

Effect of Family Structure on Child Immunization in the Rural Area

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Abstract: Negligence towards immunization may result in serious health risks not only for the deprived child but for the society too as diseases meant to be controlled by vaccination are infectious. Apart from technical loopholes, there are many factors embedded in social and cultural set up of the people which act as obstacle for success of such programs aimed at improving public health. In rural society the type of family, in which child is reared, is also significant importance in this regard. This paper aims to explore how a particular family type, nuclear or joint, affects the immunization status of children.

Introduction

From the time immemorial man has been interested in trying to control disease. The medicine man, the priest, the herbalist and the magician, all undertook in various ways to cure man's disease. The explosion of knowledge during the twentieth century has made medicine and treatment more complex. The goal of modern medicine is no longer merely treatment of sickness. The other and more important goals which have emerged are prevention of disease, promotion of health and improvement of health of individuals and groups or communities (Park 2009, 1)

Immunization is one of the major public health interventions to prevent childhood morbidity and death. The Expanded Program on Immunization was launched in India in 1978 which was later upgraded as Universal Immunization Program (UIP) in 1985. Since then much efforts and funds have been invested into this but the country is still far away from achieving the target of UIP. In India, rural areas have consistently reported lower immunization coverage as compared to the urban areas. Uttar Pradesh (UP) is far behind achieving target of Universal Immunization Program with only 22.9 per cent fully immunized children according to National Family Health Survey (NFHS) -3 report. District Level Household Survey (DLHS) -3 also reports only 30.3 per cent full immunizations for UP. It is only 29.4 per cent for rural UP.

It has been very well realized today that there are many factors lying in social and cultural milieu of the target people which act as obstacles in success of such programmes. This paper focuses on understanding as to how a particular family type, nuclear or joint, affects the uptake of child immunization services in rural areas. The paper is based on a study conducted in villages of a north Indian district, Lucknow. In the study, among many other social and cultural factors, the type of family in which the child lives has also been found to affect child immunization.

Family as a social unit

Family is a basic unit of economic cooperation and stability that generally includes at least one parent or parent substitute and children. Families provide both economic and social support for its members. It is the primary group responsible for rearing children (Bonvillain 2010, 211). In anth-

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ropological writings, different congregations of kin and affines have been labelled as types of family. The conjugal family (nuclear family) refers to a heterosexual pair and their offspring, while the extended family refers to at least two related conjugal families (Pine 2009, 223). Family is an important institution of the rural society, joint family being the ideal of agricultural economy of the rural area. Extended family takes a slightly different form of joint family when it is subjected to certain cultural norms. It has both vertical and horizontal extensions. It is productive and consumptive unit. It rests on authoritarian framework of relative power and authority. It depends on the ideal of collective responsibility and obligation.

Family as a Determinant of Individual's Behaviour

Family is the primary social unit which affects individual's life. A person's behaviour, personality and decisions are very much shaped by the type of family in which he lives. This factor is of great concern in utilization of health services including immunization. The two types of families, nuclear and extended have their own unique features which in turn have their own pros and cons in relation to this. Nuclear family gives an individual the freedom to decide his way of life. While cooperation provided by extended family allows one to live somewhat freely as responsibilities are shared. These factors are of great significance in utilization of health services. This includes both medication and prevention. Both nuclear and joint families have facilitating and impeding factors, for immunization program, lying in their set up. This paper tries to discuss the same.

Materials and Method

This paper is based on findings of a detailed study on social cultural barriers to immunization. It is carried out in the rural area of Lucknow district, Uttar Pradesh. Rural area of Lucknow district is wide spread around the Lucknow city, the capital of Uttar Pradesh, a northern state in India. The eight development blocks of Lucknow together have 822 villages (at the time of study) out of which 30 have been included in the sample. Religion wise majority population is Hindu. Scheduled tribes are negligible in number (as per census 2001). The study is based on fieldwork method and data was collected primarily through interview and observation. A sample of 210 children in the age group of 12-23 months has been selected from 30 villages of rural Lucknow with the help of 30 cluster sampling technique. While the children formed the sample for assessing immunization status in the area, their parents, family members and service providers has been interviewed and observed for their behaviour towards immunization.

In the study, according to the guidelines developed by WHO, children are considered "Fully Immunized" (FI) when they have received one dose each of BCG and Measles and 3 doses each of DPT and OPV by the age of 12 months. Those children who have missed any of the doses have been considered as "Partially Immunized" (PI). Those children, who had not received any of the above vaccine, have been considered "Non-Immunized" (NI). Immunization coverage rates for the present study are given in table no. 1.

Lower Rate of Immunization in Nuclear Family

In India joint families have been common in the traditional rural societies but the lower caste families with agricultural labour as the chief occupation were mostly nuclear. Joint family in rural area also has undergone changes under the impact of urbanisation and industrialisation. This gave way to nuclear families which therefore increased in number in rural society. Lack of sufficient and stable means of livelihood and shifting mode of occupation were causes for establishment of such individual families.

Specific features of nuclear family and their role in governing individual's health behaviour are very important in uptake of health services. In rural areas of Lucknow district, such families usually have small or no land holding which can give assured income. Therefore the father is over occupied with earning livelihood. Here women become solely responsible for taking care of children and domestic chores. The agricultural society gives some additional burden to its women folk. It necessitates her involvement in seasonal activities related to agriculture like working in the field in harvesting season. In nuclear families with small children there is nobody to support mother in household activities. Therefore for rural women, who do not take vaccination of child as an unavoidable health need, it is unnecessary for them to make an extra effort to take out time for it.

Women in nuclear family find it undesirable to leave house and other children unattended. This becomes impossible for them when houses are situated in isolated section of village. They cannot neglect older children coming back from school requiring food and attention of the mother. Further it is a problem for women of nuclear families to go out unaccompanied. Accredited Social Health Activist (ASHA) of the village faces problem of communication. Sometimes when she visits the family to inform them about the time of immunization, the mothers concerned are absent from the scene. The mothers on the other hand complained that ASHA do not come to inform. This indicates lack of understanding between the two sides.

There is problem with post vaccination care of children. Some side effects of vaccines though mild but inevitable like fever and excessive crying require some additional care of child from the parents. Some parents have seen to withdrawn vaccination due to this only. Such behaviour is more pronouncedly observed in cases where parents remained disturbed and irritated with extraneous problems. Such problems may be of meeting expenses and repayment of debt in the lack of sufficient economic means. These may also be of domestic bickering arising from drinking and abusive nature of husband or incompatibility of temperaments. Some women reported that they were unable to focus on anything including needs of children when there is one or the other cause for the mental tension in the family.

In nuclear families husband and wife are only responsible adults. They are supposed to look after all kinds of family affairs. Economic, emotional and other kind of support, even from close relatives is usually little and occasional. Such things considerably affect vaccination of their child. Here cooperation from neighbours and/or some elderly relative living nearby can be of help.

Better Coverage among Children of Joint Family

Problems in regard to immunization in extended family lie mainly in conservatism, indigenous beliefs and authority of the elder members other than the parents. Rural people, especially the older, still consider conventional health practices as good enough and resort to modern medicine only for serious illness. Vaccination does not appeal them as something compulsory for child's health. Due to these mothers have to face objection from the elders who are not convinced of the need of vaccination. In extended families younger ones, particularly daughters-in-law, are not supposed to speak back or argue. Therefore the mothers have to cancel vaccination though they are motivated and even willing. Because of being unconvinced, elderly family members do not extend support to the mother. They would dislike the mother going out for vaccination leaving household activities like preparation of meals etc. Elders may also dislike young daughters-in-law going out, talking and mixing with other women of the village in the absence of mother in law. It is obvious that at *Aanganwadi* centre women of the village meet and may gossip leading to friendship of younger women which is not acceptable to their in-laws.

It is important to mention here that joint family may also very well function as facilitator for availing immunization services. For instance, it has been observed that the new mothers may not

know about vaccination and show little interest but if they are among members who accept utility of vaccination, they have been motivated for it. Senior daughters-in-law and married daughters of the family, who have more experience in this regard, have been found to be a source of information for a new mother. All the barriers discussed in case of nuclear family can be easily sorted out or do not exist in extended family provided the members cooperate. Nuclear family type, despite the freedom it offers, limits the access of parents to immunization services due to the problems discussed earlier. This is also supported by data presented in tablet no. 2. It shows immunization status of children in relation to type of family they live in.

As clear from table no. 2, full immunization is much higher for joint families being 63.71 per cent. Compared to this nuclear families have only 45.35 per cent full immunization. Non-immunization is also much lower in joint families (6.45%) than nuclear families (22.09%). Partial immunization is 32.56 per cent for joint families, whereas it is 29.84 per cent for nuclear families. Traditionally in joint or extended families, burden of responsibilities and domestic chores do not fall totally upon the parents, but upon the entire family group. Everyone is jointly responsible for bringing up children. This reflects in better immunization coverage. But in the present changing rural society it is true till relationships among the members are cordial. There has been observed some bitterness among members living under one roof. This makes it difficult to seek support from each other in joint families. On the other hand, in nuclear families if there is no economic strain and other issues which cause frequent bickering, things are smooth. However, in the absence of support from kin child immunization is affected.

Authority Structure of Family

Family in rural Lucknow is patriarchal where father is the seat of authority. Accordingly families are dominated by eldest male, father or grandfather. Howsoever old children are, they usually respect patriarch and obey him. Where the authority lies in a family and how it is reflected in decision making, is an important aspect to determine course of action in any specific situation. The structure of authority within a family is often a factor that determines the acceptance or rejection of services offered by the department of modern medicine. This authority is an important factor in permitting an individual to take steps he feels are desirable.

'...the locus of authority and traditional decision making processes are manifest in family structure...even in small families, a patient is not free to make decisions ...' (Foster 1969, 107). In rural society of Lucknow district great authority lies in the elder people like many other traditional societies. Even the decision to seek medical care may not rest with the needy. In nuclear families also, the sole care taker of infant i.e. the mother is not independent of the authority of the father. Thus there are two important loci of authority within family in regard to immunization of children. One lies in grandparents of the child and noticeably both the sexes may be equally powerful in deciding for immunization of the child. Second locus of authority is the father who may exercise his power both in nuclear and extended family.

In families where grandparents use authority in health matters, decisions about maternity, place of delivery and child care cannot be taken by the couple. In fact all elders have a say in these issues and obviously decision of grandparents is final. There are many instances where mothers are willing or at least do not have problem with vaccination of the child but either or both grandparents authoritatively restrict her to go for vaccination. Non-acceptance of grandparents is usually due to conservative and fatalistic attitude which enforces non-belief in immunization. Old people usually go by their life experience whereby they have seen that people stayed healthy without vaccines. Belief that diseases and death are controlled by destiny reinforces non-belief in immunization. Grandparents may also withdraw from vaccination of children because of after effects. They con-

sider it as unnecessary trouble for family and for their beloved grandchild. This behaviour is again due to non-belief in this modern practice. It is a new practice for them and they have not yet developed faith in this.

It is important to note here that authority of elders, at least in matters of seeking health care is no more a universal feature of rural society. It is due to ongoing change where, like many other institutions, joint family is also shedding some of its traditional features. Also, not all the grandparents have been found to be opposing vaccination of children. In many families older people have flexible attitude. They have understood the need and accepted vaccination. They also cooperate and themselves take children for vaccination. Sometimes they simply may not interfere with the matter. They hold the opinion that it is the concern of the parents and therefore they are free to decide what they want for their child.

Fathers generally do not bother much about care of small children and do not interfere in the matter of vaccination. Wherever they do, reasons of reluctance are same as those in case of grandparents. It is seen that the mothers usually are convinced for immunization but the fathers may not. This is because it is the mother who interacts with health workers (who are invariably females) mostly and the latter gets an opportunity to persuade her.

Suggestions and Conclusion

Development programs of any kind proceed more smoothly and are more successful when the cultural patterns of the participating peoples, the values and motivations of the innovators and the social dynamics of the project setting are understood and utilised in planning and operations.

It is seen that awareness programs at the village level target women and try to explain and convince them about health programs. However, willingness of women is not sufficient in rural areas. Since it is a patriarchal society women cannot go against the wishes of the male members of the family and depend on them for many things. Therefore it is of crucial importance to include male members, especially young adults in awareness programs at village level and health campaigns. Another crucial element is the timing of the visits of these medical staff, NGO workers, ASHA and other volunteers. These people organise meetings to create awareness about immunization and other health care issues. One major flaw is that in most cases they do not bother to include men, nor they conform to the time schedule and the convenience of the people (both males and females). The doctors generally visit around 11- 12 am when most of the male members are out on work. They should visit at a time when most of the men and women are able to attend these meetings.

Now there is a growing trend for people to live in nuclear family in rural area also. Women in these families are bound to face problems arising out of this kind of family set up. In this context, both the government and the members of the community are required to make an effort in this direction to evolve a strategy. This is needed so that the mothers living in nuclear families are not deprived of availing health facilities. Some self help group of women can be formed with active cooperation of ASHA and women of their neighbourhood. Such groups can help women by taking care of their house and older children when they are going out for vaccination. It will not be difficult for such groups to cooperate as the day for immunization session is fixed for a village.

However awareness for the need of immunization is a prior requirement of such activities. This can be created through intensive publicity both through the mass media and through the word of mouth by person to person contact. The involvement of the community especially of the women folk and also of educated young male adults would prove fruitful for the immunization program. The cooperation at the community level can be supportive for both nuclear and extended family members.

Tables

Table 1: Immunization Coverage in Rural Lucknow

Sl.No.	Immunization status	Number	Per cent
1	Fully immunized (FI)	118	56.19
2	Non-immunized (NI)	27	12.86
3	Partially immunized (PI)	65	30.95
4	Total	210	100

Table 2: Immunization Status in Relation to the Family Structure

Sl.No.	Family Structure	Immunization Status of Child						Total
		FI		PI		NI		
		No.	%	No.	%	No.	%	
1	Nuclear	39	45.35	28	32.56	19	22.09	86
2	Joint	79	63.71	37	29.84	8	6.45	124

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