related issues, breastfeeding and about the child immunization. The community health workers play an imminent role to achieving health related MDGs in Pakistan (Bhutta et al., 2010). The health conditions have been improved due to LHWs programme (Bazegar et al., 1981).

According to the WHO, "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health

system but not necessarily a part of its organization, and have shorter training than professional workers."

District Bhakkar is one of the southern districts of Punjab Province and comprised plains and desert area which is considered a backward area of the Punjab. District Bhakkar comprised four Tehsils namely Bhakkar, Mankera, Darya Khan and Kalur Kot. According to the "Population Census Report 1998", the total population of District Bhakkar, are 1051456 persons. Majority of the population belongs to the rural areas and is involved in agriculture due to lack of education and industrial sector. Due to the backwardness and lack of education, the health department has a miserable condition especially in rural areas. Some BHU's has no necessary equipments even have no sufficient doctors and LHV's. Some rural areas have no BHU's in its vicinity and people have to gone many KM distance for their checkups. The main reasons of incomplete child immunization include parent's objection, disagreement and waiting time at the health facility during vaccination.

The factors affecting child immunization progress are lack of education, social engagement, unavailability of health care centres, migration, poverty, parent's outdoor activities, traditional thoughts, transportation and long waiting time during vaccination. (Abdulraheem et al., 2011).

District Bhakkar especially Tehsil mankera is totally desert area and have very low facilities like schools, hospitals, medical advancement and inappropriate health policies of Government. The condition of local health care centres (BHU's) is very miserable due to many reasons and less attention of the Government.

1.5. Significance of the Study

Sociology deals with the role and laws of societies which have different social institutions and health is the main institution of the society. Any leads to the health problem in the society. Health problem is a sign of weak nation. Diseases rate is increasing day by day especially in the local communities due to lack of health facilities, medical progression and inappropriate health policies of Government. Although there are several socio-economic and cultural reasons those prevent child health immunization, so the researcher is very interested to study the misery and the poor health conditions of the children. Most of the countries rich in the field of medicine, but the health condition of people in Pakistan are not adequate to save the children. It is entirely associated to the social and cultural aspect; it is very sensitive issue for the researcher to study this problem. The specific objectives of the study are as under:

1.6. Objectives of the Study

The specific objectives are following:

a. To find out the present health status of the child.

b. To investigate the role of health care services in promoting child immunization.

c. To explore the socio- economic and cultural factors affecting child immunization.

d. To suggest some policy measures for improving child immunization.

1.7. Hypothesis of the Study

a. Higher the level of education of mothers, more will be the chances for better child immunization process.

b. Higher the son preferences of the parents, more will be the chances of better child immunization.

c. Higher the influence of social factors, lower will be the chances of child immunization.

d. Higher the influence of economic factors, lower will be the chances for child immunization.

e. Higher the misperception regarding religion, lower will be the chances of better child immunization.

1.8. Research Question

a. What are the socio-economic and cultural factors which affecting child immunization process?

b. What is the living standard of children's parents?

c. What is the present health status of child?

d. What is the role of health care services in immunization process?

e. What are the policy measures for improving child immunization?

CHAPTER TWO

2.1. Review of Literature

Abdulraheem et al. (2011) conducted study on "Reasons for incomplete vaccination and factors for missed opportunities among rural Nigerian children." A sample size of the study was taken 154 houses by the researcher. The study showed result that the main reasons of incomplete child immunization include transport hurdles; religious determinants, long distance of polio booths and waiting time at the health facility during vaccination were responsible for incomplete vaccination of the children.

Ahmad (2010) examined study on "Immunization in Pakistan." The study investigate that the main issue of vaccine is its management that leads to the diseases and other various health problems especially for the children. Various determinants like awareness, feelings and tradition are also known to participate in the achievement or breakdown of child immunization.

Ali et al. (2010) explore study on "Community Participation in Two Vaccination Trials in Slums of Kolkata, India." The study showed result that vaccination/polio programs have many advantages but it suffered a lot of hurdles. The major hurdle in the way of vaccination is the thought of people about the side effects of vaccination. Every person and their family have the chances of both advantages and disadvantages of vaccination that reflect the participation of people in immune programs.

Ali et al. (2010) conducted study on "Perceptions of men on role of religious leaders in reproductive health issues in rural Pakistan." The study depicts that religion at an individual level have not an important part to receipt or denied from immunization.

Research depicts that the children of Hindu community are more immunized than the Muslim community due to various reasons.

Andersson et al. (2009) conducted study on "Evidence-based discussion increases childhood vaccination uptake: a random cluster controlled trial of knowledge translation in Pakistan." The study showed result that economically, the cost-benefit analysis of a family may examined the level of parents demanding child immunization. The presents expenses about immunization may proved fruitful in the future for the parents and also for their children.

Ayub et al. (2007) revealed the study on "Knowledge, Attitude and Practice Regarding Immunization among Family Practice Patients." The study showed result that almost all the children remained safe from diseases which used the vaccination properly. About more than two third populations knowing the advantages of vaccination that is why they considered the vaccination necessary for their children.

Many of the transmittable diseases can be efficiently vetoed and treated by vaccination. Immunization helps to scrap against various diseases causing organisms and strengthens protection; now vaccination is the best mode to save the children from diseases (Mathew, 2012).

Feinstein (1993) conducted study on "The relationship between socio-economic status and health." The study showed that immunization divides into proportions, one portion refers to the problem of health rank and the second measurement refers to the many factors affecting immunization like income, transport facilities that occur from differences in admittance to and utilization of health care services.

Glauber (2003) conducted study on "The immunization delivery effectiveness assessment score: a better immunization measure." The study showed result that to get more safety and to remain secured from various diseases, the children must get all necessary vaccines without missed anyone vaccine.

Halsey (2002) conducted study on "The science of evaluation of adverse events associated with vaccination." The study reveals that vaccination is the best way to control various diseases of children. The vast level of vaccination has saved millions of child's from deaths and dangerous fatal diseases.

Kabir et al. (2003) conducted study on "Non-specific effect of measles vaccination on overall child mortality in an area of rural India with high vaccination coverage" to explore the effect of immunization on the infants. The researcher get the sample from the Rural Health Services Project conclude that infants of incomplete immunization has become sick more than 3rd time than the fully immunized infants.

Koenig et al. (1988) studied the "Maternal mortality" in Matlab. The study examines the effect of immunization from 1982 to 1985. The study showed results that the high rate of vaccination had great influence on the child's health. They also conclude that vaccinated children mortality rate was 46% less than the non-vaccinated children.

Mahalanabis et al. (1995) examined "Mothers' knowledge about vaccine preventable diseases and immunization coverage of a population with high rate of illiteracy." The result of the study showed that the immunization of the every child is highly dependent upon the educational level of the parents especially mother's knowledge. The educated mothers know the advantages of immunization that is why their children become protected from the diseases.

Plotkin et al. (2008) depicts research on "Vaccines." The research explore that vaccination is one of the best economically way of primary child health protection against various diseases. It is responsible for children's health below sixty months and to get the 4th MDG's (Millennium Development Goal) that belongs to the reduction the rate of child's Mortality. Vaccination is a simple method to reduce the death rate of less than sixty age of child.

Ruijs et al. (2013) conducted study on "The role of religious leaders in promoting the acceptance of vaccination within a minority group." The study showed results that Religion has a great impact on the immunization coverage of a community and religious leaders also inspire the people and their families about child immunization. The authority of the religious leader persuaded the community to accept or reject vaccination process.

Shamsul et al. (2012) conducted study on "Factors Influencing Childhood Immunization Defaulters in Sabah, Malaysia." The study area of the study was District Kota Kinabalu, Sabah and the sample size was 315 respondents. The study depicts result that the main reason of incomplete immunization was mother's employment and family size. It is very necessary to realise the parents about the vaccination and importance of child immunization according to the schedule. The study also examined that to reduce the rate of the immunization defaulter, parents with these defaults need to be given more support and should be monitored closely.

Singarimbun et al. (1988) evaluated the study on "Social Factors Affecting Use of Immunization in Indonesia." They conclude that different socio cultural factors like gender difference, birth order, social engagement, migration, poverty, political pressure and religion affect the acceptance of child immunization. All these determinants had the positive and negative effects on the child immunization.

Waris et al. (2007) conducted study on "Knowledge, Attitude and Practice Regarding Immunization among Family Practice Patients." The sample size of the study was 97 patients which were selected to explore the result. They conclude that media has play a significant role in promoting child immunization through providing information about immunization to patients. Various problems against immunization were included lack of education and lack of funds.

Wilson et al. (2010) evaluated that "Could Parents be Held Liable for not Immunizing their Children?" in Canada" to conclude the effect of immunization of the health of children. They conclude that parents of infected children were increased risk of disability and death through declining routine immunizations. The result showed that a single individual could not normally be held causally responsible for the outbreak of immunization but a group of individuals could be found to be responsible for this problem.

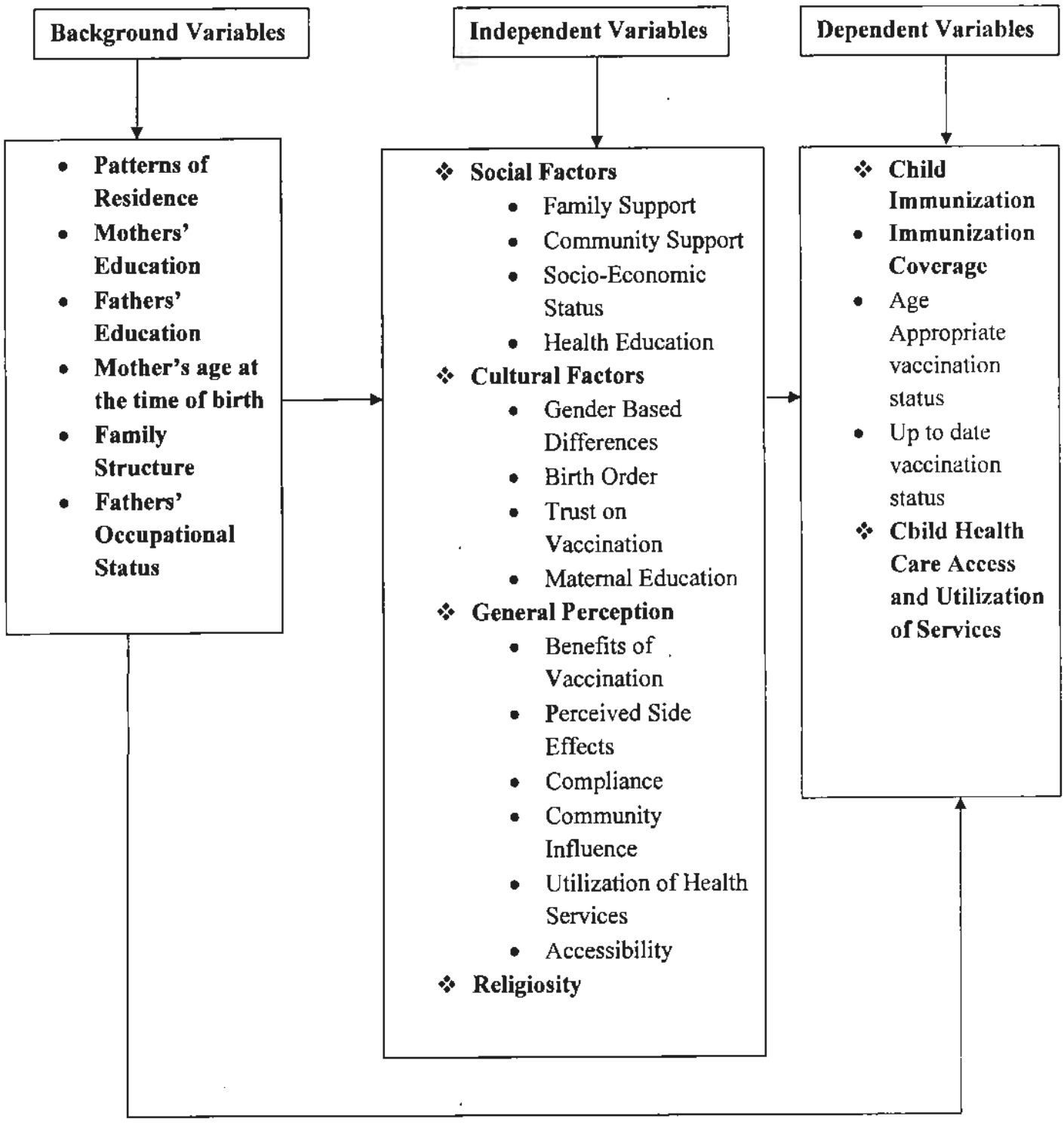
Without some northern areas, almost all areas of the Pakistan have the low rate of child immunization than the than the required ratio of immunization. It shows the occurrence of polio cases all over the country from some previous years. Throughout this period, extensive efforts would be made to develop the worth of polio vaccination campaigns but not the immunization coverage (Hasan et al., 2010).

2.2. Theoretical Framework

The researcher has conducted study on the socio-economic and cultural factors affecting child immunization. Herd immunity theory is also related to the immunization which researcher used in his study. The herd immunity theory was presented by an American researcher called Hedrich, in 1933.

It explains that a sufficient number of people of an area are protected themselves from diseases through various methods of protection then whole the community have the chances of protection from diseases. When a major part of the community were fully immunized from diseases then a little portion of the unimmunized will also remain safe. The herd immunity theory presented that vaccination play an important role in immunization and helpful to stop the spread of disease in the whole community. Complete immunization saves anybody from his birth to till the death. Health care providers also suggest the people to become fully immunized themselves because when a large portion becomes healthy then diseases have a little chance to prevail. Non immunized people have more chances of diseases and disability as compared to the fully immunized people in the community.

2.3. Conceptual Framework



CHAPTER THREE

3.1. Research Methodology

Methodology guides that which type of measures should be occupied to design and accomplish a study, how the researchers accumulate the necessary information during study, what tools and techniques should be used to collecting, analyzing and interpreting the results. Methodology is in fact, an absolute frame work for the entire research activities.

3.2. Research design

In order to have an efficient and deep understanding of the research topic, quantitative research method has used to get the necessary information from the respondents. The researcher has used the cross sectional research design in this study. The cross sectional research design focuses the studies related to temporal terms or within the short span of time

3.3. Study Area

The research has been conducted in District Bhakkar. District Bhakkar is a backward area of Pakistan which is situated in the south of the Punjab province. The district comprises four Tehsils namely Bhakkar, Darya Khan, Kalur Kot and Mankera. In 1981, Bhakkar was created a separate district after the separation from Mianwali. Most of the Bhakkar's area comprises greater Thul. Bhakkar is a "Saraiki Wasaib" in Punjab province. Total area of district Bhakkar is 8153km^2. According to the National Program of Health Office 2014, the total population of Bhakkar is 14, 92,333. Due to its backwardness and lack of basic health facilities like health and education, the tendency of child health immunization is low that is why the people spent miserable life. The low rate of child immunization tends to increase the child morbidity and mortality rate in District Bhakkar.

3.4. Sampling

Sampling is very important to get a part of population from the whole population. A sample represents the whole population. In this research, two tehsils (out of four tehsils) has been selected by the researcher namely tehsil Bhakkar and tehsil Mankera through random sampling.

3.4.1. Sampling Frame

A sampling frame is the total list of the whole population. The detail of population is as under:

Table No. 3.1. List of Tehsil Wise Population

District Population	14,92,333
Tehsil Wise Population of District Bhakkar	
Bhakkar	6,15,191
Mankera	2,29,705
Target Population of Two Tehsils	8,44,896

Source: Report of Health Office Bhakkar, 2014

The sample has been taken through following formula.

$$n = N/1+N\,(e)^2$$

$$n = 844896/1+844896\,(0.05)^2$$

$$n = 844896/2113.24$$

$$n = 399.81072$$

$$\mathbf{n=400}$$

A sample of 400 respondents selected from 5 union councils (3 UC's from Tehsil Bhakkar & 2 UC's from Tehsil Mankera) of district Bhakkar through Multistage random sampling and also proportionate random sampling was used to illustrate the sample from target population. The sample has been taken from following various UC's:-

Table 3.2. List of UC's Wise Target Population

Sr.#	Union Council	Population
Tehsil Bhakkar		
1	Daggar Rahtas	59
2	Daggar Aulakh	94
3	Kirari Kot	27
Tehsil Mankera		
4	Gohar Wala	124
5	Litton	96
Total		400

In present research, the respondents of the study were the parents (both fathers & mothers) of the children.

3.4.2. Sampling Technique

Multistage random sampling design has been adopted by the researcher to draw the sample. Three UC's selected from Tehsil Bhakkar and two UC's were selected from Tehsil Mankera. Two villages were randomly selected from each UC. Moreover, the distribution of the respondents would be employed by using proportionate random technique.

3.5. Tools of Data Collection

3.5.1. Interview Schedule Construction

The soundness of the research totally depends upon the data collection tools. An interview schedule has developed to collect information from respondents in face to face interaction. In the current research, researcher also developed the interview schedule to assemble suitable information from the respondents. In interview schedule, the researcher used Likert-scale consists of five response categories to determine a variety of aspects amongst the respondents.

3.5.2. Pre-Testing

It is very important to make research tools effective. Pre-testing provides the way of modification in the interview schedule before its finalization. Pre-testing tells the researcher that what modifications should be done to collect all necessary information during data collection process.

3.6. Socio-economic Characteristics

For the current research, the indicators identifying the socio-economic characteristics of the respondents were included age, education; occupation of respondent, family occupation, respondent's income, family income and type of family etc.

1. Age

Age is the essential character in any study which affects the behaviour of people at the various steps. Age refers to the living years by a person since their birth to till now. The age was categorized as:

Sr. No	Age
i.	Up to 20
ii.	21-30
iii.	31-40
iv.	Above

2. Income

Income is commonly determinants that made the social status of a person in the society and show the living standard. The monthly family income is as under:

Sr. No	Monthly Income
i.	Up to 10,000
ii.	10.001-20,000
iii.	20,001-30,000
iv.	Above 30,000

3. Education

Education plays a prominent role and is measured extremely significant social sign in considerate and central the actions of a person. Education was categorized as:

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	16+

4. Occupation

Occupation is a source of income of people which represents their living standard. Occupation of a person reflects his social status. In every society, various occupations are adopted by the people for economic, social, or prestige rewards than the others. In rural communities, majority of the people (both male & female) were engaged in the occupation of agriculture while some people have the occupation of skilled labour, own business, government and private jobs. Some women took the responsibility of housewife.

The occupation was categorized as:

Occupation of the respondent							
Labour	Agriculture	Skilled Labour	Govt. Employee	Private Employee	Business	Hose Wife	Others

5. Family Structure

Family is defined as "a relatively permanent group of people related by ancestry, marriage, or adoption, who live together, form an economic unit, and undertake of their young" (Griffiths, A. M., 1997).

Family is one of the fundamental institutions of the society. The family arrangement has important economic, social and cultural consequences. According to the structure there are three types of family.

- **Nuclear family**
- **Joint family**
- **Extended family**

3.7. Data analysis

The data has analyzed to draw results and suitable statistical techniques were used. It is a process to draw conclusion about the information from unrefined data. After the collection of data, the data has analyzed. After the collection of data, the data has analyzed through the Statistical Package for Social Sciences (SPSS). Furthermore, the following statistics would be used for the statistical manipulations of statistical data in this research.

3.7.1. Percentage

Simple percentage or average was intended to explain the fundamental characteristics of households and to observe the socio-economic characteristics of respondents. In order to examine the comparison of different variables, percentage of different categories of the data was concluded in current study.

The percentage was calculated by using the following Formula:

$$P = \frac{F \times 100}{N}$$

Where,

P = Percentage

F = Observation

N = Total Observation

3.7.2. Mean

Mean is a very common average. Mean of a value or number is obtained by dividing the total of all the values by their numbers. The formula of mean is as under:

$$\text{Mean} = \bar{x} = \frac{\sum fx}{\sum f}$$

3.7.3. Standard Deviation

The standard deviation is the advanced type of average and is the optimistic square root of variance. The formula of standard deviation is as under:

$$\text{S.D} = s = \sqrt{\frac{\sum (x - \bar{x})^2}{n}}$$

3.7.4. Maximum Value

Maximum Value Maximum value used to find out the largest value in a data set. It is denoted by the Xm.

3.7.5. Minimum Value

Minimum Value Minimum value used to obtain the smallest value in a data set. It is denoted by the X0.

3.7.6. Correlation

A correlation is a statistical technique that is used to compute the relationship between two variables. Correlation coefficient is normally used in study. In current research,

Correlation was used to explore the relationship between various variables. A perfect correlation lies between -1 and +1 that measures the relationship between two variables. A positive value of correlation represent positive and a negative value represent a negative or inverse relationship between two variables. The degrees of correlation are as under:

i. Zero represents absence of correlation or no correlation.

ii. Perfect correlation lies between -1 to +1.

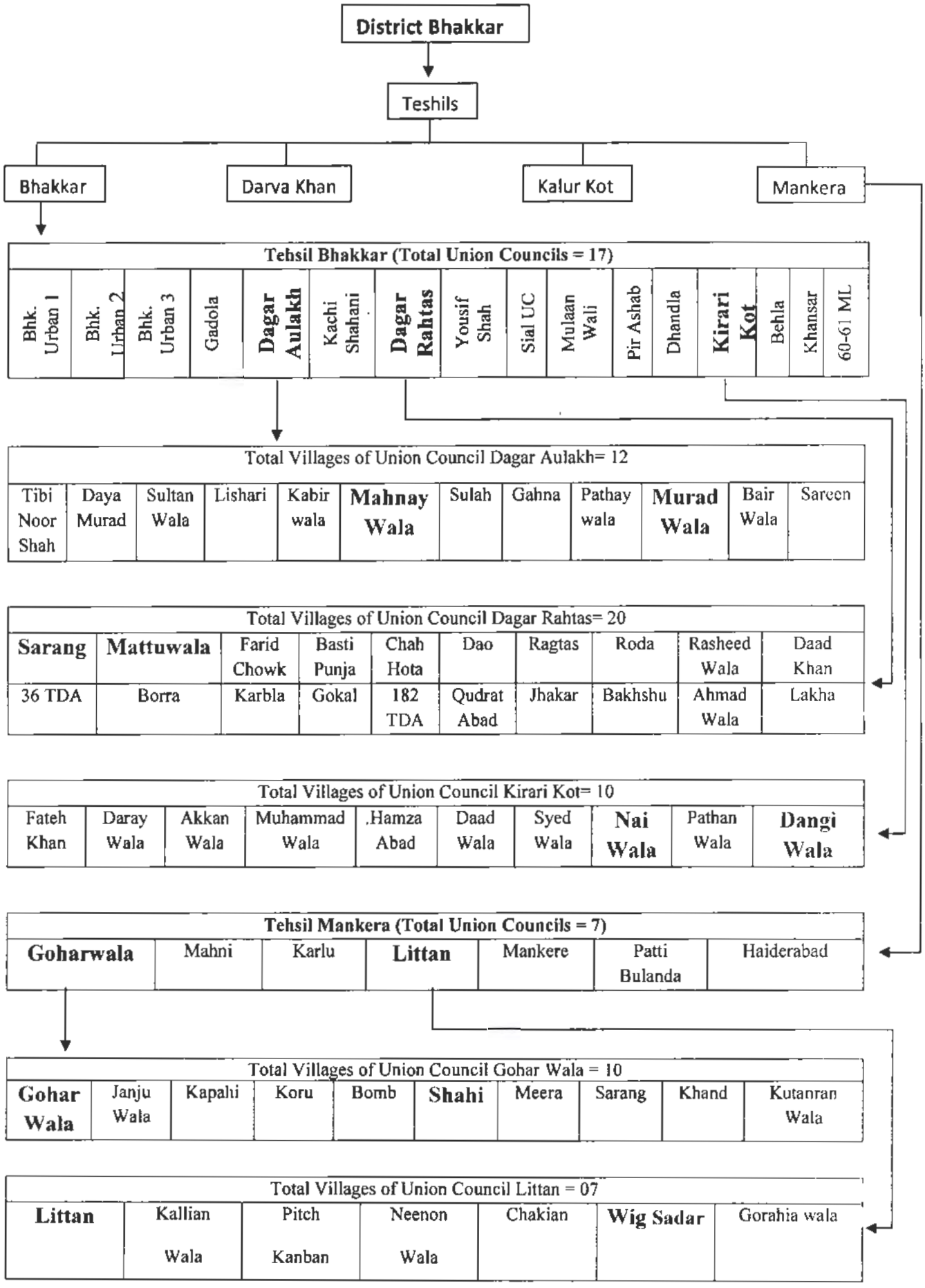
iii. Correlation up to +0.25 and -0.25 represent positive and negative weak correlation respectively.

iv. Correlation from 0.26 to 0.49 considered medium correlation.

v. Correlation between +0.50 to +0.74 and -0.50 to -0.74 considered positive and negative correlations respectively.

vi. Correlation between +0.75 to 1 is considered strong positive and -0.75 to -1 represent strong negative correlation.

3.8. Sampling Framework



Tehsil Bhakkar (Total Union Councils = 17)															
Bhk. Urban 1	Bhk. Urban 2	Bhk. Urban 3	Gadola	**Dagar Aulakh**	Kachi Shahani	**Dagar Rahtas**	Yousif Shah	Sial UC	Mulaan Wali	Pir Ashab	Dhandla	**Kirari Kot**	Behla	Khansar	60-61 ML

Total Villages of Union Council Dagar Aulakh= 12											
Tibi Noor Shah	Daya Murad	Sultan Wala	Lishari	Kabir wala	**Mahnay Wala**	Sulah	Gahna	Pathay wala	**Murad Wala**	Bair Wala	Sareen

Total Villages of Union Council Dagar Rahtas= 20									
Sarang	**Mattuwala**	Farid Chowk	Basti Punja	Chah Hota	Dao	Ragtas	Roda	Rasheed Wala	Daad Khan
36 TDA	Borra	Karbla	Gokal	182 TDA	Qudrat Abad	Jhakar	Bakhshu	Ahmad Wala	Lakha

Total Villages of Union Council Kirari Kot= 10									
Fateh Khan	Daray Wala	Akkan Wala	Muhammad Wala	.Hamza Abad	Daad Wala	Syed Wala	**Nai Wala**	Pathan Wala	**Dangi Wala**

Tehsil Mankera (Total Union Councils = 7)						
Goharwala	Mahni	Karlu	**Littan**	Mankere	Patti Bulanda	Haiderabad

Total Villages of Union Council Gohar Wala = 10									
Gohar Wala	Janju Wala	Kapahi	Koru	Bomb	**Shahi**	Meera	Sarang	Khand	Kutanran Wala

Total Villages of Union Council Littan = 07						
Littan	Kallian Wala	Pitch Kanban	Neenon Wala	Chakian	**Wig Sadar**	Gorahia wala

CHAPTER FOUR

Data Analysis and Presentation

The current chapter Results and Discussion, is the important element of a study. In this chapter, the researcher analysed and presents the data after its collection from the field (Bhakkar). SPSS (statistical package for social sciences) and other statistical techniques have been used for the scrutiny of first hand or primary data. The data has been presented in tabular form along with explanation and description. To explore the suitable result of the research, two methods of analysis have been used, which are as under:

1. Univariate Analysis
2. Bivariate Analysis

4.1. Univariate Analysis

In univariate method of analysis, only a single variable is used to examine the results. In this method, the variable should be in the form of dependent or independent variable. The current chapter comprises following eleven univariate tables.

Table 4.1.1: Distribution of the respondents by their age, no. of (male & female) children, age of last child and education of the respondents

Age of the respondent (in completed years)	Frequency	Percentage
i. Up to 20	06	1.5
ii. 21-30	238	58.8
iii. 31-40	151	37.2
iv. 40+	10	2.5
Total	405	100
Mean 29.85 Years S.D 05.22 Years Minimum Value 19 Years Maximum Value 50 Years		
No. of Male children of the respondents		
i. No Male Child	79	19.5
ii. 1-2	268	66.2
iii. 3-4	56	13.8
iv. 4+	02	0.5
Total	405	100
Mean 01.41 S.D 01.02 Maximum Value 5		
No. of Female Children of the respondents		
i. No. of Female Child	96	23.7
ii. 1-2	260	64.2
iii. 3-4	46	11.4
iv. Above 4	03	0.7
Total	405	100
Mean 01.24 S.D 01.03 Maximum Value 6		
Age of tbe last child of respondents (in completed months)		
i. Up to 10	132	32.6
ii. 11-20	145	35.8
iii. 21-30	79	19.5
iv. 31-40	32	7.9
v. 41-50	11	2.7
vi. Above 50	06	1.5
Total	405	100
Education of the respondent		
i. Illiterate	95	23.4
ii. Primary	76	18.8
iii. Middle	137	33.8
iv. Matric	57	14.1
v. Above Matric	40	9.9
Total	405	100

The table consist on age, education and number of children etc. Table 4.1.1 comprised of variables age of the respondents, number of children (both male & female) and the age of the last child of the respondents. Age means the total number of years, a person living after his birth. In this research, the age of the respondent has been calculated in the

completed years. Age is the most important indicator for the division of labour. All people have different working abilities according to the age and health. A person becomes rational as he grew. In this research, the age of the respondent has been calculated in the completed years.

Table 4.1.1 shows that only one and half percent (married) respondents belongs to the age up to 20 years, 58.8 percent were fall in the age category of 21–30 years. Further, 37.2 percent fall in the category of 31-40 years and 2.5 % fall in the age group of 41-50. Mean of the age was 29.8 years while S.D calculated 5.22. According to the result, 59 percent (married) respondents have the age up to 30 years which indicate that most people were young.

Table reveals the total children (both male and female) of the respondents. The date reveals that majority (66.2 percent) of the respondents having 1-2 male while 64.2 percent respondents have 1-2 female children. Only 14.3 percent respondents have male children and 12.1 percent respondents have the female children in the age group of 3-4 and above. 19.5 and 23.7 percent respondents have no male and female child respectively. Maximum number of male and female children is 5 and 6 respectively in a family.

At the end, table shows the result of respondent's education. According to the result 23.4 % were illiterate while 33% of the respondents have middle education. The 24% respondents have education up to the matric or above matric level. The low level of education effects the child immunization badly.

Table 4.1.2: Division of the respondents according to their family type, occupation and family occupation

Family types		Frequency	Percentage
i.	Nuclear	130	32.1
ii.	Joint	269	66.4
iii.	Extended	06	1.5
Total		405	100
Occupation of the respondents			
i.	Labour	86	21.2
ii.	Agriculture	155	38.3
iii.	Skilled Labour	45	11.1
iv.	Govt. Employee	55	13.6
v.	Private Employee	27	6.7
vi.	Business	37	9.1
Total		405	100
Respondent's family occupation			
i.	Labour	78	19.3
ii.	Agriculture	172	42.5
iii.	Skilled Labour	32	7.9
iv.	Govt. Employee	11	2.7
v.	Private Employee	8	2.0
vi.	Business	8	2.0
vii.	House Wife	96	23.6
Total		405	100

Family is a set of individuals, who are living collectively. Family lies in the shape of nuclear, joint and extended types. Table 4.1.2 depicts that 32.1 percent families of the respondents have nuclear family while 66.4 % belongs to joint family system. Majority rural families have joint family system to fulfil their needs with their limited resources and to support their parents and relatives. Only 1.5 percent respondent's families have extended type of family.

Table 4.1.2 also represents the occupation of the respondents and shows that 38.3 percent respondents have agriculture occupation. This category shows that agriculture was a major occupation in the rural communities. Further 13.6, 6.7, 9.1, 11.1 and 21.2 percent respondents were from Government jobs, private jobs, own business, skill laboured and

unskilled labour (Occupations) respectively. A greater portion (42.5 percent) people of the household of the respondents were associated with agricultural sector, 2.7 percent have government jobs while 2.0 percent person in the household of the respondents who have private job. Further 2.0 percent people have their own business. The 7.9 percent people were skilled labour. After the agriculture, unskilled labours were available in a large number. The 19.3 percent people have no skills and they were engaged in unskilled labour on daily wages. Further 23.6 percent members of the respondent's household were performing the duty of housewife. The table reveals that there was a greater portion of the respondents and also of the household members who have the oecupation of agriculture. So, agrieulturc and unskilled labour were the major occupations of the respondents and also of the household members of the respondents.

4.1.3: Division of the respondents according to monthly incomc and family expenditures

Monthly income (In Rs.)		**Frequency**	**Percentage**
i.	Up to 10,000	140	34.6
ii.	10,001- 20,000	210	51.8
iii.	20,001- 30,000	46	11.4
iv.	30,000+	09	2.2
Total		405	100
Mean Rs. 14719	**S.D Rs. 6455**	**Minimum Value Rs. 2000**	**Maximum Value Rs. 40,000**
Monthly income of the respondent's family			
i.	No income	98	24.2
ii.	Up to 10,000	110	27.2
iii.	10,001-20,000	137	33.8
iv.	20,001-30,000	34	8.4
v.	30,000+	26	6.4
Total		405	100
Mean Rs. 13127	**S.D Rs.15181**	**Maximum Value Rs. 1,20,000**	
Monthly expenditures of the respondents			
i.	Up to 10,000	155	38.3
ii.	10,001-20,000	211	52.1
iii.	20,001-30,000	25	6.2
iv.	30,000+	14	3.4
Total		405	100
Mean Rs.14391	**S.D Rs. 78534**	**Minimum Value Rs. 5000**	**Maximum Value Rs. 70,000**

Table 4.1.3 consists of the income of the respondents and their families' income. The table reveals that 34.6 % respondents have income up to Rs.10, 000. The very high percentage 51.8 percent people had in the income category of Rs. 10,001-20,000. In the category of Rs. 20,001-30,000, 11.4 percent were involved and only 2.2 percent respondents fall in the category of above Rs.30, 000 incomes from all sources. Mean of the respondent's income is calculated as 14719, standard deviation was 6455, minimum income is Rs.2000 and maximum income of the respondents was Rs.40, 000. In the household income, 27.2 percent people also have their income less than Rs.10, 000 and 33.8 percent people of the respondent's household fall in the (income category) of Rs.10, 001 to 20,000. The 8.4 percent people fall in the category of Rs.20, 001 to 30,000, and only 6.4 percent people earn more than Rs.30, 000 per month. The 24.2 percent of the household member (female) have no income because they perform the duty of housewife. The mean of the household income was 13,127, standard deviation 105181, minimum income was Rs. 2000 and maximum income was Rs. 1, 20,000. Expenditure means the amount which is spent by a person to fulfil his requirements and for his/her satisfaction. Table also shows that 38.3 percent people of the household of the respondents spent their income up to Rs.10, 000. Further 52.1 percent exist in the category of respondents expenses of Rs.10, 001 to 20,000. The 6.2 percent household fall in the expenditure group of respondents Rs.20, 001 to 30,000 and only 3.4 percent household spend their income above Rs.30, 000 to fulfil their needs. Majority 52.1 percent of the respondents and also his household had their monthly expenditure up to Rs.10, 001 to 20.000. Mean, standard deviation, minimum and maximum expenditure was also calculated. The mean of expenditure was 14,391, standard deviation 78,534, minimum value of expenditure was Rs. 5000 and maximum expenditure was Rs. 1, 20,000.

Table 4.1.4: Division of the respondents according to their child health status, first & last illness of child, child's birth place and vaccination card availability status

Current health status of the respondent's child	Frequency	Percentage
i. Healthy	313	77.3
ii. Sick	92	22.7
Total	405	100
First illness of child after birth (in months)		
i. Healthy	313	77.3
ii. Up to 5	65	16.0
iii. 6 to 10	17	4.2
iv. 11to 15	8	2.0
v. 15+	2	0.5
Total	405	100
Last illness of child after birth (in months)		
i. Healthy	313	77.3
ii. Up to 5	22	5.4
iii. 6 to 10	24	5.9
iv. 11 to 15	19	4.7
v. 15+	27	6.7
Total	405	100
Child birth place		
i. At Home	224	55.3
ii. Private Hospital	107	26.4
iii. Govt. Hospital	74	18.3
Total	405	100
Child's vaccination card availability		
i. Yes	266	65.7
ii. No	139	34.3
Total	405	100

Table 4.1.4 shows the currently health status of the respondent's child. According to the data, 77.3 percent of the respondent's children are healthy while 22.7 percent of the children are sick due to many reasons. The majority of the healthy child shows that children received proper health related care like vaccination facilities.

Table under discussion 4.1.4 reveals the number of first and last illness of the child in completed months. The data in above mentioned table unfolds that about 77.3 percent of the respondent's children have no health issue while 16 percent of the children were ill up to the age of 5 months, 4.2 percent were ill during the age of 6 to 10 months, 2 percent

were falls in the age category of 11 to 15 and remaining only 0.5 percent children were ill first time in their life after the age of 15 months.

Table 4.1.4 also depicts that the 5.4 percent children become ill (for the last time) up to the age of 5 months, 5.9 percent were ill during 6 to 10 months, 4.7 percent become ill in the age of 11 to 15 months. Further, the 6.7 percent children were ill after the age of 15 months at the last time of their illness.

In the table, the birth place of the last child of respondents shows that 55.3 percent mothers were give birth her last baby at home while 26.4 percent mother give birth her baby at private and only 18.3 percent at government hospitals. The low ratio of child's birth at government hospital shows that the people have less satisfied from government hospitals than the private due to non availability of hospital nearby or many other reasons.

The table's result also shows the child vaccination card availability status. The table depicts that 65.7 percent children have the vaccination cards while 34.5 percent have no their vaccination cards. This is the miserable condition of the health care centres and also vaccination teams.

Table 4.1.5: Distribution of the respondents by their child's current health status

Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
i. Child becomes sick without vaccination.	1.5 (6)	3.2 (13)	10.1 (41)	29.4 (119)	55.8 (226)	4.35	0.89
ii. Your child received proper vaccination.	0.7 (03)	7.7 (31)	13.1 (53)	26.7 (108)	51.9 (210)	4.21	0.99
iii. Self Medication is better than vaccination.	40.5 (164)	23.7 (96)	21.0 (85)	4.4 (18)	10.4 (42)	2.20	1.30
iv. People used substitution of vaccination.	14.3 (58)	14.8 (60)	17.3 (70)	30.6 (124)	23.0 (93)	3.33	1.36
v. Vaccinator gave polio to the child during illness.	8.6 (35)	15.6 (63)	7.7 (31)	24.9 (101)	43.2 (175)	3.79	1.37
vi. Polio/vaccination is fruitful for the child.	0.7 (03)	2.0 (8)	12.8 (52)	25.5 (103)	59.0 (239)	4.48	1.70
vii. Vaccinator use one syringes for many children.	45.2 (183)	26.7 (108)	15.3 (62)	4.0 (16)	8.9 (36)	2.05	1.25
viii. Pcople said to the vaccinator to use new syringe.	9.4 (38)	12.1 (49)	10.9 (44)	45.9 (186)	21.7 (88)	3.59	1.22
ix. Reuse of syringe creates complications for the child.	3.5 (14)	2.7 (11)	17.5 (71)	33.8 (137)	42.5 (172)	4.09	1.01
x. Vaccinator gave all vaccines that are necessary for the child.	3.5 (14)	0.2 (1)	13.8 (56)	29.6 (120)	52.8 (214)	4.28	0.95

This table is consisting on the current health status of the children. Majority (85.2%) respondents were either agree or strongly agree in response to opinion that child becomes sick without vaccination. Furthermore, 4.7% were either disagree or strongly disagrec with opinion 10.1 percent remain silent. Result depicts that high percentage (85.2%) respondents were agree or strongly agree with opinion about their child becomes sick without vaccination.

Table show results that their child received proper vaccination. Result depicts that 78.6% of the respondents were either agree and strongly agree with opinion about their child received proper vaccination. Moreover, the data explains that 8.4 percent respondents was disagreeing and strongly disagree about opinion while 13.7% give no answer.

Table reveals that self medication is better than the vaccination. The data in table reveals that only 14.8% were said, self medication is better than the vaccination. About 62.2% refuse to accept the statement and 21% remained silent. Result reveals opinion that people used substitution of vaccination for the better health of the child. It shows that about 53% said that it's right while 17.3% respondents had no answer. Result shows that 29.1 percent respondents refused to agree that people used substitution of vaccination for the better health of the child. The current table 4.1.5 indicates that respondent's opinion that vaccinator gave polio to the child during illness of the child. The table unfolds that majority (68.1%) was accept; while 24.2 percent reject opinion that vaccinator gave polio to the child during. Table also shows that polio/vaccination is fruitful for the health of child. In result, high majority (84.5%) has positive and about 2% have negative answer. The 12.8 percent respondents remain quiet.

The result also indicates the respondent's opinion that vaccinator used one syringe for many children. The table under discussion reveals that 12.9% respondents said that vaccinator used one syringe for many children but majority (71.9%) was against the opinion and 15.3 percent respondents gave no opinion that vaccinator used one syringe for many children. The result shows that one fifth respondents were strongly disagreed with opinion that the people said to the vaccinator to used new syringe for the every child during vaccination. Furthermore, the data unfolds that majority of the respondents (67.6 percent) were agree with opinion and 10 percent respondent remained silent. The result that reuse of syringes creates complication for the child's health. In reply, three fourth

(76.3%) of total accepted and 2.7 percent rejected the opinion. The 17.5% respondents said that they don't know about this statement. In addition, the result shows that a very high percentage (82.4 percent) of the (including 29.6 percent agreed, 52.8 percent strongly agreed) respondents were agreed and 3.7% were disagreed when they were asked that vaccinator gave all vaccine that are necessary for the health of child during his vaccination period. The 13.8 percent respondents give no answer.

Table 4.1.6: Division of the respondents according to their economic factors affecting child immunization

	Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
i.	Low income of parents is the major cause of incomplete immunization.	10.4 (42)	4.2 (17)	3.5 (14)	32.8 (133)	49.1 (199)	4.06	1.28
ii.	Family income affects the immunization.	9.6 (39)	4.0 (16)	4.4 (18)	33.8 (137)	48.1 (195)	4.07	1.24
iii.	Occupation affects the child immunization.	7.7 (31)	2.2 (9)	3.0 (12)	34.8 (141)	52.3 (212)	4.22	1.13
iv.	Education plays a vital role to complete child immunization.	0.2 (01)	1.7 (7)	2.5 (10)	35.4 (143)	60.2 (244)	4.58	0.57
v.	The children of high educated parents are more immunized than the low educated parents.	2.5 (10)	2.0 (8)	8.6 (35)	39.5 (160)	47.4 (192)	4.27	0.89
vi.	Spouse education also affects the child immunization.	7.9 (32)	7.7 (31)	8.4 (34)	38.3 (155)	37.8 (153)	3.90	1.21
vii.	Outdoor activities of parents are responsible for incomplete immunization.	4.4 (18)	7.4 (30)	4.7 (19)	44.9 (182)	38.5 (156)	4.06	1.06
viii.	Spouse outdoor activities are responsible for incomplete immunization.	4.2 (17)	8.1 (33)	7.7 (31)	35.1 (142)	44.9 (182)	4.08	1.10
ix.	Spent most of your time outside from house.	17.3 (70)	18.5 (75)	6.9 (28)	27.4 (111)	29.9 (121)	3.34	1.49
x.	The poor and rich children immunized equally.	21.5 (87)	9.5 (40)	25.4 (103)	20.7 (84)	22.5 (91)	3.13	1.43

Result depicts the economic factors affecting child immunization. The first statement in the table reveals that the low income of the parents is the major cause of incomplete immunization. It shows that about 81%, 4.2% respondents were respondents agree and disagree respectively. 3.5% were remained silent about the opinion that the low income of the parents is the major cause of incomplete immunization of their child and remaining included in disagree.

The result reveals that high majority (81.9%) of the respondents were strongly agree that the family income of the respondents affect child immunization while 4% were disagreed and 9.6% said they don't know about this question. The results unfold that the occupation of the respondents affects child immunization. It shows that 87.1% were agreeing or strongly agree about opinion and only 9.9% were disagree. Moreover, data shows that education plays a vital role to complete child immunization. Education has very strong influence on the personality of a person. It helps the individual to struggle for successful social/professional life. Education is the most important factor that helps to choose path in life. Education creates awareness to the people and asset in earning better livelihood for family and it own betterment. Result reveals that 35.4% were agreeing and 60.2% were strongly agreeing that education plays a vital role to complete child immunization.

Table shows also that the children of high educated parents are more immunized then the low educated parents. Result reveals that 86.9% were strongly agree that the children of high educated parents are more immunized then the low educated parents and other were against the majority. Additionally, two third majority of total said that spouse education affect the child immunization of their children while other remains disagree. The 83.4% and other were respectively agreeing and disagree that outdoor activities of the parents are responsible for incomplete immunization of the child. Another statement depicts that spouse outdoor activities of the respondents are responsible for incomplete immunization.

The data in the table reveals that fourth fifth majority (80%) of total were agree, 7.7%,12.3% had no answer and not agree respectively that spouse outdoor activities of the respondents are responsible for incomplete immunization of the child.

The results reveal that 57.3 percent respondents were spent most of their time outside from the house while 35.8% respondents refused and 6.9% respondents have no answer. Table also shows that 43.2%, 31% respondents were agreeing disagree respectively but other had no answer about statement.

Table 4.1.7.1: Division of the respondents according to their social factors affecting child immunization

Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
i. Vaccination preference given to the male child.	54.1 (219)	29.1 (118)	5.9 (24)	4.4 (18)	6.4 (26)	1.80	1.15
ii. People have trust on unknown vaccinators.	17.3 (70)	9.9 (40)	12.1 (49)	30.9 (125)	29.9 (121)	3.46	1.44
iii. The head of family is against the vaccination.	50.6 (205)	27.4 (111)	2.0 (8)	10.6 (43)	9.4 (38)	2.01	1.34
iv. Family members perform child vaccination duty in your absence.	11.6 (47)	10.1 (41)	3.0 (12)	31.9 (129)	43.5 (176)	3.85	1.38
v. Long waiting time for vaccinators affects immunization process.	15.6 (63)	5.9 (24)	2.2 (9)	44.7 (181)	31.6 (128)	3.71	1.38
vi. Social engagement responsible for incomplete immunization.	17.3 (70)	13.3 (54)	12.8 (52)	28.1 (114)	28.4 (115)	3.37	1.45
vii. Community has political pressure to stop vaccination.	52.3 (212)	27.4 (111)	4.7 (19)	10.1 (41)	5.4 (22)	1.89	1.21
viii. Unreliable services of vaccinators affect child immunization.	5.4 (22)	7.9 (32)	10.6 (43)	44.2 (179)	31.9 (129)	3.89	1.10

The results of current table reveal the respondent's opinion about the statement that people of the community gave preference to the male child. The results show that 10.8 percent respondents were agree or strongly agree with that people of the community gave preference to the male child while the high number of the respondents (83.2 percent) were not approve this opinion and other gave no opinion.

Results reveals that majority (60.8 percent) of the respondents said that people have trust on unknown vaccinator. But 27.2% denied accepting the opinion. According to the 47.4% respondents, the head of the family is against the vaccination. 50.6% denied and a fewer percentage has no answer.

Three fourth percentage of respondents said that family member perform child vaccination duty in their absence, 20.7% gave negative and remaining gave no response. A little more than three fourth (76.3%) percentage said that the long waiting time for vaccinator affect immunization process of the child but one fifth (21.5%) of total percentage reject the opinion and left fewer said sorry about answer.

More than fifty (56.5%) percentage, little less than one third (30.6%) and other (12.8%) were accept, reject and have no idea respectively about that social engagement is the responsible for incomplete immunization of the child.

The 15.5% have the political pressure, a major portion (79.7%) has no political pressure to stop vaccination of their children in the community and remaining told nothing. More than three fourth (76.1%) percentage said that the unreliable services of the vaccinators affects the child immunization process, 15.2% have disagreement, and 10.6% of population become neutral.

Table 4.1.7.2: Division of the respondents by their social factors affecting child immunization

Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
i. Media campaign regarding immunization creates awareness among parents.	16.8 (68)	8.4 (34)	4.7 (19)	36.5 (148)	33.6 (136)	3.75	1.03
ii. Limited time vaccinator visit is responsible for incomplete immunization.	9.4 (38)	6.9 (28)	3.0 (12)	49.4 (200)	31.4 (127)	2.21	1.04
iii. Lack of parent's motivation regarding vaccination affects immunization.	4.9 (20)	1.5 (6)	7.9 (32)	47.9 (194)	37.8 (153)	4.24	0.82
iv. Vaccinator gave vaccine to the child in your absence.	13.3 (54)	11.1 (45)	3.7 (15)	34.1 (138)	37.8 (153)	4.20	0.77
v. Vaccinator attitude affects vaccination.	4.4 (18)	2.5 (10)	3.7 (15)	47.9 (194)	41.5 (168)	3.30	1.18
vi. People cooperate with vaccinator to improve immunization process.	2.0 (8)	3.2 (13)	7.2 (29)	38.3 (155)	49.4 (200)	3.18	1.20
vii. Government give significant attention on child immunization in this area.	8.9 (36)	10.1 (41)	10.1 (41)	41.5 (168)	29.4 (119)	2.49	1.18
viii. Vaccination team visits properly in your area	4.4 (18)	13.1 (53)	6.2 (25)	33.3 (135)	43.0 (174)		

The results show majority (70.1%) percentage were agreeing but 25.2% not agreeing that the media campaign regarding immunization create awareness among parents.

Additionally, 80.8 percent agree with the opinion that limited time vaccinators visit is responsible for incomplete immunization. Only 3% have no answer while other have not justified with this. A major portion (85.7%) said that less parent's motivation regarding vaccination affects child immunization. 6.4% against the statement and 7.9% was silent.

The 71.9 % population was agreeing, 24.4 were disagreed and left percentage gave no answer that vaccinators gave vaccine to the child in their absence. 47.9% said that vaccinator's attitude affects the child immunization and 6.9% not said that vaccinator's attitude affect the child immunization.

A major portion (87.7%) from population said that people cooperate with vaccinator to improve child immunization process while 5.2% were disagreeing and 7.2% said sorry. More than seventy (70.9%) agree, one fifth percentage was against and 10% remains silent about statement that Govt. give significant attention on child immunization in their areas. The current portion of result reveals that three fourth (76.3%) percentage was agreeing and 17.5% were disagreeing that vaccination team visits properly in their area.

Table 4.1.8.1 Division of the respondents according to their cultural factors affecting child immunization

Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
i. Residential status affects the immunization process.	4.0 (16)	4.2 (17)	4.2 (17)	36.0 (146)	51.6 (209)	4.27	1.01
ii. Migration affects the child immunization.	3.0 (12)	9.4 (38)	2.5 (10)	32.1 (130)	53.1 (215)	4.23	1.07
iii. People have migration during child's vaccination period.	4.4 (18)	4.4 (18)	14.1 (57)	37.0 (150)	40.0 (162)	4.04	1.06
iv. Most people in our society do not respect to the vaccinator.	43.7 (177)	28.9 (117)	7.7 (31)	13.1 (53)	6.7 (27)	2.10	1.28
v. Vaccines are the best than self medication.	3.0 (12)	5.2 (21)	23.5 (95)	28.4 (115)	40 (162)	3.97	1.05
vi. Vaccination has its side effects.	17.8 (72)	29.9 (121)	26.4 (107)	13.6 (55)	12.3 (50)	2.73	1.25
vii. Self medication has its side effects.	2.0 (8)	8.6 (35)	25.4 (103)	33.3 (135)	30.6 (124)	3.82	1.03
viii. The trust of parents on vaccinators / polio team is increasing with passage of time.	1.0 (4)	2.7 (11)	15.8 (64)	41.7 (169)	38.8 (157)	4.15	0.85
ix. People satisfied with the vaccinator work.	8.6 (35)	13.8 (56)	20.0 (81)	29.6 (120)	27.9 (113)	3.54	1.27
x. Vaccinator security threats exist in your area.	61.2 (248)	31.6 (128)	3.5 (14)	2.7 (11)	1.0 (4)	1.51	0.78

It includes the cultural factors affecting child immunization. Majority of respondents (87.6%) were agree that residential status of the people affects the immunization process of their children. 8.2% population was disagree and other said that they didn't know.

Vary high percentage (85.2) argue that migration of the people affects the immunization process of their children. 12.4% gave negative argue and left percentage gave no argue.

Result reveals that three fourth percentages argue that people migrated during their children vaccination period. The 4.4% presented negative answer and 14.1% have no answer.

About 27.7% population presented that people of various communities may not give respect to the vaccinator but 72.6% presented that it's not true.

More than two third (68.4%) argue that vaccines are best than the self medication for the health of children while 8.2% presented that vaccines are not best and 23.5 % said they have no idea.

The next statement in the under discussion table shows that vaccination have its side effects. In result, 25.8 percent of the respondents were either strongly agreed or agreed while 47.7 percent were disagreed or strongly disagreed to the statement and 26.4 percent of the respondents gave answer as they had no opinion about the statement.

The two third (66.9%) of total percentage argue that self medication had its side effects, 8.8% said that it's not fact 25.4% said they don't know.

The fourth fifth (80.5%) percentage has negative argued that the trust of the parents on vaccinators/polio teams increasing with the passage of time and only 3.7% have positive argued while 15.8% have no argue.

More than fifty (57.5%) of the total percentage said that people satisfied with the work of vaccinators but 22.4 percent were not satisfied. The 20 percent respondents said that they don't know about this.

Result showed that about 3% population said that vaccinator security threats exist in their areas but the majority (92.8 percent) of the respondent's percent were said that vaccinator have no security threats exist in their areas.

Table 4.1.8.2 Division of the respondents according to their cultural factors affecting child immunization

Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
xi. Community support the vaccinators during vaccination/polio days.	2.5 (10)	4.9 (20)	7.7 (31)	50.4 (204)	34.6 (140)	4.1	1.0
xii. Community mobilization promotes child immunization.	16.5 (67)	6.4 (26)	12.6 (51)	46.7 (189)	17.8 (72)	3.4	1.3
xiii. Vaccinators visit door to door during polio/injection campaign.	11.4 (46)	9.6 (39)	0.7 (3)	35.8 (145)	42.5 (172)	3.9	1.3
xiv. Lack of information about day of immunization is obstacle of immunization	4.2 (17)	1.7 (7)	3.7 (15)	48.4 (196)	42.0 (170)	4.2	1.0
xv. Complications from previous injections stop immunization.	7.9 (32)	10.9 (44)	12.3 (50)	34.1 (138)	34.8 (141)	3.8	1.2
xvi. Distance to the health facility is the hurdle of incomplete vaccination.	1.7 (7)	5.7 (23)	2.5 (10)	21.1 (207)	39.0 (158)	4.3	2.7
xvii. Lack of vaccines is the obstacle of child immunization	2.7 (11)	2.2 (9)	5.9 (24)	52.8 (214)	36.3 (147)	4.2	0.8
xviii. Poor sanitation (unclean bag, vaccine and syringes) affects immunization	3.0 (12)	0.5 (2)	3.5 (14)	44.7 (181)	48.4 (196)	4.3	0.8
xix. Unawareness of parents from the importance of 2nd and 3rd dose of vaccine affect immunization	2.7 (11)	0.2 (1)	5.7 (23)	44.2 (179)	47.2 (191)	4.3	0.8

Very high percentage (85%) of total population said that community support the vaccinators during vaccination/polio days, 7.4 gave negative argues and left have no argued.

Result showed that 64.5 percent agreed and strongly agreed with the opinion that community mobilization promotes child immunization and 22.9% of the respondents were disagree or strongly disagree; the 12.6 percent respondents have no argue.

A majority (78.3%) of the population have opinion that vaccinators visit door to door during vaccination days and 21 percent respondents gave opposite argue while only 0.7 percent respondents don't know.

Very high portion (90.4%) of population presented that lack the information of immunization day is the major obstacle of child immunization but 5.9% said that it is not fact.

More than two third (68.9%) respondents asked that complication form the previous injection stop child immunization but 18.8% have their different view that it is not true while 12.3%. remain silent.

The three fifth (60.1%) of population asked that distance to the health facility from the respondents is hurdle in the way of child immunization while 7.4% were not agree. The remaining had no answer.

The 89.1% part if the population stated that lack of vaccines during vaccinator's tour is responsible to incomplete child immunization, 4.4% were against and left portion had no argue. Results unfold that almost all (93.1%) population presented that poor sanitation (unclean bag of vaccinators, vaccines and syringes) affect child immunization.

Major part (91.4%) of sample size have argued that lack of parental awareness from the importance of 2nd and 3rd doze of vaccine affects the ratio of child immunization, some of the ratio have negative or no argue.

Table 4.1.9: Division of the respondents according to their religious factors affecting child immunization

Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
i. The traditional community against the vaccination/polio.	51.9 (210)	26.9 (109)	9.1 (37)	7.2 (29)	4.9 (20)	1.9	1.1
ii. Religious leaders motivate the community about child immunization.	22.0 (89)	12.8 (52)	7.2 (29)	30.4 (123)	27.7 (112)	3.2	1.5
iii. Religion has a strong impact on the health related behaviour of community.	16.5 (67)	6.7 (27)	10.1 (41)	30.6 (124)	36.0 (146)	3.6	1.4
iv. Most religious leaders did not support the polio Program whole-heartedly.	33.3 (135)	22.0 (89)	10.9 (44)	20.5 (83)	13.3 (54)	2.6	1.4
v. Regular mosque announcement conducted by Imams during polio days.	22.7 (92)	19.3 (78)	4.4 (18)	25.2 (102)	28.4 (115)	3.1	1.5

Result reveals that religious factors affecting child immunization. This table also reveals that if the religious affect the child immunization or not. The first statement in the table reveals that the traditional communities are against the children vaccination/polio.

The data in table indicates that only 12.1 percent of the respondents were asked that the traditional communities are against the children vaccination/polio and high percentage negative status (disagrees and strongly disagree) about the statement (the traditional communities are against the children vaccination/polio) of respondents shows that traditional communities are not against the child immunization process.

The current table also shows the respondent's opinions that religious leader motivate the community about child immunization. The 14.4 percent were agreeing. The high number of (58.1 percent) was having negative answer.

Table depicts the religious impact on immunization that the religion has a strong impact on the health related behaviour of the community. The two third (66.6%) majority stated that religion has a strong impact on the health related behaviour of the community.

It shows that most of the religious leaders did not support the polio program with whole heartedly. One third (33.8%) considered that the religious leaders did not support the polio program with whole heartedly, 55.3% considered negatively. Only 10.9% have no reply.

Greater than the half (53.6%) of majority stated that regular mosque announcement conducted by the imams during polio days. Remaining percentage said there is no trend of announcement.

Table 4.1.10: Division of the respondents according to the role of health care centres in child health immunization

Statement	SDA 1	DA 2	NO 3	A 4	SA 5	Mean	S.D
i. Health care centres facilitate the community.	15.1 (61)	8.1 (33)	5.9 (24)	37.0 (150)	33.8 (137)	3.7	1.4
ii. Workshops/awareness campaigns about immunization held by Health care centres increased child immunization	18.8 (76)	15.6 (63)	15.1 (61)	31.4 (127)	19.3 (78)	3.2	1.4
iii. Vaccination team visit again in case the absence of child at home	15.6 (63)	18.3 (74)	11.4 (46)	27.9 (113)	26.9 (109)	3.3	1.4
iv. Govt. hospitals provide better facilities than the private hospitals	19.3 (78)	15.6 (63)	14.8 (60)	30.4 (123)	20.0 (81)	3.2	1.4
v. Health care centres conduct vaccinators trainings	27.9 (113)	17.8 (72)	19.8 (80)	23.2 (94)	11.4 (46)	2.7	1.4
vi. Health care centres play a vital role in reducing child mortality rate	15.1 (61)	12.6 (51)	15.1 (61)	33.3 (135)	24.0 (97)	3.4	1.4
vii. Health care centre celebrate Mother and Child Health week in your area	47.4 (192)	24.9 (101)	15.8 (64)	7.2 (29)	4.7 (19)	2.0	1.2
viii. Health care centre meet with the local politicians, religious and community leaders to improve immunization	53.3 (216)	25.2 (102)	12.6 (51)	7.4 (30)	1.5 (6)	1.8	1.0
ix. Health care centre hold events to promote immunization	56.0 (227)	21.5 (87)	11.9 (48)	8.6 (35)	2.0 (8)	1.8	1.1
x. The staff of Health care centre is cooperative with the people	37.5 (152)	13.1 (53)	8.4 (34)	24.2 (98)	16.8 (68)	2.7	1.6

It shows various statements regarding the role of health care centres in covering the child immunization. The health care centres play a vital role in the health status of communities that were living in the vicinity of that centres. The table under discussion reveals that high percentage (70.8 percent including 37 percent were agreed and 33.8 percent were strongly

agreed) that health care centres facilitate the communities and remained percentage have negative reply.

Fifty (50.7%) fifty of the total percentage presented that workshops/awareness campaigns about immunization held by health care centres, increased child immunization in the communities. Furthermore, the data unfolds that 34.4 percent were disagreed and strongly agreed with that said statement while 15.1 percent of the respondent were gave no answer.

The data in table reveals the respondent's opinion about that vaccination team's visit again in case the absence of child at home. The 33.9% stated that it is true and 57.8% stated not true. Remaining 11.4% don't stated any else.

The results depict that 50.4% were agree, while 34.9 percent (out of which15.6 disagreed and 19.3 strongly disagreed) of the respondents were disagreed when they were asked that Govt. hospital provides better facilities than the private hospitals. Remaining 14.8 percent respondents gave answer as no opinion.

Table under discussion also unfolds that respondent's opinion their nearest health care centres conducted vaccination trainings. The data in table reveals that 34.6% were agree that their nearest health care centres of conducted vaccination trainings. Moreover, the data explains that 45.7% were disagreeing and remaining was quiet.

The data in table reveals that about half (57%) of the total percentage presented that health care centres play a vital role in reducing child mortality rate. 27.7% have an opposite answer while 15.1% have no answer.

The 27.7% respondents presented that health care centre conducted Mother and Child health week in their areas for the better health of the child and mother also. only 11.9% were strongly agreed while 15.8 percent have no answer. The majority (72.3%) stated that

health care centres not celebrate Mother and Child health week in their areas for the better health of the child and mother also.

The current table indicates that respondent's opinion that health care centres meet with the local politicians, religious and community leaders to improve child immunization. The data in table shows that only 8.9% part of population presented that health care centres meet with the local politicians, religious and community leaders to improve child immunization while majority (78.5%) of population had negative response and 12.6% were give no response.

In result, 8.8% stated that health care centres hold events to promote child immunization in their areas but three fourth (77.5%) majority was stated that health care centres not hold events to promote child immunization in their areas. and 11.9% stated that they have no answer.

Result shows the respondent's opinion that the staffs of their nearest health care centres is cooperative with the people of the community. The table under discussion reveals that only 41 percent respondents presented that the staffs of their nearest health care centres are cooperative with the people of the community. The half of the (50.6%) population stated that the staffs of their nearest health care centres are not cooperative with the people of the community. about 8.4 percent respondents gave no opinion that if the staffs of their nearest health care centres is cooperative with the people of the community or not.

Table 4.1.11: Distribution of the respondents by the availability & type of health care centres, no. of workshops and campaign methods of health care centres

Is any health facility near to the respondents	Frequency	Percentage
i. Yes	269	66.2
ii. No	137	33.8
Total	405	100
Type of health facility near to the respondents		
i. No health facility	137	33.8
ii. Govt. Hospital	266	65.7
iii. Private Hospital	03	0.5
Total	405	100
No. of workshops held by health care centres		
i. 0	403	99.6
ii. 1-5	02	0.4
Total	405	100
No. of workshops attend by the respondents		
i. 0	403	99.6
ii. 1-5	01	0.2
iii. 6-10	01	0.2
Total	405	100
Campaign method of the health care centres		
i. No Method used	123	30.4
ii. TV Adds	45	11.1
iii. News Paper	0	0.0
iv. Speaker Announcement	155	38.3
v. All Methods	82	20.2
Total	405	100

Result shows the availability of health care centres in their areas, type of health facilities, no. of workshops conducted by the health care centres and campaign methods of health care centres. The above table's statistics reveals that majority (66.2 percent) of the respondents were asked that they have health facilities in their areas while 33.8 percent respondents asked that there is no health facility in the vicinity of their communities.

Table also reveals the respondent's opinion about the type of health facility; either they have a Govt. health facility or private. In reply, the majority (65.7 percent) of the respondent were asked that they have Govt. health facilities and only 0.5 percent

respondents have private health facilities while 33.8 percent respondents have not any health facilities in their areas.

Furthermore table under discussion depicts that all (99.6 percent) of the respondents were gave their opinion that there were no workshops conducted by their nearest health care centres in their areas while only 0.4 percent of the respondents said that 1-5 workshops were conducted by the health care centres in last one year in their areas.

The result depicts either the respondent's opinion about the workshops that if they were attend any workshop or not in last one year. The only 0.4 percent respondents said that they attended 1-10 workshops in the last year while about all (99.6 percent) of the respondents were gave their opinion that there were no workshops conducted by their nearest health care centres in their areas.

The table also reveals the campaign methods, used by the health care centres to increase the rate of child immunization. The table's statistics shows that 11.1 percent respondent said that health care centres used TV, 38.3 percent said that speakers announcement and 20.2 percent said that health care centres used both (TV & speaker announcement) to increase the rate of child immunization. The 30.4 percent respondents gave their opinion that no method has been used by the health care centres.

4.2. Bivariate Analysis

In the second method of analysis, two variables are used to investigate the results of the study. In this, the one variable is depending upon the other, called dependent and other is called independent variable. This chapter consists of six bivariate tables which are as under:

Table 4.2.1: Correlation (r) between education of mothers and better child immunization

Higher the level of education of mothers, more will be the chances for better child immunization process.

Null hypothesis: There is no significant positive correlation between education of mothers and child immunization.

Alternative hypothesis: There is significant positive correlation between education of mothers and child immunization.

Independent Variables	**Dependent Variable (Child immunization)**
Education of mothers	0.094**

**. Correlation is significant at the 0.01 level (2-tailed).

P-Value 0.000

The result depicts the association among education of mothers & child immunization. The Correlation analysis shows a high positive relationship/correlation ($r = 0.094$, $p < 0.01$) between education of mothers and child immunization. The result reject null hypothesis and accepted that there is a positive correlation exist among education of mothers & child immunization. This result examines that educations of mothers has strong relationship with child immunization.

Table 4.2.2: Correlation (r) between son preferences and child immunization

Higher the son preferences of the parents, more will be the chances of better child immunization.

Null hypotbesis: There is no positive association among son preference & better child immunization.

Alternative hypotbesis: There is positive association among son preference & better child immunization.

Independent Variables	**Dependent Variable (Child immunization)**
Son preferences	0.016**

**. Correlation is significant at the 0.01 level (2-tailed).

P-Value 0.000

Result reveals positive but weak association (r = 0.016, p <0.01) among the son preferences of the parents and their child immunization. Hence, the null was rejected and opposite hypothesis accepted.

Table 4.2.3: Correlation (r) among social factors and child immunization

Higher the influence of social factors, lower will be the chances of child immunization.

Null hypothesis: There is no opposite relationship among social factors & child immunization.

Alternative hypothesis: There is opposite relationship among social factors & child immunization.

Independent Variables	**Dependent Variable (Child Immunization)**
Social Factors	-0.199**

**. Correlation is significant at the 0.01 level (2-tailed).

Table depicts a negative weak relationship among social factors and child immunization (r = -0.199, p <0.01). So, the null hypothesis that there is no opposite association among social factors and child immunization was rejected and proves that there is an opposite relation among social factors and child immunization exists.

Table 4.2.4: Correlation (r) among economic factors and child immunization

Higher the influence of economic factors, lower will be the chances of child immunization.

Null hypothesis: There is no considerable negative correlation among economic factors & child immunization.

Alternative hypothesis: There is considerable negative correlation among economic factors & child immunization.

Independent Variables	**Dependent Variable (Child Immunization)**
Economic Factors	-0.247**

**. Correlation is significant at the 0.01 level (2-tailed).
P-Value 0.000

Table results explore the negative weak association among economic factors and child immunization with a level of -0.247. The results rejected the null hypothesis. The study examines that the immunization become low when raise the influence of economic factors on the people.

Table 4.2.5: Correlation (r) among cultural factors and child immunization

Higher the influence of cultural factors, lower will be the chances of child immunization.
Null hypotbesis: There is no considerable negative association among cultural factors & child immunization.
Alternative hypothesis: There is considerable negative association among cultural factors & child immunization.

Independent Variables	**Dependent Variable (Child Immunization)**
Cultural Factors	-0.137**

**. Correlation is significant at the 0.01 level (2-tailed)
P-Value 0.000

The above table depicts the association among cultural factors & child immunization. The Correlation shows a significant negative weak association between cultural factors & child immunization. The results accepted alternative hypothesis and explore that the negative weak correlation among cultural factors & child immunization ($r = -0.137$, $p < 0.01$).

Table 4.2.6: Correlation (r) among religion misperception and child immunization

Higher the misperception regarding religion, lower will be the chances of better child immunization.

Null hypothesis: There is no considerable negative association among religion misperception & child immunization..

Alternative hypotbesis: There is considerable negative association among religion misperception & child immunization.

Independent Variable	**Dependent Variable (Child Immunization)**
Religion Misperception	-0.125**

**. Correlation is significant at the 0.05 level (2-tailed).

The current table explores the affiliation among religion misperception and child immunization between the people of local communities. The results accepted alternative hypothesis and explore a considerable weak negative association among religion misperception & child immunization ($r = -0.125$, $p < 0.05$). This result reveals that religion misperception and child immunization has an important relationship.

CHAPTER FIVE

SUMMARY, MAJOR FINDINGS, CONCLUSION AND SUGGESTIONS

5.1. Summary

Immunization plays a significant role in the child's health status of any community, country or throughout the world. Vaccination is efficient and harmless way to avert transmittable diseases and its interrelated deaths in the world. Although the many health reimbursement, vaccination occur the complication. The objective of the research was to recognize the public awareness concerning vaccination and to explore the socio-economic and cultural factors affecting child immunization. The research also has the objective to depict the role of health care centres in promoting child immunization.

Immunization plays a key role to accomplish the child's basic health requests. To examine the socio-economic and cultural factors affecting child immunization in District Bhakkar, There were 10 villages (from 5 UC's) randomly selected in current study to explore various factors. The data was collected from 4 villages of Tehsil Mankera and 6 villages of Tehsil Bhakkar. There were 405 households selected through proportionate simple random sampling and further selection of households was conducted with the help of voter lists. The data was analyzed through statistical package for social sciences (SPSS) and other statistical techniques (mean, standard deviation, minimum and maximum values) were used to illustrate conclusion. The major findings of the study are as follows:

5.2. Major Findings

5.2.1. Socio-Economic Characteristics of the Respondents

- Majority of the (58.8 percent) of respondents were young and belongs to working age group.
- Two third (66.2 percent) respondents had (1-2) male children and a little less than two third (64.2 percents) had (1-2) female children.
- A little more than half (55.3 percent) of the respondent's last children belongs to the age of 11-30 months.
- A little more than two third (66.4 percent) of the respondents were from joint family type and a little less than one third (32.1 percent) respondents were from nuclear family system.
- More than one third respondent and 42.5 percent household were engaged with agricultural sector. Further less than one fifth (19.3 percent) respondents were unskilled labourer and a little less than one third (23.6 percents) household (wives) were performed the duty of house wife.
- Over whelming majority (86.4%) of respondents and 61 percent household had monthly income up to Rs, 20,000 while majority (60.4 percent) household had monthly expenditure up to Rs. 20,000.
- A little less than one fourth (23.4 percent) of the respondents were illiterate, two fifth (42.6 percent) have qualification up to the middle and one fourth (24 percent) have the qualification of matric and above the matric level.
- Over whelming majority (81.9 percent) presented that low income of parents is the major cause of incomplete immunization and little less than three fourth of the respondent (74.9 percent) were agreed with that family income affects the immunization.

- Over whelming majority of the respondents (87.1 percent) revealed that occupation affects the child immunization and almost all of the respondents (95.6 percent) were agreed that education plays a vital role to complete child immunization.
- Over whelming majority of the respondents (86.9 percent) stated that the children of high educated parents are more immunized than the low educated parents and three fourth of the respondents (76.1 percent) stated that spouse education also affects the child immunization. Further, 38.4 percent stated that outdoor activities of parents are responsible for incomplete immunization.
- A little than two third (57.3 percent) of the respondents revealed that they spent most of their time outside from house and more than two fifth (43.2 percent) respondents stated that the poor and rich children immunized equally.

5.2.2. Present Health Status of the Child

- A little more than three fourth (77.3 percent) of the respondent's child were currently healthy.
- Only one fifth (20.4 percent) children were become ill for the first time after their birth up to the age of 10 months.
- More than half (55.3 percent) mothers gave birth to their children at home, little more than one fourth (26.4 percent) at private hospital and only less than one fifth (18.3 percent) mothers gave birth to their children at Govt. Hospitals.
- Two third (65.7 percent) of the respondent's children have their vaccination cards.
- The 85.2% were agreed when they were asked that child becomes sick without vaccination and a little more than three fourth of the respondents (78.6 percent) were either agreed or strongly agreed with that their child received proper vaccination.
- A little less than two third of the respondents (64.2 percent) were disagreed with that self medication is better than vaccination

- The 68.1 percent stated that vaccinator gave polio to the child during illness over whelming majority (84.5 percent) of the respondents were agree that polio/vaccination is fruitful for the child.
- Less than three fourth of the respondents (71.9 percent) were strongly disagree with the opinion that vaccinator use one syringes for many children while a little more than two third (67.6 percent) were agree that people said to the vaccinator to use new syringe.
- Three fourth of the respondents (76.3 percent) revealed that reuse of syringe creates complications for the child and over whelming percentage of the respondents (82.4 percent) explained that vaccinator gave all vaccines that are necessary for the child.

5.2.3. Social Factors

- The majority of the respondents (60.8) percent respondents were strongly agreed that people have trust on unknown vaccinators.
- A little than forth fifth (78 percent) respondents were strongly disagreed that the head of family is against the immunization and three forth (75.4 percent) respondents were strongly agreed that family members perform child vaccination duty in your absence.
- More than three fifth (76.1 percent) of the respondents were agreed that unreliable services of vaccinators affect child immunization.
- Less than three fourth of the respondents (70.1 percent) were agreed that media campaign regarding immunization creates awareness among parents and about more than fourth fifth (80.8 percent) of the respondents revealed that limited time vaccinator visit is responsible for incomplete immunization.

- Less than three fourth of the respondents (71.9 percent) stated that vaccinator gave vaccine to the child in your absence.
- The over whelming majority (89.4 percent) of the respondents stated that vaccinator attitude affects vaccination and also an over whelming majority of the respondents (87.7 percent) said that people cooperate with vaccinator to improve immunization process.
- A little less than three fourth (70.9 percent) of the respondents stated that people cooperate with vaccinator to improve immunization process and Government give significant attention on child immunization in this area. Furthermore, little more than two third (76.3 percent) respondent gave their positive opinion that vaccination team visits properly in your area.

5.2.4. Cultural Factors

- Over whelming percentage (87%) were agreed that residential status affects the immunization process and also over whelming majority (85 percent) of the respondents revealed that migration affects the child immunization.
- A little more than three fourth (77 percent) respondents were agreed with that people have migration during child's vaccination period and a little less than three fourth (72.6 percent) of the respondents were strongly disagreed that most people in our society do not respect to the vaccinator.
- A little more than two third (68.4 percent) agreed with that vaccines are the best than self medication and about little less than half (47.7 percent) of the respondents said that vaccination has not its side effects while two third (66.9 percent) respondents said that self medication has its side effects.

- Four fifth (80%) stated that the trust of parents on vaccinators / polio team is increasing with passage of time and more than half of the respondents (57.5 percent) were agreed that people satisfied with the vaccinator work while over whelming majority (92.8 percent) of the respondents were said that there are no vaccinator security threats exist in their area.
- A over whelming majority (85 percent) of the respondents were agreed that community support the vaccinators during vaccination/polio days.
- 78.3 percent stated that vaccinator's visit door to door during polio/injection campaign.
- A little more than two third (68.9 percent) of the respondents were agreed with complications from previous injections stop immunization and three fifth (60.1%) stated that distance to the health facility is the hurdle of vaccination.
- The over whelming majority (89.1%) stated that lack of vaccines is major obstacle of child immunization while almost all (93.1 percent) of the respondents were said that poor sanitation (unclean bag, vaccine and syringes) affects immunization. Furthermore, over whelming majority (91.4 percent) of the respondents stated that unawareness of parents from the importance of 2^{nd} and 3^{rd} dose of vaccine affect immunization.

5.2.5. Religious Factors

- The 78% respondents presented that the traditional community against the vaccination/polio while little less than three fifth (58.1 percent) were stated that religious leaders motivate the community about child immunization.

- Two third (66.6 percent) majority were agreed that religion has a effect on the health related behaviour of community 55.3% were stated that most religious leaders support the polio Program whole-heartedly.
- Almost fifty percent were stated that regular mosque announcement conducted by Imams during polio days in their areas.

5.2.6. Role of Health Care Centres

- Less than three fourth (70.8 percent) of the respondents were gave their opinion that health care centres facilitate the community and about half of the respondents (50.7 percent) were agreed that workshops/awareness campaigns about immunization held by Health care centres increased child immunization.
- 54.8 percent portion were presented that vaccination team visit again in case the absence of child at home and half (50.4 percent) of the respondents were stated that Govt. hospitals provide better facilities than the private hospitals.
- Slightly more than half (57.3 percent) of the respondents were stated that health care centres play a vital role in reducing child mortality rate.
- Less than three fourth (72.3%) were stated that health care centre didn't celebrate mother and child health week in their areas while more than three fourth (78.5 percent) of the respondents were disagree with that health care centre meet with the local politicians, religious and community leaders to improve immunization.
- A little more than three fourth (77.5 %) were disagree that health care centre hold events to promote immunization.
- About two third (66.2 percent) of the respondents revealed that they have a health facility near their houses and a little less than two third (65.7 percent) of the respondents explained that they have Govt health facilities near by their houses.

- The statistical data revealed that almost all of the respondents (99.6 percent) stated that there was no workshop conducted by the health care centres to promote child immunization in their areas and a little less than two fifth (38.3 percent) of the respondents were said that speaker announcement is the major source of campaign method of health care centres in their areas.

5.3. Conclusion

The present research has been conducted to examine the socio-economic and cultural factors affecting child immunization in District Bhakkar. It was conducted to explore a variety of reasons that affect the immunization process of the children less than the 60 months of age group. Usually, it looks that why the children of the local communities could not received polio and necessary vaccines properly?

Local communities of Tehsil Mankera (of district Bhakkar) are entirely desert and highly dependent on agricultural locale. In these circumstances, the poor local communities are hardly accomplish their fundamental wants with their limited resources. Due to their limited resources and poverty, it is very difficult for the people to complete their child's immunization.

In some local communities of this area, females participate in the agricultural work to minimize agricultural expenditures which is the foremost reason of incomplete immunization of their children because the mother's absence from home is the responsible to remain children from polio/vaccination. Some people migrate from one area to the other areas due to many reasons like crops cutting season. Due to migration, their children are missed the dozens of polio or vaccines. The people of less developed areas have miserable health conditions. In some areas, there are no any health facilities like Govt. or private hospital or clinic and other health facilities like specialist doctors,

medicines and gynecologists etc. The people have gone to many kilo meters for their checkups due to absence of health facility or unavailability of doctors and medicines. The children's polio and vaccination situation is also horrible in some areas, especially in tehsil mankera. Some children have not their vaccination cards. Due to low education, outdoor activities, low income, political pressure, social engagement, lack of motivation regarding immunization, limited time vaccinator's visit, high religious values, lack of information about immunization and residential status are the major causes that affect the child immunization in local areas of District Bhakkar.

The role of health care centers regarding child immunization is also unsatisfied. The health care centers are not conducted any workshop and awareness campaigns about child immunization. The uneducated people have no awareness about the polio and vaccination. The health care centers are also not conducted vaccinator training which creates complication for the children after the time of vaccination. People have to gone many kilo meters to the city hospital due to the deficiencies improper functioning of BHU's.

Immunization plays a vital role in the health status of the children. The current immunization status of children is miserable in local communities but now this situation is improving in these areas due to medical advancement and new health technologies.

5.4. Suggestions

- The awareness program is needed to be launched to create better awareness about the importance of immunization. The local (politician & religious) leaders should take some steps to improve the current situation of immunization especially in local areas.
- Local communities and politicians should cooperate with the local health care centres and also with the government to improve child immunization.
- The religious leaders should motivate the local communities about immunization.
- The local administration should develop the monitoring and evaluation system of vaccinators & polio teams and built new health care centres in the rural areas.

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APPENDIX

INTERVIEW SCHEDULE

SOCIO-ECONOMIC AND CULTURAL FACTORS AFFECTING CHILD IMMUNIZATION IN DISTRICT BHAKKAR

Union Council: _____ Village: _____

SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENTS

1. Age (In completed years)				
2. Number of Children	Male		Female	
3. Age of your last child (In months)				
4. Type of family	Nuclear	Joint	Extended	

5. Education of the respondent

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	16+

6. Your occupation	
7. Family occupation	
8. Your income	**(Rs.)**
9. Family income	**(Rs.)**
10. Expenditures of family	**(Rs.)**

PRESENT HEALTH STATUS OF THE CHILD

11. Current status of child's health (If Healthy, go to# 14)	Healthy	Sick
12. First illness of tbe child after birth (in months)		
13. Last illness of the child after birth (in months)		

14. Child birth place	At home	At private hospital	At Govt. Hospital	At Dai Home

15. Do you have a card where vaccinations are written down?(If No, go to # 18)	Yes	No

16. Copy thc immunization data from the card.

Vaccine taken	Day	Month	Year
BCG			
OPV0			
OPV1			
OPV2			
OPV3			

Pentavalent1				
Pentavalent2				
Pentavalent3				
Measles				

17. Write the name of vaccine that received by the child but not recorded on card	

18. Total number of vaccines received by the child	

19.Variable	**Strongly Disagree**	**Disagree**	**No Opinion**	**Agree**	**Strongly Agree**
Child becomes sick without vaccination	1	2	3	4	5
Your child received proper vaccination	1	2	3	4	5
Self Medication is better than vaccination	1	2	3	4	5
People used substitution of vaccination	1	2	3	4	5
Vaccinator gave polio to the child during illness	1	2	3	4	5
Polio/vaccination is fruitful for the child	1	2	3	4	5
Vaccinator use one syringes for many children	1	2	3	4	5
People said to the vaccinator to use new syringe	1	2	3	4	5
Reuse of syringe creates complications for the child	1	2	3	4	5
Vaccinator gave all vaccines that are necessary for the child	1	2	3	4	5

ECONOMIC FACTORS AFFECTING CHILD IMMUNIZATION

20.Variable	**Strongly Disagree**	**Disagree**	**No Opinion**	**Agree**	**Strongly Agree**
Low income of parents is the major cause of incomplete immunization	1	2	3	4	5
Family income affect the immunization	1	2	3	4	5
Occupation affects the child immunization	1	2	3	4	5
Education play a vital role to complete child immunization	1	2	3	4	5
The children of high educated					

parents are more immunized than the low educated parents	1	2	3	4	5
Spouse education also affects the child immunization	1	2	3	4	5
Outdoor activities of parents are responsible for incomplete immunization	1	2	3	4	5
Spouse outdoor activities are responsible for incomplete immunization	1	2	3	4	5
Spent most of your time outside from house	1	2	3	4	5
The poor and rich children immunized equally	1	2	3	4	5

SOCIAL FACTORS AFFECTING CHILD IMMUNIZATION

21.Variable	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
Vaccination preference given to the male child	1	2	3	4	5
People have trust on unknown vaccinators	1	2	3	4	5
The head of family is against the vaccination	1	2	3	4	5
Family members perform child vaccination duty in your absence	1	2	3	4	5
Long waiting time for vaccinators affect immunization process	1	2	3	4	5
Social engagement responsible for incomplete immunization	1	2	3	4	5
Community has political pressure to stop vaccination	1	2	3	4	5
Unreliable services of vaccinators affects child immunization	1	2	3	4	5
Media campaign regarding immunization create awareness among parents	1	2	3	4	5
Limited time vaccinator visit is responsible for incomplete immunization	1	2	3	4	5
Lack of parents motivation regarding vaccination affects immunization	1	2	3	4	5
Vaccinator gave vaccine to the child in your absence	1	2	3	4	5
Vaccinator attitude affects vaccination	1	2	3	4	5
People cooperate with vaccinator					

to improve immunization process	1	2	3	4	5
Government give significant attention on child immunization in this area	1	2	3	4	5
Vaccination team visits properly in your area	1	2	3	4	5

CULTURAL FACTORS AFFECTING CHILD IMMUNIZATION

22.Variable	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
Residential status affects the immunization process	1	2	3	4	5
Migration affects the child immunization	1	2	3	4	5
People have migration during child's vaccination period	1	2	3	4	5
Most people in our society do not respect to the vaccinator.	1	2	3	4	5
Vaccines are the best than self medication	1	2	3	4	5
vaccination have its side effects	1	2	3	4	5
Self medication have its side effects	1	2	3	4	5
The trust of parents on vaccinators / polio team is increasing with passage of time.	1	2	3	4	5
People satisfied with the vaccinator work	1	2	3	4	5
Vaccinator security threats exist in your area	1	2	3	4	5
Community support the vaccinators during vaccination/polio days	1	2	3	4	5
Community has political pressure to stop vaccination	1	2	3	4	5
Community mobilization promotes child immunization	1	2	3	4	5
Vaccinators visit door to door during polio/injection campaign	1	2	3	4	5
Lack of information about day of immunization is obstacle of immunization	1	2	3	4	5
Complications from previous injections stop immunization	1	2	3	4	5
Distance to the health facility is the hurdle of incomplete vaccination	1	2	3	4	5
Lack of vaccines is the obstacle of child immunization	1	2	3	4	5

Poor sanitation (unclean bag, vaccine and syringes) affects immunization	1	2	3	4	5
Unawareness of parents from the importance of 2nd and 3rd dose of vaccine affect immunization	1	2	3	4	5

RELIGIOUS FACTORS AFFECTING CHILD IMMUNIZATION

23.Variable	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
The traditional community against the vaccination/polio	1	2	3	4	5
Religious leaders motivate the community about child immunization	1	2	3	4	5
Religion has a strong impact on the health related behaviour of community	1	2	3	4	5
Most religious leaders did not support the polio Program whole-heartedly	1	2	3	4	5
Regular mosque announcement conducted by Imams during polio days	1	2	3	4	5

ROLE OF HEALTH CARE CENTRES IN CHILD IMMUNIZATION

24.Variable	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
Health care centres facilitate the community	1	2	3	4	5
Workshops/awareness campaigns about immunization held by Health care centres increased child immunization	1	2	3	4	5
Vaccination team visit again in case the absence of child at home	1	2	3	4	5
Govt. hospitals provide better facilities than the private hospitals	1	2	3	4	5
Health care centres conduct vaccinators trainings	1	2	3	4	5
Health care centres play a vital role in reducing child mortality rate	1	2	3	4	5
Health care centre celebrate Mother and Child Health week in your area	1	2	3	4	5
Health care centre meet with the local politicians, religious and	1	2	3	4	5

community leaders to improve immunization					
Health care centre hold events to promote immunization	1	2	3	4	5
The staff of Health care centre is cooperative with the people	1	2	3	4	5

25. Is there any health facility which provides vaccination service, near to you? (If No, go to # 27)	Yes	No

26. Which type of health facility exists near to you?	Govt. Hospital	Private

27. No. of workshops in last one year	0	1-5	6-10	11-15	15+

28. No. of workshops attend by you or spouse	0	1-5	6-10	11-15	15+

29. Campaign methods of Health care canters	Tv Adds	News paper	Speaker announcement	All methods

30. Please give some suggestions to improve the process of child immunization

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