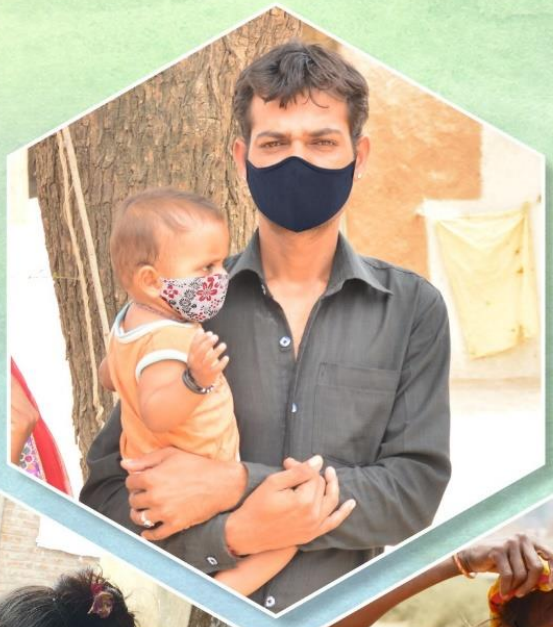
सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Intensified Mission Indradhanush 4.0

2022

Operational Guidelines



Vaccination Saves Life – Let's get our Children Vaccinated

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Acronyms

AD		Auto Disable	IPC	:	Inter-Personal Communication
AEFI	:	Adverse Event Following Immunization	ITSU	:	Immunization Technical Support Unit
ANM	:	Auxiliary Nurse Midwife	JE	:	Japanese Encephalitis
ANMOL	:	ANM online	JSI		John Snow Inc
ASHA	:	Accredited Social Health Activist	MAS	:	Mahila Arogya Samitis
AVD	:	Alternate Vaccine Delivery	MCP	:	Mother and Child Protection
AWW	:	Anganwadi Worker	MCV	:	Measles Containing Vaccine
BMGF		Bill and Melinda Gates Foundation	MI	:	Mission Indradhanush
BRIDGE	:	Boosting Routine Immunization Demand Generation	MO	:	Medical Officer
BTFI	:	Block Task Force for Immunization	MO I/C	:	Medical Officer in Charge
CAB		Covid Appropriate Behaviour	MoHFW	:	Ministry of Health and Family Welfare
CBO	:	Community Based Organization	MP		Micro Plan
CCE		Cold Chain Equipment	MR	:	Measles & Rubella
CCT		Cold Chain Technician	NCC	:	National Cadet Corps
CIF		Case Investigation Form	NFHS	:	National Family Health Survey
CMO	:	Chief Medical Officer	NGO	:	Non-Governmental Organization
COVID-19	:	Corona Virus 2019	NHSRC	:	National Health System Resource Centre
COWIN	:	Covid Vaccine Intelligence Network	NMNR	:	Non-Measles Non-Rubella Rate
CRF		Case Reporting Format	NPSP	:	National Public Health Surveillance Project
CS	:	Civil Surgeon	NUHM	:	National Urban Health Mission
CSO	:	Civil Society Organization	NYK	:	Nehru Yuva Kendra
CSR		Corporate Social Responsibility	ODK		Open Data Kit
CTFI		City Task Force for Immunization	PCV	:	Pneumococcal Conjugate Vaccine
DIO	:	District Immunization Officer	PHC	:	Primary Health Centre
DM	:	District Magistrate	PIP	:	Program Implementation Plan
DPT	:	Diphtheria, Pertussis and Tetanus	PW		Pregnant women
DTFI	:	District Task Force for Immunization	RCH	:	Reproductive & Child Health
ESI		Employees State Insurance	RI	:	Routine Immunization
eVIN	:	electronic Vaccine Intelligence Network	RVV	:	Rotavirus Vaccine
FIC	:	Full Immunization Coverage	SACS		State AIDS Control Society
FLW	:	Front Line Worker	SBCC	:	Social and Behaviour Change Communication
GSA	:	Gram Swaraj Abhiyan	SEPIO	:	State EPI Officer
HCS	:	Head Count survey	SIO		State Immunization Officer
HMIS	:	Health Management Information System	STFI	:	State Task Force for Immunization
HR	:	Human Resource	Td	:	Tetanus and adult Diphtheria
HRA	:	High-Risk Area	UHND		Urban Health and Nutrition Day
HRD		Human Resource Department	UIP	:	Universal Immunization Program
HW	:	Health Worker	UNDP	:	United Nations Development Program
IAP	:	Indian Academy of Pediatrics	UNICEF	:	United Nations Children's Fund
ICDS	:	Integrated Child Development Scheme	UPHC	:	Urban Primary Health Centre
IEC	:	Information, Education and Communication	USAID		United States Agency for International Development
ILR		Ice Lined Refrigerator	VHSNC	:	Village Health Sanitation and Nutrition Committee
IMA	:	Indian Medical Association	VPD	:	Vaccine-Preventable Disease
IMAS		Immunization Monitoring and Analyzing Software	WCD	:	Women and Child Development
IMI	:	Intensified Mission Indradhanush	WHO	:	World Health Organization
			WUENIC	:	WHO/UNICEF Estimates of National Immunization Coverage

Executive summary

India launched Mission Indradhanush, a special catch-up vaccination drive in December 2014. The flagship programme aims to strengthen Routine Immunization coverage by reinforcing learnings from polio eradication activities.

The mission has shown a positive impact on immunization coverage. A post IMI Coverage Evaluation Survey (CES) conducted in 2018 showed an increase in immunization coverage by 18.5 percentage points. These efforts also resulted in India achieving highest ever DTP-3 coverage of 91% in 2019 (as per WUNEIC estimates).

The achievements made in the past were offset by the COVID-19 pandemic, with an estimated 2.3 crore children under the age of 1 year left unvaccinated with basic vaccines and 1.7 crore have not received even their 1st dose of DTP vaccine globally. About 62% of those missed children are in ten countries, of which India ranks first, with the highest number of missed children. The DTP coverage in India dropped from 91% in 2019 to 85% in 2020.

This coupled with other inequities in immunization based on wealth, education, urban-rural setting, etc., has further contributed to the immunization gap.

As the COVID-19 pandemic has disrupted essential immunization services due to multiple reasons, the possibility of un/partially vaccinated children being exposed to the risk of vaccine-preventable diseases is very high. As the poorly vaccinated cohort increase in an area/pocket, there is a high risk of disease outbreaks.

Thus, to catch up on gaps that might have emerged due to the pandemic, Intensified Mission Indradhanush 4.0 has been planned to reach out to unvaccinated and partially vaccinated children and pregnant women. The available data utilized to apply multi-variant analysis for selection of the areas for IMI-4.0 in 2022 include.

- Number of children not vaccinated with age-appropriate Penta- 1, MCV- 2 and fIPV- 2 vaccine doses, based on HMIS coverage (April to September 2021)
- Full Immunization coverage as per NFHS- 5 survey
- Reduction in number of RI sessions conducted as per HMIS report for 2019 and 2021 (April-Sep)
- Incidence of Measles, Rubella and Diphtheria cases from VPD surveillance data
- Non-Measles Non-Rubella discard rate (Quality of VPD surveillance)
- Demographic risk factor(s) (States and WHO-NPSP)

Based on the above criteria, districts have been identified where the number of missed children is high. Similarly, the district and block team should identify the blocks/urban units/ villages/urban areas where high numbers of such missed children are expected.

Three rounds of intensified Mission Indradhanush will be conducted in the identified districts as per the following schedule:

Round 1: 7th February 2022 onwards

Round 2: 7th March 2022 onwards

Round 3: 4th April 2022 onwards

Unlike in the past, each round will be conducted for seven days, including RI days, Sundays, and public holidays

Changes in IMI 4.0 from previous IMI

1. **Focus areas**: In addition to the focus on high-risk areas, this IMI will focus on areas where RI sessions were impacted due to COVID-19 pandemic and in the urban areas
2. **Head count survey**: will be conducted in the entire district that has been selected based on the parameters defined above. The HTH survey to be conducted during the upcoming Polio NID could be used in these districts for identifying children who may be missed out or left out. Sessions will be planned based on the number of missed children and pregnant women identified.
3. **Session timings**: Flexible session timings will be followed. "On demand vaccination timings" in consultation with the community will ensure better turn-out of beneficiaries.

Capacity building of health workers

All health workers who will be engaged in IMI 4.0 will be oriented on the following key programme aspects:

1. How to conduct head count survey and prepare due list of beneficiaries
2. Importance of high-risk areas and how to focus on such areas
3. Preparing micro plans, including communication activity planning
4. Orientation on planning and reporting formats
5. Capacity Building for Adverse Events Following Immunization (AEFI) surveillance and crisis management
6. Covid appropriate behavior during the IMI 4.0 activities

Quality of the activity will be ensured through intensive supervision and monitoring of the activity by supervisors, external monitors, and task force mechanism.

Daily reporting of coverage against the targets will be ensured through the following mechanisms:

- Recording and reporting through hard copy on a predefined format
- Reporting through Google sheet
- Reporting through IMI 4.0 portal

Coverages will be tracked by the block and district task forces to identify gaps and ensure mid-course corrections.

Introduction

Immunization is one of the most cost-effective public health interventions in the world. Routine immunization was introduced in India as Expanded Immunization Program in 1978 and was later expanded into Universal Immunization Program (UIP) in the year 1985. UIP is one of the largest public health programs in the world.

At present, UIP targets nearly 2.7 crore newborns and 2.9 crore pregnant women per year. About 1.2 crore routine immunization (RI) sessions are planned annually, with vaccines stored across ~29,000 cold chain points and distributed to the session sites through alternate vaccine delivery system (AVDS) in cold chain.

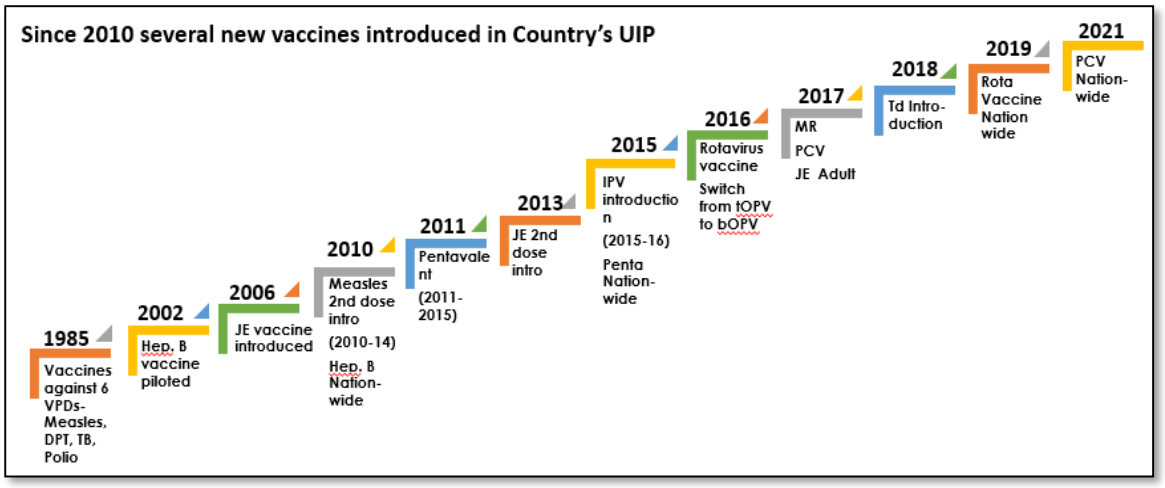


Figure 1Introduction of New Vaccines under UPI

UIP offers vaccines against 11 Vaccine Preventable Diseases (VPDs) nationwide and Japanese Encephalitis (JE) in endemic districts. The UIP has significantly contributed to reduction in morbidity and mortality due to VPDs and decrease in infant mortality. Since its implementation, several vaccines have been introduced in UIP. The current list of vaccines used in UIP and the schedule is given in **Annexure- 1.**

The Ministry of Health and Family Welfare (MoHFW) has taken a number of initiatives to strengthen immunization coverages and introduce and scale up new vaccines like HiB containing pentavalent, inactivated Poliovirus Vaccine, diphtheria containing Td vaccine, measles rubella vaccine, rotavirus vaccine and pneumococcal conjugate vaccines.

In 2015, the MoHFW introduced Electronic Vaccine Intelligence Network (eVIN), an innovative technological solution aimed at strengthening vaccine supply chain across the country. The software and SIM enabled temperature loggers enable real time monitoring of stock, storage condition and supply of vaccines across the country. The system was further successfully expanded into CoWIN for registration and tracking of beneficiaries for COVID-19 vaccines and has learnings for scaling up into routine immunization.

Mission Indradhanush (MI)

India launched Mission Indradhanush, a special vaccination drive in December 2014. The flagship programme aimed to strengthen routine immunization coverage by reinforcing learnings from polio eradication activities. The mission targeted unvaccinated and partially vaccinated children less than 2 years of age to reach >90% full immunization coverage and unvaccinated pregnant women.

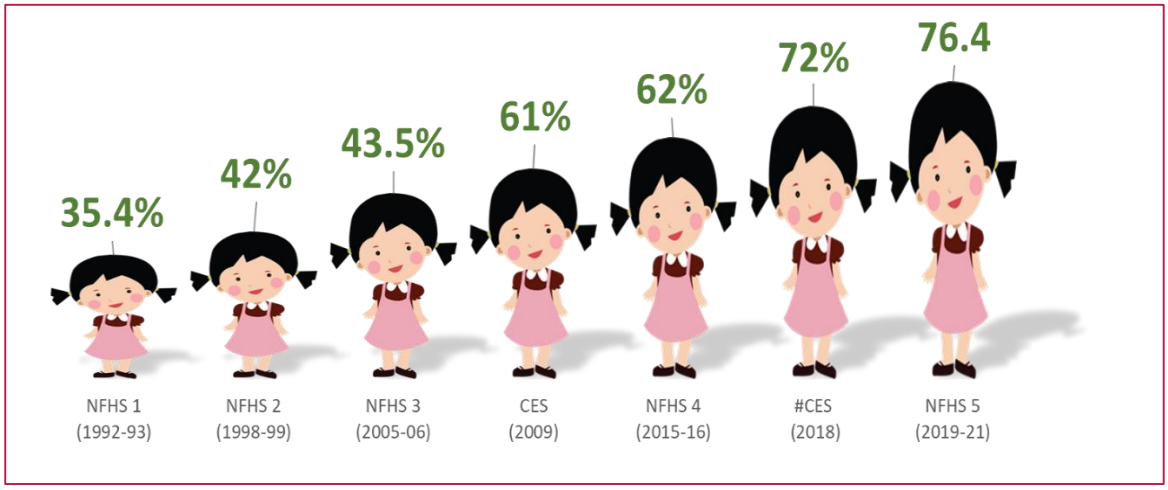


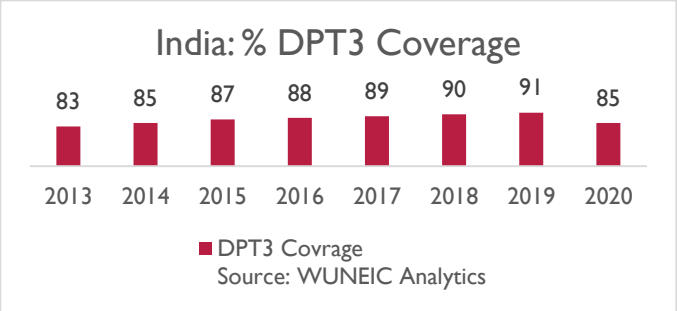
Figure 2 Progression of Immunization Coverage

The mission leveraged accountability frameworks encompassing state, district, and block level through task forces, with meticulous planning, effective communication, social mobilization, training, robust implementation, and supervision.

The mission has shown a positive impact on Immunization coverage. While the first two phases of Mission Indradhanush resulted in 6.7% increase in full immunization coverage in a year, a survey carried out in 190 districts covered in Intensified Mission Indradhanush (5th phase of Mission Indradhanush) shows 18.5% points increase in full immunization coverage as compared to NFHS-4 survey carried out in 2015-16. With strong and continuous efforts through routine immunization throughout the country and focused intervention in high risk and low coverage areas through MI/IMI, India has achieved full immunization coverage (12 to 23 months age) of 76.4% in 2019-21 (NFHS- 5). The same was low at 35.4% in 1992-93 (NFHS-1). ***(Figure 2: Progression of Immunization Coverage)***

Chapter-1: Rationale for IMI- 4.0

The partially vaccinated and unvaccinated children are at risk of morbidity and mortality due to vaccine preventable diseases. It is critical to identify and vaccinate these children, who are widely distributed across the country. Apart from routine immunization program, the focused approach in the past through intensified vaccination drive (MI & IMI) successfully identified partially and unvaccinated children and pregnant women and gained rapid increase in vaccination coverage. These efforts resulted in India achieving highest ever DTP-3 coverage of 91% in 2019 (as per WUENIC estimates). The recently released results of NFHS-5 show an overall increase of 14.4 percentage points in full immunization coverage (FIC) as compared to NFHS-4. 30 of the 36 States/UTs have shown an increase in FIC as compared to NFHS-4.



Graph 1.1 DPT-3 Coverage

1. Recent drop in immunization coverages

COVID-19 pandemic has adversely impacted immunization coverages across the globe, with an estimated 2.3 crore children under the age of 1 year left unvaccinated with basic vaccines and 1.7 crore have not received even their 1st dose of DTP containing vaccine. About 62% of these missed children are in ten countries, of which India ranks first, with the highest number of missed children.

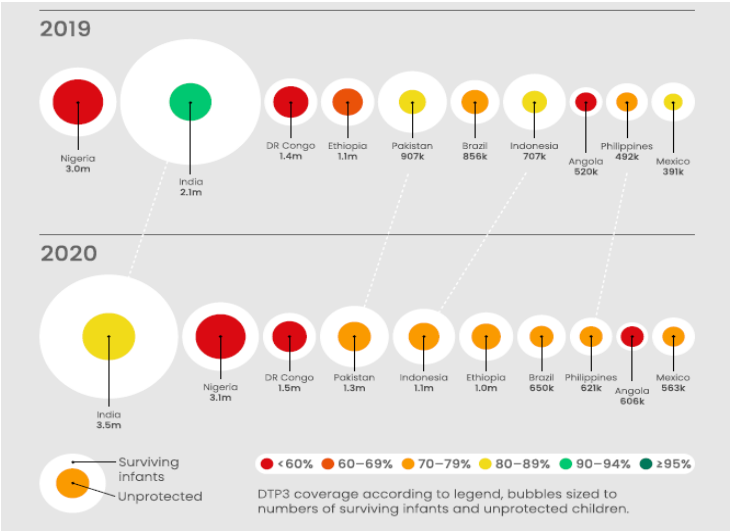


Figure 1.1- Global DPT3 Coverage, 2019 & 20

In India, Covid-19 pandemic disrupted RI services in the last two years (2020 & 21) that resulted a fall in immunization coverage. The fall was maximum in the first quarter of 2020 (26% fall as compared to 2019 - HMIS).

As per WUENIC estimate, 21 lakh children didn't receive their DPT3 doses in 2019, which rose to about 35 lakhs in 2020. This fall in DPT3 coverage resulted in additional burden of 14 lakh missed children. Hence a rapid intervention is needed to quickly vaccinate these children to prevent VPD outbreak.

Even after resumption of RI services in the later part of 2020, the restricted movement compounded by fear of exposure/contracting COVID-19 infection limited the access to services. The disruption affected the conduct of immunization sessions and supply chain management. The migrants returning to their native places were difficult to track and vaccinate.

As the partially and unvaccinated cohort increases in an area/pocket, there is a high risk of disease outbreaks. The disrupted VPD surveillance potentially may miss or not pick up these outbreaks.

Hence, it is essential to rapidly immunize these children while VPD surveillance is being strengthened.

Deep dive to understand reasons for missed children during Covid-19 pandemic in India

MoHFW, Government of India mandated WHO India to conduct a rapid and independent survey to inform impact of the pandemic on RI services, reasons for missing due vaccine doses and deep dive analysis for resolving the bottlenecks and propose solution to rapidly undertake course correction. The study was undertaken in 14 districts across 7 states (Assam, Bihar, Jharkhand, Maharashtra, Rajasthan, Tamil Nadu, and Uttar Pradesh) in August 2021. The deep dive revealed that interruption of immunization services is largely due to suspension of RI sessions, health workers (HW) engaged in Covid related activities, HW/family members affected with COVID-19, focus shifted from RI program to overall Covid-19 pandemic management and hesitancy among the community for vaccination and migration of population.

2. Intra and inter-state variations in immunization coverage

The last 3 NFHS surveys have shown overall progress in immunization coverage, however, the progress is not uniform across states and districts. The coverage increased from 43.5% in 2005-06

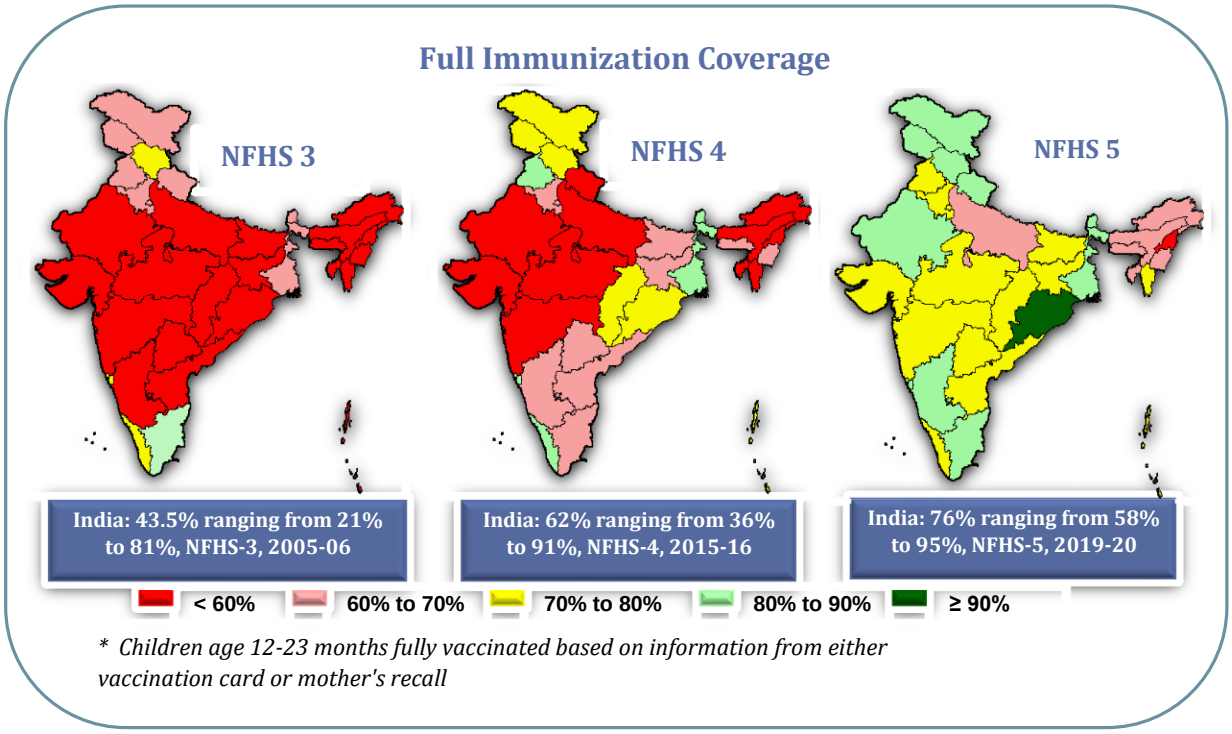


Figure 1.2- NFHS 3, 4, and 5 Immunization Coverage 12-to-23-month Children, India

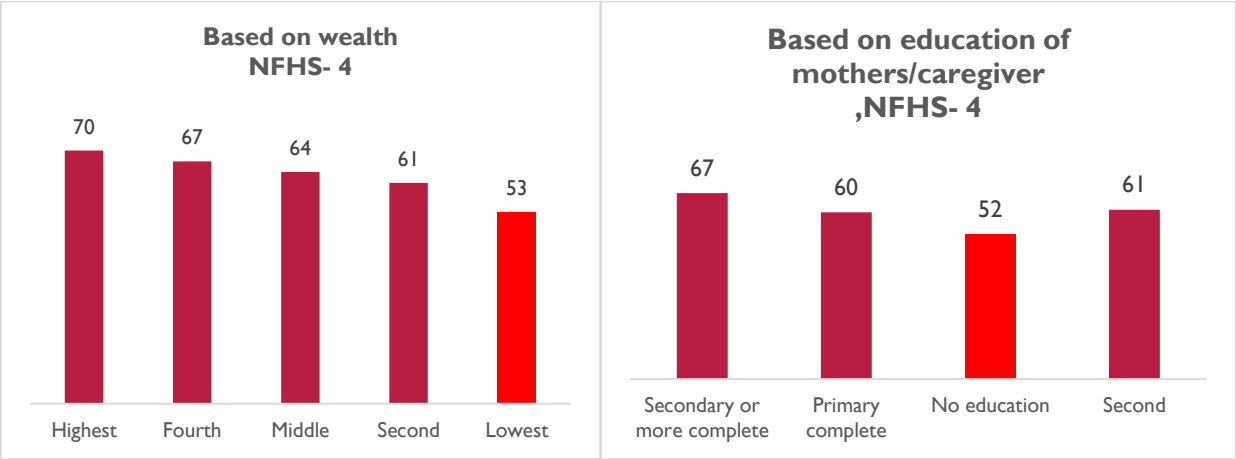
(NFHS-3) to 76% in 2019-20 (NFHS-5). The Immunization coverage in different states ranges from 71% to 100% in 2019-20. **(Figure: 1.2)**

3. Inequities in Immunization:

The MoHFW has taken various efforts in strengthening RI across the country, through system strengthening, adding new vaccines to the immunization schedule, new technologies and innovative strategies. However, inequities in vaccination coverage exist due to geographical, social/cultural/demographic variance etc.

Inequities based on wealth and education

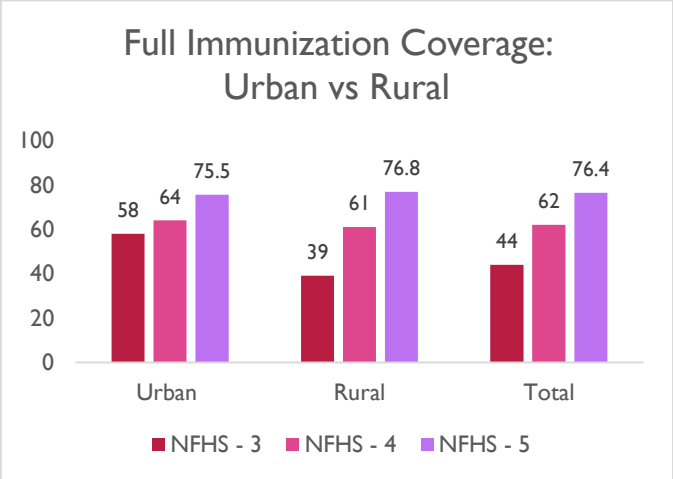
The reach of Immunization services and service uptake is lowest among those with no education, and lowest wealth status (Graph 1.2)



Graph 1.2- Immunization Coverage based on Wealth, Education and Caste/Tribal - India (NFHS-4 2015-16)

Rural/ Urban variations:

The progress in immunization coverage is not uniform in urban and rural areas. The vaccination coverage was lower in rural at 39% than urban (58%) areas in 2005-06 but, the same in 2019-20, the rural has shown higher coverage at 76.8%, and 1% higher than urban. Between 2005-06 (NFHS 3) and 2019-21 (NFHS-5), the coverage gain is 25% (39% to 76.4%) in rural whereas it is only 11.5% in urban (58% to 75.5%) areas. ***(Graph: 1.3)***



Graph 1.3- Full Immunization Coverage in Urban and Rural - India NFHS 3, 4 & 5

The challenges in enhancing urban immunization coverage are multiple, including high migration, rapid urbanization, health manpower shortage, poor infrastructure, and vaccine hesitancy.

While activities for immunization coverage improvement are being undertaken in all states, there is an urgent need to rapidly improve the coverages through IMI in select districts/states.

Chapter-2: Risk prioritization and district identification for IMI 4.0

The districts where the number of missed children is high have been identified. Similarly, the district and block team should identify the blocks/urban units/ villages/urban areas where high numbers of such missed children are expected.

1. District selection criteria for IMI 4.0

The MoHFW has utilized the data and applied multi-variant analysis for selection of the areas for IMI-4.0 in 2022. The data and information across the country was subjected to ranking through weighted scoring mechanism. Based on broad data range of score ***(Table: 2-1)*** and districts recommended by states for IMI, the MoHFW prioritized 374 districts ***(Annexure 2A)*** to implement IMI- 4.0 in 2022. The IMI 4.0 would be also conducted in the 75 districts under the Azadi Ka Amrut Mahotsav ***(Annexure 2B)***.

Risk assessment for district prioritization				
Category	**Criterion**	**Justification**	**Data Source**	**Max. Score**
Immunization Coverage Data	Children Missed Penta-1 (number & %)	Access to immunization / target zero dose	HMIS coverage April- Sep 2019- 2021	10
	Children Missed FIC (number & %)	Completion of first-year vaccination	NFHS-5	20
	Children Missed MCV-2 (number & %)	Completion of second-year vaccination	HMIS coverage April- Sep 2019-2021	10
	Children missed fIPV-2 (number & %)	Mitigating the risk of cVDPV and WPV importation	HMIS coverage April- Sep 2019- 2021	10
	Decline in Immunization session (Apr- Sep 2019 vs Apr-Sep 2021)	Impact of second wave of Covid pandemic	HMIS	15
VPD Surveillance Data	Incidence of Diphtheria and Pertussis in <5 years per 100,000 population	High incidence of VPDs in 2020	DPT surveillance	10
	Incidence of Measles and Rubella In <5 years per 100,000 population	High incidence of VPDs in 2020	MR surveillance	10
	Non-Measles Non-Rubella (NMNR) rate: 2020	Surveillance Quality	MR surveillance	5
Demographic Data	Districts with migratory population/ vaccine hesitancy/ other risk factors	Demographic risk factor	NPSP and State feedback	10

Table 2-1- Risk Assessment criteria, justification, data source and score for District Prioritization -IMI 4.0, 2022

2. Head count survey in identified districts

The information as available in HMIS may be used to estimate the target population. If the coverage in a district is 76%, then the remaining 24% would be the target which may be distributed across various blocks. The number of beneficiaries as per the percentage would be the estimated target and the headcount survey should be able to identify those estimated. Head Count Survey (HCS) is to be conducted in the entire district 2-3 weeks before start of catch-up campaign following the COVID-19 precautions. Based on the HCS, unvaccinated and partially vaccinated children will be identified for each area and listed for coverage under IMI.

HCS: Special precautions that need to be undertaken during the ongoing COVID-19 pandemic:

- Team members suffering from COVID-19 like symptoms i.e., fever, cough, respiratory distress etc. should not be deployed for survey
- Survey team should practice infection prevention control (IPC) measures:
  - Wear a facemask during the activity
  - Wash hands before start of activity and at every house use alcohol-based sanitizer
  - Interact with family members at the door of house or less crowded place following social distancing to minimize the risk of COVID-19 transmission
- Ensure that family members are also wearing facemask / face cover during interaction with survey team
- Provide message on key COVID-19 appropriate behaviors, including physical distancing, cough etiquette and hand washing/ sanitization.

Areas with a high number of unvaccinated and partially vaccinated children and pregnant women should be targeted, with special focus on:

- Areas with disrupted RI services due to COVID-19 pandemic: Areas where RI sessions were not conducted due to lock down, containment, health workers affected by Covid, Areas with high burden of Covid cases, Containment areas especially in urban cities. Each IMI district should prioritize the block/villages/mohalla/ward such areas affected during Covid pandemic.
- **High-risk areas** as defined for polio eradication activities including non-migratory/ settled and migrant high-risk areas. Tenants, families who had temporarily **migrated** for work, nomadic sites, Brick Kilns Construction Sites Others
- New-born who was delivered at home. **However, new-born delivered at health facility should not lose focus.**
- Villages/areas with Vacant sub centers, two or more consecutive missed routine immunization sessions.
- Hard to reach and areas with vaccine hesitancy
- Urban areas specially slums,
- Areas with high incidence of Measles, and other VPDs,
- Areas like orphanage, prisons, red-light areas, riverine areas, migration for agriculture etc.
- Tribal areas
- Other difficult areas: Areas hit by natural calamities (e.g., flood). The areas under social/political/or other conflicts need additional administrative support.

Based on the Head Count survey, the line list of targets beneficiaries (children and pregnant women) is to be updated on the RCH portal. The District Immunization Officer should ensure that all the areas in the district are mapped to ANMs, so that the entire population residing in that area is considered while deciding the target beneficiaries.

3. Microplanning

The overall success of the program depends on the quality of micro plans. The district follows a bottom-up approach in planning for IMI. ANM prepares the micro plan at the sub-center based on the headcount survey and identified high risk areas. The ASHA, AWW and ASHA supervisors are part of the planning at this micro level. The plan is prepared to reach pockets of unimmunized and partially immunized children and pregnant women within a block. Based on the need, a communication plan is also prepared at the sub-center. The block and district focus on systems strengthening, vaccine & cold chain management, supervision of activities, rationalized work distribution among ANMs, managing additional HR and other requirements. The overall micro plan preparation is under supervision and monitoring. Planning for communication activities is another important component in the micro plan. The plan is prepared at the sub-center, block, and district level to increase the demand generation, addressing the vaccine hesitancy and other communication challenges.

Chapter-3: Target population and Schedule

The goal of the IMI 4.0 is to protect the children from vaccine preventable diseases. Target entire population in a selected district, identify the target beneficiaries and prioritize those who are at high risk for IMI 4.0 as described in chapter 2. This includes the beneficiaries in HRAs and those in pockets who are difficult to reach through RI.

1. Target Beneficiaries:

The target beneficiaries for the mission are unvaccinated/partially vaccinated pregnant women and children up to 2 years of age.

Target: Unvaccinated/partially vaccinated

- Pregnant women
- Children between 0 to 2 years (0 – 23 months)

Note:

- Pregnant women target includes all those women who are currently pregnant on the day of headcount survey and due for vaccination either with primary or booster dose for Td.
- The target children include all those **born in or after February 2020** and due for one or more vaccines. The identified children would also be those who have missed out any of the newly introduced vaccines of Rotavirus vaccine and PCV.

2. Timeline for IMI

Three rounds of IMI 4.0 will be conducted, one each in February, March, and April 2022 in the selected districts as below:

- Round 1: 7th February 2022 onwards
- Round 2: 7th March 2022 onwards
- Round 3: 4th April 2022 onwards

Each round of IMI 4.0 will be spread over seven days may include RI days, Sundays, and public holidays in view of the ongoing Covid vaccination drive.

Note: For any deviation in working days, DIO should seek approval from State Immunization Officer.

3. Session timings

- Health worker should **engage with the leaders of the community to identify appropriate date, venue, and timing of the session,** if required, especially in areas where the target population (such as daily wages, factory workers, Nomad population, etc.,) may not be available during regular session time.
- In such situation, the district administration can utilize flexible session time to reach and maximize vaccination of such high-risk populations.
- In remaining areas, sessions may be conducted from **9 AM to 4 PM.**

4. Types of sessions:

Outreach sessions: conducting the IMI session at the same RI site may not help to reach the target. It is crucial to identify a place nearer to the target groups for maximum achievement. The session site should meet the following criteria:

- Available closer to the target group
- Easily accessible and information reachable to community in advance
- Acceptable by the community
- Highly visible to people
- Suitable, considering COVID-19 situation

- **In vaccine hesitant areas,** community accepted sites can boost immunization coverage. Sessions sites in the community run hospitals/schools/community owned halls, public/private hospitals, schools and colleges, premises of local influencers, panchayat hall etc., are more acceptable and convenient for all the beneficiaries.
- **In urban areas,** urban health and wellness centers, family welfare centers, private hospitals, premises of NGOs/professional medical associations, etc. can be utilized.
- **In high-risk areas** like brick kilns, nomadic sites, hamlets etc., select a clean, convenient, comfortable place in a shaded place making sure the **vaccines are not exposed to direct sunlight.** With proper planning and mobilization, the vaccine wastage is to be kept to the minimum during mobile sessions. Wherever required, plan for mobile sessions for optimal use of resources. Support of CSOs to create kiosks to attract residents for vaccination may be elicited.
- **Shifting of IMI session:** ANM can plan for two outreach sessions in a same day if the sites are nearby (e.g., nomadic site/ brick kiln outside the village, two sites for HRA population, two corners in a large village, two majra/tola/hamlet). The injection load should be low in both areas, and easy for the team to move from one place to other.

Mobile sessions: The benefits are maximized through mobile session in the areas where the number of target beneficiaries is small, area is scattered, hard to reach, does not have place to sit, migratory population etc.

- The mobile session covers two are more sessions on a same day that are far apart with small number of target beneficiaries and hard to reach.
- Vehicles such as Teeka express, Government/hired vehicles, etc., should be used.
- DTFI should discuss mobile session plan to get support from other departments
- The block medical officer plan for mobile session in mobile team planning format MP- 4
- Make sure the headcount survey is completed all the areas, due list is prepared, and the beneficiaries have prior information on date and time of vaccination
- The MoIC ensures the reach of mobile van at all these sites on scheduled date and time, with manpower for vaccination and mobilization.
- MoIC ensures the conduct of mobile session under close monitoring and supervision.

Note- for mobile sessions and shifting of sessions:

- Supply and use separate vials of BCG, MR, and Rota virus vaccines at each site. Any of these vials opened at one site should not be used to vaccinate children in another site. A new vial should be opened at each of the site.
- The vials with applicable open vial policy should be used at multiple sites to minimize vaccine wastage. Mark date and time of opening on each vial while opening. Use at successive RI/IMI sessions till 28 days of opening. Verify VVM and expiry. Follow sterile instructions.

Demand driven vaccination sessions:

Step-1: Identification of influencers: Identify the influencers in the catchment area. Influencers can be gram Pradhan, community or religious leaders, teachers, NGO members, RWA or ward members, counsellors etc. A meeting should be arranged with the identified influencers.

Step-2: Identify best venue, time, date/day: Once the influencers are identified and met, best venue, time, and date/day to conduct vaccination sessions may be enquired. Efforts should be made to scale up the community ownership for mobilizers for future.

If the sessions are already being conducted and needs the placement/modification of sessions, it should be done in concurrence with community. It is important to ensure that services meet the needs of the population and should be offered at the appropriate locations and times, and well promoted, using locally appropriate communication channels to reach all the community. Vaccination sessions particularly the days that they are held, and the time of day should be scheduled to be convenient for the community. UHND/VHND forums may be used to approach the influencers.

Step 3: Head count survey and Due list generation: The Due list is to be generated based on head count survey. The due list is to be informed to the leaders of the community (elderly, religious leaders, gram Pradhan etc.). The leaders of the community may be encouraged to certify that all the children due for any vaccination have been captured in the due list.

Step-4: Update micro plans to conduct sessions as per community needs: Once immunization-session schedules are decided and agreed to with the communities, it is imperative that they be adhered to. Micro plans should be modified to reflect newly/revised session sites and plans, and further coverage data will be compared as against the baseline coverage data.

Changing and cancelling scheduled sessions can result in loss of confidence in the service. A critical part of planning, therefore, is to ensure that sufficient vaccines, injection supplies, and cold-chain equipment are available, and that all logistical needs are in place well in advance of the session date. When planning services for the 'hard to reach', programme managers may consider package of services that can be provided during outreach.

Step-5: Engage community leadership for mobilization: It is imperative that once the liaison is established with the influencers, they are included in routine immunization for community awareness and mobilization. Community members may be involved to assist with organizing outreach sessions, record-keeping, and tallying, and providing a venue and other support for the health team.

Chapter-4: Preparatory activities

The preparatory activities focus on orientation and capacity building, vaccine and supply chain management, convergence with other departments & agencies, communication strategy, monitoring and evaluation and accountability framework.

1. Orientation and Capacity building

Training of all front-line health workers and supportive staff is necessary to ensure quality of service delivery, communication, documentation and in administrative support. To ensure quality of training, the MoHFW will develop training material, and the national level health officials and partners will facilitate National level training of trainers (ToT) as per the timeline shared. Trained trainers will conduct cascaded training using standard training materials. State Governments will ensure need-based adaptation of training materials and guidelines.

Training components:

1. How to conduct head count survey and prepare due list of beneficiaries
2. Importance of high-risk areas how to focus on such areas
3. Preparing micro plans, including communication activity planning
4. Recording & Reporting,
5. AEFI surveillance,
6. New initiatives

National — MoHFW and partners

- Develop guidelines and training material
- Sensitise and train state level trainers
- Support in state level trainings, Interministerial coordination

State — State Immunization Officer and Partners

- Conduct state ToT and train DIO and one Medical officer and partners
- Provide timeline
- Review progress of trainings in all disticts & blocks

District/City — District Immunization Officer and partners

- Training of block/urban Medical officers, cold chain handlers, data managers, admin & finance managers
- provide timeline and review progress of block level trainings

Block — Block Medical Officer and partners

- Training of ANM and Mobilizers (ASHA & AWW)

2. Vaccine & Supply chain management

An effective vaccine and supply chain management to supply vaccines and logistics in sufficient quantities while maintaining the vaccine quality is to be ensured.

eVIN helps in real time monitoring of vaccines across the nation at different level. eVIN to be utilized for ensuring availability of vaccines, forecasting and indentation for the required doses.

Open vial policy is followed (except BCG, JE, MR and Rotavirus vaccines) to minimize vaccine wastage. Vaccines are supplied to the session sites through alternate vaccine delivery system (AVDS) in a vaccine carrier, maintaining cold chain. The training plan includes capacity building of all the staff handling vaccines.

3. Convergence with Ministries, other departments & agencies

The roles and responsibilities of each department are given in Chapter 11- Areas of support from other ministries/departments and role of partners. However, state may customize and expand the list or responsibilities of the departments involved as per local requirement. Convergence of medical college representatives, professional bodies such as Indian Medical Association (IMA), Indian Academy of Pediatrics (IAP), representatives at district level, developmental partners including WHO, UNICEF, UNDP, BMGF, voluntary organizations such as NCC, NSS and NYK, non-government organizations such as Lions Club International, Rotary International, Red Cross, CSOs etc. will be required. Department of Information and Publicity and state media agencies need to be optimally utilized during the campaign. Designated officers including those from Information and Broadcasting (I&B) department would need to be involved in organizing and overseeing all communication and public relations' (PR) activities to ensure effective communication with stakeholders, media and the public at state and district level.

4. Communication strategy

Intensified Mission Indradhanush 4.0, the flagship programme for accelerating immunization demand and coverage for unreached children has been bolstering the mobilization of communities and addressing the barriers to vaccination/immunization. This round of IMI is very critical as COVID-19 has slowed the pace of routine immunization and many children and pregnant women have missed their scheduled immunization doses and hence are out of safety net for VPDs. IMI 4.0 will focus on identifying these missed out and dropped out beneficiaries and covering them with their due immunization doses. The MoHFW issued guidance in mid-April 2020 itself to resume immunization services following strict COVID-19 protocols which were followed by the states through proper planning to initiate immunization services effectively.

5. Monitoring and evaluation

The monitoring and evaluation is one of the important components of IMI. A strong M&E framework is on board to evaluate the progress, identify the gaps and take actions.

Preparatory stage: the districts implementing IMI are evaluated through self-assessment tool and assessment of readiness for IMI. The self-assessment tool includes information on task force meetings, assignment of monitors, training status, progress in micro planning activities. The information collected from medical officers and field monitors are shared with MoHFW on a weekly basis.

Implementation stage: the national, state and district level monitors conduct intensive monitoring in the high priority district/block/urban areas. The monitors from Government and partners will monitor IMI sessions to observe the quality of services and identify the programmatic gaps. The information is collected in a standard tool, complied, and shared at all level. Apart from this, partner agencies will do community survey through House-to-House monitoring to assess the field level coverage.

The major indicators assessed through monitoring include:

- Full immunization coverage in the monitored area
- No. of areas with more than 2 partially immunized children out of 5 monitored
- Availability of district level communication plan
- Convergence with ICDS

6. Accountability framework

A strong ownership of district administration and health department is key for the successful implementation of the mission. The accountability is strengthened through task force at national, state, district, city, and the block.

National	PMO & MoHFW provide overall guidance and review
	National Task Force to plan and review progress
	Training/Orientation of state health officials
	Communication to state administration & other concern departments
	Communication strategy, prototype of IEC materials
State	Steering Committee ensures accountability framework
	State Task Force for Immunization for overall guidance and monitoring
	State review committee to review progress,
	State level training of all district level master trainers
	Coordination with other departments and partners
	Oversee Communication activities, funds allocation, and supply chain
District/City	DTFI/CTFI to support in planning, interdepartmental coordination, and resolving issues
	District Review Committee to monitor and review progress
	Coordination with other departments/partners and urban bodies
	District health official as nodal officer for each block/Urban units
	Distribution of funds, vaccines, IEC materials Logistics to blocks/Urban units
Block	BTF headed by BDO to support in planning, coordination and resolving issues
	Block review committee to review progress and ensure timeliness
	Timely distribution of funds, IEC materials, logistics and training of HW
	Micro planning with adequate HR allocation

Chapter- 5: Planning for IMI session

Complete RCH portal registration and entry before the end of December 2021. This would be followed by a house to house visit to complete the information and identify the missed and dropped out children and pregnant women.

1. Head count survey

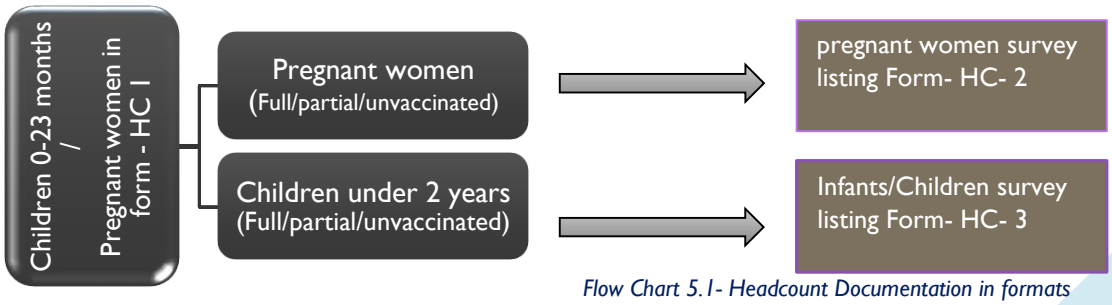
Headcount survey will provide a baseline data for planning for IMI 4.0. ASHA/AWW/Link workers must complete headcount survey in the entire district as per the timeline. The objective of the headcount survey is to reach the entire population and list out all the pregnant women and children under 2 years of age in an area. Compare with the details available in RCH portal or else complete/ register them. The activity is carried under intense monitoring and supervision.

Figure 5 -1- House Marking for Headcount Survey

- The ASHA/AWW/Link worker trained on head count survey and assigned to the village/ Mohalla /Area for headcount survey
- Complete entries on RCH portal/ ANMOL
- On each day, 25-30 houses shall be planned
- HW to survey on non-RI days and completed within 5-7 days
- The survey should cover all the households in the area in a systematic way, using polio micro plan or any other possible way and marking each house visited **(Figure 5.1)**
- The urban areas should be covered by the front-line health workers in the urban areas.
- The assigned supervisor observes the activity, cross checks 5 houses and provide hands on training

Steps for survey at each house:

- Follow Covid appropriate behavior
- Greet the family and explain the purpose of visit
- Capture the details in the first row of House-to-House survey form (Form-3)
- The details of all pregnant women irrespective of vaccination status if present, enter in pregnant women survey listing form (Form-4)
- Details of children under 2 years of age irrespective of vaccination status, enter in Infants/children survey listing form (Form-5)
- Put house marking and move to next house.
- At the end of survey, verify all the houses in the area are covered using house marking.



Flow Chart 5.1- Headcount Documentation in formats

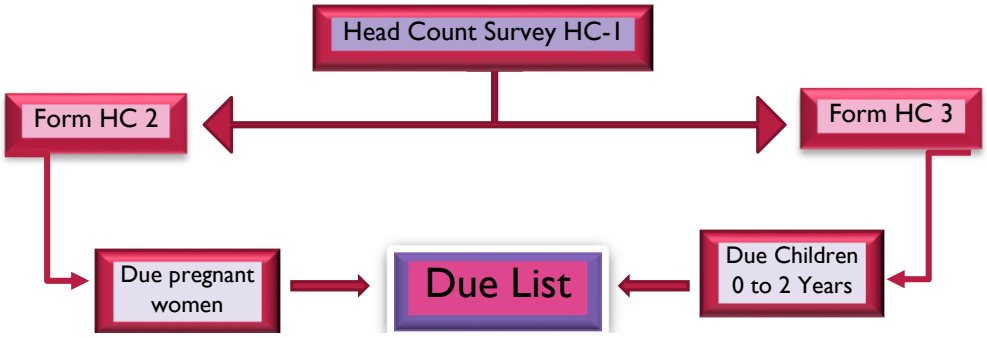
Logistics required: Head Count survey form- HC 1, 2, & 3, pen, chalk, personal protection kit

Points to Remember:

- Headcount survey is done in all the areas, irrespective of recent/past survey done for RI or any other purpose
- Urban and peri urban areas, especially HRAs need special plan and focus under intense supportive supervision as well as administrative support to avoid missed areas/ population
- The survey should include houses/children from other areas like Tenants, Migrants, Relatives of housemate who are likely to stay till upcoming IMI session planned
- The children born on or after 1st February 2020 are eligible under 2 children
- As these districts are at high risk for VPDs, utilize the headcount survey activity to strengthen VPD surveillance. Train/orient all the health care workers during block level training to identify and report Acute Flaccid Paralysis (AFP), Fever with Rash (FR), Diphtheria, Pertussis, and Neonatal tetanus.

2. Due list preparation:

Once the head count survey is completed, ASHA/AWW/Link worker prepare the due list with the support of ANM in the sub-center. The due pregnant women, and the children under the age of 2 years due for any vaccine as per age are enlisted. The number of due beneficiaries is shared with ANM/vaccinator. The source of document is form 5 and form 6



Flow Chart 5-2 - Due List Preparation from Headcount Survey Register

3. Micro planning:

The micro plan for IMI is developed from the bottom to top level. The ANM prepares the micro plan at the sub center and shares it with the planning unit, UPHC or block. The medical officer in charge collects micro plan from the sub-centers, complies them and prepares a block micro plan. The medical officer reviews, finalize, and share it with the DIO. The data is entered into IMI 4.0 portal as per the timeline.

Sub-center level micro planning

Responsible person: ANM/assigned staff

Process:

- **Meeting:** ANM conducts a meeting with ASHA supervisor, ASHA/AWW / Link workers in the sub-center.
- **Data collection:** Collect survey form- 3,4 &5 and due list from all the staffs and verify the quality and completeness

- **Data Verification:** Check if all the due children for the upcoming IMI have been listed. If no, correct it.
- **Data entry:** List out all the villages/Mohalla/area and the number of due children in each
- **Area selection:** ANM discuss with ASHA supervisors, ASHA, AWW/Link worker and decides on the places in need of IMI
- **Selection of session site:** The team discuss and select a session site which is most,
    - accessible to beneficiaries,
    - acceptable by all communities,
    - available on the day of IMI
    - appropriate for Covid situation
- Selection of Mobilizers: the ANM discuss with the team and finalize at least two mobilizers for each of the area/session sites and get their details.

All the details are entered in Sub-Center micro planning format (MP- 1)

Sub-Centre Planning (Format MP 1)

MP 1 - IMI 4.0 Sub-Centre Planning — For ANM

(MO IC to ensure this format is filled for all sub-centres including vacant sub-centres)

Name of sub centre: Block: Name & mobile number of ANM:

S. No	Name of villages, hamlet, slum, migrant area, etc.	Head count done (Y/N)	Population based on head count (Write NA if head count not done)		If yes, number of immunization sessions required	Mention reason for additional session* (Write code) 1/2/3/4/5/6/7	Location of session site(s) foradditional session(s)	Name, designation & mobile no of mobilizers only for areas requiring immunization sessions (write name of ASHA, AWW/link worker)
			0–2 years	Pregnant women				1
								2
								1
								2

Figure 5-2- Sub center Micro Plan Format MP-1

Block/urban area planning

The block review committee review the micro plan received from all the sub-center, compile in Block/urban micro plan format MP-2.

Manpower requirement

- One vaccinator and two mobilizers are in a team for each IMI session for an injection load up to 60-70. For more beneficiaries, add one more vaccinator. The vaccinator for a session could be ANM from same sub-center/sub-center of same block or another block in the district or hired vaccinator. The ANM from rural can be assigned to urban during IMI
- Assign one influencer for each session, especially in the vaccine hesitant areas.
- The MoIC is responsible to assign all the existing staff available in the block for IMI. Ensure 7 ANM working days in a block is utilized.
- Plan judiciously for IMI- 4.0, without considering manpower constraint. Plan as much sessions as required to vaccinate all target children. There is no upper limit for number of sessions in a block/district
- The MoIC plan for necessary fixed, outreach and mobile sessions in the block. Assign existing manpower wherever possible. Utilize available trained staffs for fixed sessions or nearby sites
- For additional vaccinators, share the plan and discuss with DIO. DIO will assign ANM from other blocks based on the available resources from other blocks

- If there is still manpower shortage, hire vaccinators. There is a provision for hired vaccinator in NHM, for which guidance may be taken from DIO.
- The hired vaccinators can be retired ANM/trained staff, vaccinators from NGOs, private nursing home/hospitals/medical colleges, ANM/Nurse training institutes, ESI, central Government health facilities including Railways and Military, Urban development agency, health staff from corporation, and community-based organizations.
- Make sure that the hired vaccinators are well trained before IMI on immunization schedule, safe injection practices, AEFI management, documentation, and reporting, and in communication

Block/urban area planning (Format MP 2)

S. No	Name of sub-centre	Head count done (Y/N)	Population based on head count (Write NA if head count not done)		No of immunization sessions required	If mobile session, write "mobile". For other sessions, mention location of session site(s).	Name, designation & mobile no of mobilizers (ASHA, AWW/ link worker)	Which ANM will conduct immunization session in this area			
			0–2 years	Pregnant women				ANM of same sub-centre	ANM of other sub-centre from same block	ANM from outside block	Hired ANM
							1				
							2				
							1				
							2				

Figure 5-3 - MP-2 format for Block/Urban Area Planning

District level planning & HR distribution

- The micro plan received from the blocks are compiled at the district.
- The District review committee review the completeness and quality of each micro plan.
- The committee analyze the number of ANM days available at each block against planned sessions.
- DIO rationalize the workload and assign HR
- The details are entered in micro plan format MP- 5.

Communication plan

The MoIC must ensure the communication plan is included in micro plan both in urban and rural areas. The formats for communication plan are given in annexure 6.

Chapter-6: Organizing IMI session

1. Vaccine, logistics supply chain management

The cold chain handler responsible for vaccine, logistics and supply chain management receives training at the district.

Before IMI:

The cold chain handler checks:

- Vaccine availability in sufficient quantity. Indent for the requirements.
- Availability of syringes, vaccine carriers, ice packs, tally sheet, needle destroyer, bags for waste management
- Cold chain, vaccines expiry dates, VVM
- Functioning of ILR/Deep freezer, backup plan for power failure, enough ice packs are kept in deep freezer
- Vehicles are available for Alternate Vaccine Delivery (AVD) and the person is well informed on IMI micro plan and route plan
- The copy of final IMI micro plan and vaccine distribution plan

Figure: 6-3 - Alternate Vaccine Delivery for Vaccine Distribution to Outreach Session from Cold Chain Point

During IMI days:

Morning:

- Conditioning of ice packs – this is the most important during RI/IMI days
- Pack vaccines and diluents in zipper bags
- Vaccine carrier and logistics transported to session sites through AVDS
- Document the supply in the register and eVIN

Evening:

- Ensure all the vaccine carriers with un-used and used vaccines (with open vial policy) reach the cold chain point through AVD in the evening.
- Store returned vaccines in ILR
- Ensure stock entry of returned vaccines and timely reporting on eVIN
- Dispose returned immunization waste as per biomedical waste management guidelines

2. Communication activities

Effective pre-publicity using all relevant media like mass media, mid media and on ground IPC in the identified population with focus on migrants, urban slums, hard to reach population and clusters with high vaccine hesitancy. This could effectively be done by engaging with influencers and proper display of relevant IEC material along with health workers door to door campaign with key messages highlighting benefits of immunization and preparing community for common AEFIs and their management. It is very important to communicate and sensitize all beneficiaries and key

programme stakeholders that COVID-19 has badly interrupted RI and many children missed their routine immunization making them all very vulnerable for diseases which could be prevented with timely administration of scheduled immunization.

On the day of immunization – vaccine specific benefits and common minor side effects must again be discussed with the family getting their child immunized. The next visit date indicated in the MCP card must also be communicated clearly. Family should be told whom to contact in case of any moderate or serious AEFI. Use mobilization teams (prachar toli), influencers or volunteers to reach families who did not turn up for vaccination for reminder call and share risk of specific VPDs.

3. Mobilizing beneficiaries

Prior information to beneficiaries makes the beneficiary ready for vaccination. The mobilizer ensures all the beneficiaries are well informed before IMI. The ASHA/AWW checks the due list and prepares an invitation card (Bulawa Parchi), writing the date and time of IMI session and due vaccines for each beneficiary. The cards are issued to all the beneficiaries at least a day prior to IMI session.

Immunization Invitation card (State name :2022-23)
Counter Foil

District ----------

Block/Urban area ----------

ASHA/ Mobilizer Name ----------

Place & Date of Immunization ----------

Pregnant woman/Child Name ----------

Husband/ Father's Name ----------

Due Dose Name ----------

Immunization Invitation card (State name :2022-23)

District ----------

District ----------

Block/Urban area ----------

ASHA/ Mobilizer Name ----------

Place & Date of Immunization ----------

Pregnant woman/Child Name ----------

Husband/ Father's Name ----------

ASHA/ Mobilizer to provide this invitation card by encircling the due dose to every child/pregnant woman before the session start

Td 1 / 2 / B	BCG	OPV 1 / 2 / 3 / B	Penta 1 / 2 / 3	f IPV 1 / 2	MR 1 / 2	JE 1 / 2	PCV 1 / 2 / B	RVV 1 / 2 / 3	DPT B 1 / 2	Td 10 / Td 16

Figure:6-4 - Model Invitation Card for Due Vaccination

Follow staggered approach to avoid overcrowding at the session site. ASHA/AWW prepares an hourly allotment to the due beneficiaries and ask them to reach the session as per the time allotted. Do not encourage more than one caregiver for each beneficiary.

- Allocate 4 to 5 beneficiaries for an hour
- Ensure not more than 5 people (Care giver/beneficiary) sit at any given time during the session
- Ensure the caregivers and beneficiaries wear a mask and maintain social distancing
- Hand wash facilities are available and followed

On the day of IMI, the mobilizer keeps a copy of due list in hand. At least two mobilizers (ASHA/AWW/Link worker/Volunteer) actively mobilize all the beneficiaries. They get the support of influencer/s to mobilize families with Vaccine Avoidant Behavior. Check the Tally sheet and ensure all got vaccinated.

4. Vaccination process

Objective: of IMI session is to provide all due vaccines to the target beneficiaries at the nearest possible session site, while ensuring quality of services.

Covid appropriate behavior: the health worker should follow and ensure Covid appropriate behavior; hand wash facility to the beneficiaries, health workers and beneficiaries wear mask, sanitize hands before vaccinating every child, maintain social distancing, and adequate ventilation at the session site.

Before starting a session: before starting the session, the ANM should verify:

- All the vaccines and diluents are available in sufficient quantity, vaccines and diluents are not broken, within expiry date, and VVM is in usable stage, adequate syringes are supplied, Anaphylaxis management kit (adrenaline within expiry date), availability of tally sheet, IEC materials
- The mobilizers are available and mobilizing the beneficiaries, Influencers are available
- Due list is updated, and mobilizers have the copy
- Hand wash facility is available and Covid appropriate behavior is followed throughout the session

Safe injection practices: Follow guidelines on safe injection practices; use AD syringes, avoid contamination of needle and vaccine vial, prevent needle stick injury, check expiry date, write date and time on opening a new vial, do not use BCG, MR, JE, and Rota beyond 4 hours, and follow open vial policy for other vaccines, follow the guidelines on biomedical waste management, and inject vaccines at appropriate site and route. (Refer: Unit- 5, Safe injections and waste disposal, Immunization handbook for medical officer, 2017)

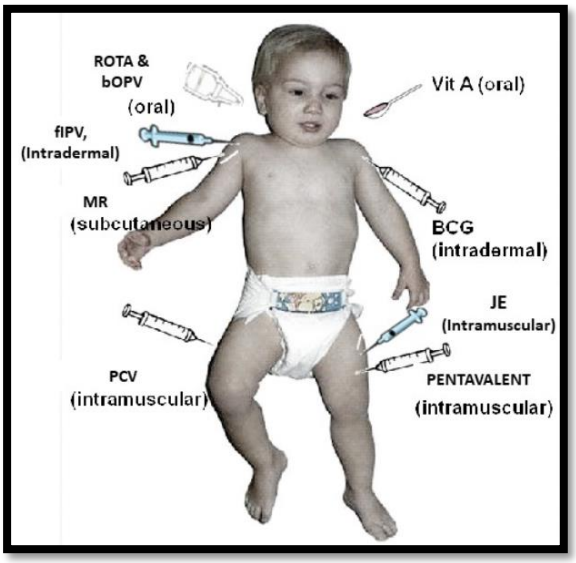


Figure:6-5 - Site of Vaccination under UIP

Four key messages: the ANM delivers 4 key messages to all the beneficiaries.

1. What vaccine was given and what diseases it prevents?
2. What minor adverse events could occur and how to deal with them
3. When and where to come for the next vaccine?
4. Keep immunization card safe and bring it along at the next visit.

Full Immunization: child has received BCG, 3 doses of OPV, 3 doses of pentavalent and Measles/MR-1 before one year of age. As the Rotavirus vaccine and PCV are rolled out Nationwide, a child is to be considered fully vaccinated if he/she has received these vaccines along with the routinely mentioned vaccines.

Complete Immunization: the child has received DPT- Booster-1 and MR- 2 before the age of two years.

Immunization schedule: always follow National Immunization schedule (Refer: Annexure- 1)

- Follow Immunization schedule and vaccinate children and pregnant women with all the due vaccines as per age
- However, in certain situation, the child may reach the session site late missing all the vaccines, or certain vaccines (left out and drop out). The aim of IMI is to vaccinate these unvaccinated and partially vaccinated children. Remember following rules while vaccinating these children.
    - Do not give BCG after one year of age
    - Do not initiate pentavalent, fIPV, PCV and RVV if the child has not received a single vaccine or initiated before one year of age.
    - If the child has already received one or two doses of pentavalent, PCV and RVV before one year of age, vaccinate the missed one with adequate gap in between doses and complete the immunization schedule
- If a child reaches late after receiving one or two doses of Penta, Rota, PCV, fIPV and OPV, do not repeat the previous dose. Administer the due doses as per guidelines.
- **Minimum gap:** when a child is late beyond the scheduled time, ensure a minimum gap of at least:
    - 4 weeks between two doses of Penta, OPV, RVV
    - 4 weeks between MR- 1 and MR- 2 (if the child reach beyond 16 months and has not received the 1st dose)
    - 2 months between 2 doses of PCV and fIPV
    - 3 months between JE- 1 & 2 (if the child reaches after 16 months and have not received 1st dose)
    - 6 months between Penta/DPT- 3 and DPT Booster
- **Contact medical officer/supervisor for any clarification**

5. Vaccinating Zero dose children

Zero-dose children are those who have not received any routine vaccines. For operational purposes, zero-dose children are defined as those missing the first dose of diphtheria-tetanus pertussis-containing vaccine. They are highly prone to VPDs. Identify these children in your district and prioritize them for vaccination. However, the vaccines are allowed till certain age under UIP; BCG <1 year, OPV and MR <5 years, DPT <7 years, and JE<15 years. Do not use these vaccines beyond this age.

Upper age limit for vaccination under UIP		
Vaccine	Upper age limit	• If a child has already received one or two doses of Penta, Rota, fIPV or PCV before, continue the due doses even after 1 year of age.
Hepatitis B (Birth dose)	24 hours	
OPV Zero dose	15 days	
BCG	1 year	
Penta, fIPV, PCV, Rota	1 year	
OPV	5 years	
Measles/MR	5 years	
DPT	7 years	
JE	15 years	

Table 6-1 - Upper Age Limit for Vaccination Under UIP

Similarly, do not initiate Penta, Rota, fIPV, and PCV if the child is coming for vaccination for first time after one year of age. However, if the child has taken one or two doses of these vaccines before one year, the remaining doses can be given.

Vaccinating Zero Dose Children of > 1 Year Age			
	1st dose	Follow up vaccination	Booster
Zero Dose Children >1 Year Old	DPT- 1	DPT- 2 & 3 at 4 weeks interval	6 months between 3rd and booster doses
	OPV- 1	OPV-2 & 3 at 4 weeks interval	
	MR- 1	4 weeks between MR-1 & 2 (2nd dose 16-24 months)	
	JE- 1	3 Months between JE-1 & 2 (2nd dose 16-24 months)	
	Do not give BCG, PCV, ROTA, Penta		

Table 6-2: Vaccinating Zero Dose Children of > 1 Year of Age

A focus on reaching zero-dose children does not stop at providing the first dose of DTP-containing vaccine. The goal is to ensure these children are fully immunized with all vaccines as per the UIP schedule.

6. Vaccinating beneficiaries

Ensure no child/PW are left unvaccinated in the IMI area.

Vaccinate:

- All the due beneficiaries in the due list
- Any due beneficiaries not in the due list/direct visit to session site
    - The pregnant women or children who have recently shifted to the area
    - The relatives of the residents
    - Anyone missed/not included in headcount survey
    - Recently migrated to the HRAs
- Vaccinate beneficiaries even if they do not have RI card in hand. Ask the history of previous vaccination and find the due vaccine.
- If a child has taken vaccines in private sector and is due for any vaccine/s, and willing to take/continue under UIP, vaccinate them as per UIP schedule. Follow these children in the subsequent IMI rounds and/or RI sessions till complete immunization.
- Provide all the vaccine doses that are immediately due, as per the schedule.
- The order of administration of multiple vaccines should be such that oral vaccines are administered before injectable vaccines.

In all the above situations, check the RI card. If not available, take a proper history and find the due vaccines. **Contact medical officer/supervisor for queries.**

Minimizing vaccine wastage is necessary. During IMI, ensure all the vaccines are supplied to each session. No child should be left unvaccinated. Every opportunity should be utilized to vaccinate these missed children.

7. AEFI management and reporting

AEFI Management Center: Each facility staffed with MO in the government or private health facilities are mapped and each of the session sites are geographically linked to the nearby AEFI management center. These centers are equipped with AEFI treatment kit. ***(Refer: Immunization Handbook for Medical Officers, 2018)***

AEFI reporting: For severe and serious AEFIs, immediate focus of ANM should be to stabilize the child. Then, contact the MO for help and follow their instructions. The same is recorded in tally sheet. MO will inform the DIO over phone and share the Case Reporting Form (CRF) with DIO within 24 hours. The DIO and AEFI committee will follow with case investigation. The AEFI is also reported in the weekly H-002 report and in HMIS. The severe and serious AEFIs are reported through SAFEVAC.

The MoIC should ensure that block level training includes AEFI management and reporting, the logistics supply to all the sites includes anaphylaxis kit.

1. Job aid/dose chart (as per age) for adrenaline
2. Three ampoules of Adrenaline (1:1000 aqueous solution)
3. Three Tuberculin syringes (1ml)
4. Three 24G/25G needle
5. Swabs -3
6. Updated contact list of DIO, PHC/CHC Medical officers, referral center and local ambulance services
7. Adrenaline administration record slip

8. Documentation and reporting

After vaccinating each pregnant women/due child, ANM should enter the details in the tally sheet. The tally sheet must reach the cold chain point on the same day along with the vaccine carrier**.** ***(Refer to Chapter: 7 Recording and Reporting)***

9. Closure of IMI session

ANM should close the session at the scheduled time only. ANM/ASHA/AWW/Link worker together prepare the due list for the upcoming round referring to the current duelist, Tally sheet, and Headcount survey. Ensure the vaccines with open vial policy are kept in the zipper bag and kept safely in the vaccine carrier, Tally sheet and other logistics are sent back through AVD.

Chapter-7: Recording and reporting

As done for earlier rounds of MI & IMI, recording and reporting data of vaccination during Intensified Mission Indradhanush 4.0 rounds will be done in the standardized formats and reported in the google sheet and IMI 4.0 portal. To manage the data reporting and analysis, the IMI portal which was developed during IMI 2.0/IMI 3.0 will be utilized with some nomenclature modifications. This portal will capture block-wise IMI coverage while this data will be entered at the district level.

The data collection and timely reporting is important for data analysis and make programmatic correction. The systems used in IMI are:

- Recording and reporting through hard copy
- Reporting through Google sheet
- Reporting through IMI 4.0 portal

It is important that quality data is captured through all the above-mentioned modalities in a timely manner.

1. Recording and reporting through hard copy and google sheet

- **ANM** enters the details of beneficiary wise vaccines given in a standardized format. The tally sheet is sent to block along with vaccine carrier through AVD or supervisors collect and share in the evening meeting
- **Block:** the person assigned for reporting collects Tally sheet form all the session sites, compile and enter in Block Reporting Format and send it to DIO office
- **District:** the data handler/person assigned for reporting receives Block reporting format from all the blocks/urban units, compiles in District Reporting format and share it with state as per timeline. The district-level coverage data (antigen wise data and daily vaccine and diluents utilization reporting) will then be entered in the google sheet
- After the entry is completed for district level, the state and national level output (key immunization coverage indicator report) will be generated automatically.

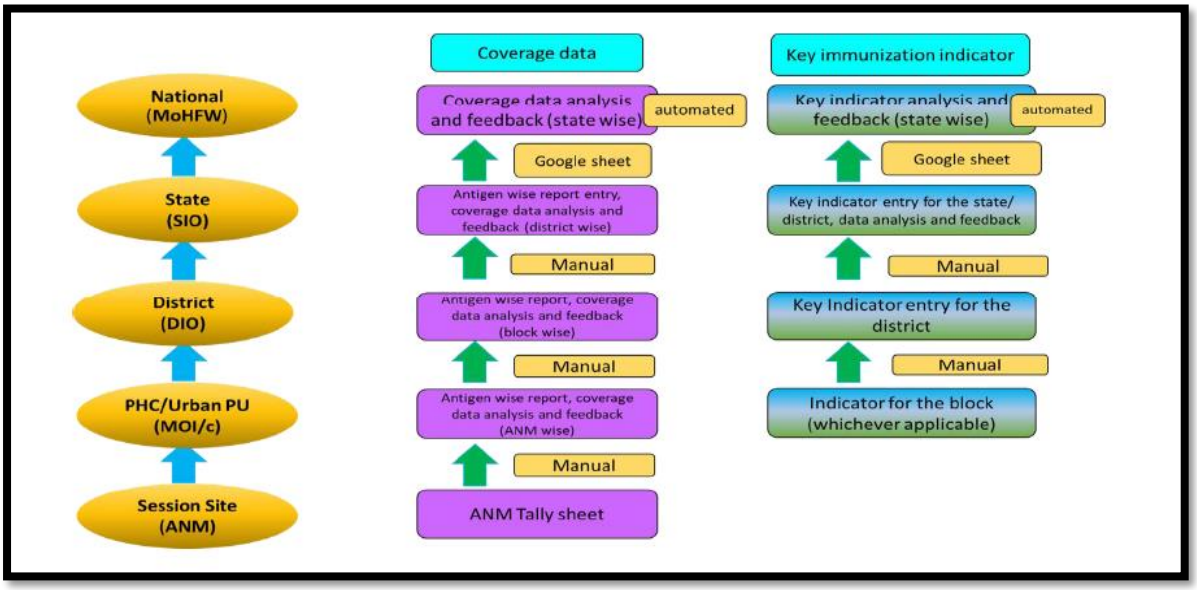


Figure 7.1- IMI Data Flow

- The data flow for IMI 4.0 recording and reporting of coverage data and key dashboard indicator on immunization (manual and google sheet) is illustrated in the Figure 7-1; IMI Data flow
- The DIO should ensure that the data is collected and shared to state through Google sheet daily in the evening as per timeline
- The key indicator entered in the google sheet is automated. Hence, district and state wise feedback analysis is generated
- Daily data generation and data analysis helps the state and district to review the progress and take corrective steps.

2. IMI 4.0 portal for preparatory and coverage data

To manage the data reporting and analysis, IMI 2.0 portal was developed in consultation with MoHFW, immunization partners and National Health Portal. The same will be updated for IMI 4.0 rounds on the similar lines. The portal will capture block-wise coverage while this data will be entered at the district level.

Development and hosting of the portal

Login credentials specific for each district will be provided with rights of data entry, editing, viewing, report and dashboard visualization. The credentials will also be provided to the state

Table 0-1: IMI Data Flow

and national level users with rights of visualizing report and dashboard on immunization coverage and key indicators.

Data flow and reporting

The standardized data collection formats developed by the Government of India will be used and data entry will be done in those formats. The State Immunization officer will be responsible to ensure data entry for immunization coverage. The data entry will be done as per the flow matrix in **Figure-7.2** below.

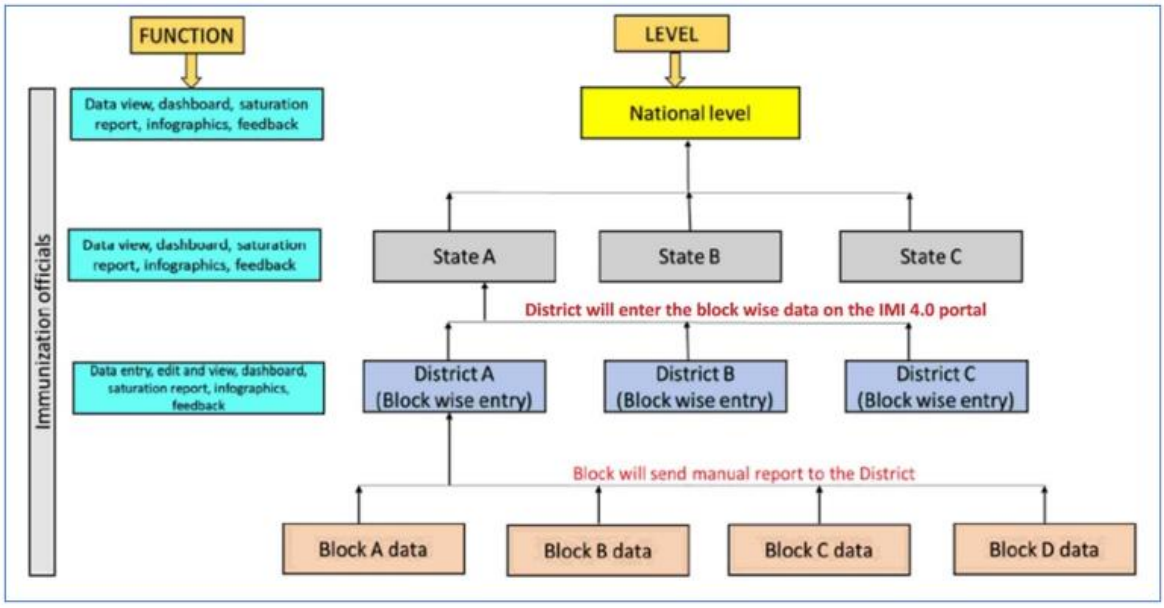


Figure 7-2 IMI Data flow

During the preparatory phase, target population of children, pregnant women and session planned will be entered block wise separately for urban and rural area **(Annexure 4).** This will be uploaded in the IMI 4.0 portal immediately on completion of head count survey. The portal for the target entry will be frozen/blocked a week before the start of the activity. Apart from these, coverage data and status of saturation of blocks for children and PW need to be entered block wise **(Annexure 4).** The portal will have options to upload images/ documents/ other resources in the field at the district level. The district immunization officer needs to collate, review, and ensure data uploading at the district. A team at the national level will screen the images and documents before uploading on the dashboard.

Features of the IMI 4.0 portal

The portal is envisaged to have two main modules including the data input and output module. The data input module will have provision to enter the target and coverage data while the output module will have analytics report and dashboard report for immunization coverage data and social media indicators.

Output module

The performance of the activities will be extensively monitored at each level including the highest level in the Ministry. There will be provision for generating output reports of immunization coverage data, social media indicators. Dynamic reports and Info graphics, maps and charts will be included in the dashboard displaying analytical information.

Benefits of IMI portal

- Monitoring the progress at each level, highest at the ministry
- Generates reports of immunization coverage data up to block level
- Availability of dashboard with Dynamic reports and Info graphics, maps, and charts

3. RCH Portal

Based on the Head Count survey, the line list of target beneficiaries is to be updated on the RCH portal.

Any child who is born on or after February 2020, should be registered on the RCH portal. The vaccination status of such children should also be captured on the portal. The District Immunization Officer is to ensure that all the areas in its jurisdiction are mapped to ANMs, so that the entire population residing in that area is considered while deciding the target beneficiaries.

Chapter-8: Communication strategy for IMI 4.0

Background

Intensified Mission Indradhanush 4.0, the flagship programme for accelerating immunization demand and coverage for unreached children and pregnant women has been bolstering the mobilization of communities and addressing the barriers to vaccination/immunization. This round of IMI is very critical as COVID-19 has slowed the pace of routine immunization and many children and pregnant women have missed their scheduled immunization doses and hence are out of safety net of VPDs. IMI 4.0 will focus on identifying these missed out and dropped out beneficiaries and covering them with their due immunization doses. The **MOHFW issued guidance in mid-April** 2020 itself to resume immunization services following strict COVID 19 protocols which were followed by the states through proper planning to initiate immunization services effectively.

1. Objectives of IMI 4.0 communication campaign

The main goal of the communication strategy will be to raise awareness among communities on benefits of immunization leading caregivers to make necessary changes in behaviors which are beneficial for immunization services. Multipronged approaches are required to achieve the results.

The campaign will have the following specific objectives:

- Identify specific communication challenges and the reasons for vaccine hesitancy among the target audience
- Position IMI 4.0 as an opportunity at their closest step to protect children against various VPDs and empower the communities/ caregivers through timely, accurate information about Immunization through credible and acceptable communication channels, as well as information on the Covid Appropriate behaviors and practices.
- Address any misinformation, myths regarding the immunization and motivate the caregivers to avail the services through the integrated approach of interdepartmental and inter-ministerial cooperation and coordination.
- Strengthen the network of regional relevant local influencers/ supporters/ leaders/ media for the immunization programme and create an enabling environment for immunization services.

The target population

- Urban slums, Tribal population, Migrant population
- Population in hard-to-reach areas
- Local Influencers/ leaders/ volunteers and frontline workers

2. Messages to be delivered

Following specific messages will also be delivered to the communities:

Overarching messages of IMI 4.0

- The child/ children must be immunized timely and completely to develop immunity and stay protected against Vaccine Preventable Diseases (VPDs)
- Children need to be provided all vaccines as per immunization schedule which needs to be completed
- Risks of not vaccinating or incomplete vaccination needs to be communicated effectively with a clear understanding of the way the community perceives risks from immunization and vaccines
- Messaging for vaccine-hesitant individuals and families to address specific areas of hesitancy
- Communicating the appeal of RI to return to a state of normalcy will have to be balanced with key messaging emphasizing the critical need of Immunization with following the adequate CAB (Covid Appropriate Behavior).
- Phrasing the continuation of the CAB as the default rather than as additional. For example, "We have to continue following the COVID practices of mask-wearing, social distancing & regular handwashing even with the vaccine, so that it continues to reduce the spread of the virus".
- Underscore the economic and social impact of not vaccinating/value & benefit of vaccinating: collaterals can emphasize a) the high financial cost of not vaccinating, contracting a disease, and paying for treatment in the future b) the chance of impacting mental and physical strength, thereby impacting productivity, resulting in low economic growth and prospects.

3. Activities to be undertaken

All stakeholders in the vaccination of children – Government- Health and other departments, religious and community leaders, community influencers, Civil Society Organizations (CSOs), NGOs will work towards the aim of "NO CHILD LEFT WITHOUT DUE VACCINATION"

Some new activities proposed specifically for IMI 4.0 include:

- **Teeka Mitra Tolis** will be constituted in the villages/urban areas by active involvement of PRIs, ANM, ASHA, AWW.
- **Teekakaran Nigrani Committees** to be constituted with active support of PRIs, Health Department, other relevant Department and other CSOs, NGOs working in the villages/Urban Areas, for tracking the status of immunization of the children with the help of FLWs
- Formation of a **Prachar toli** 3 to 4 days in advance followed by a folk media play a day or two in advance from the actual immunization day highlighting importance of immunization. Prachar toli to be tagged to each session site.

- Celebration of full vaccination status of the village at the Anganwadi centers through festive celebration
- Sharing of success stories, videos of immunized children, their caregivers as 'My tikakaran story' from states shared on print media and social media platforms

Taking forward the learnings from social mobilization and community engagement from COVID - 19, partnerships with CBO-CSO, faith-based groups, networks, professional organizations and associations, youth networks will be leveraged for IMI 4.0. Use of social **media platforms and tools** based on regional need and demand will be a key approach for IMI 4.0 to reach and engage caregivers and their influencers.

Activities in Urban Slums

Key Stakeholders: The key stakeholders in urban slums include Line Ministries,Development Authority, Town & Country (T& C) Planning Department, Housing Board, Slum Clearance Board, Metropolitan Planning Committee, District Planning Committee, District Collector, District level finance committees, Member(s) of Legislative Assembly, District Collector, Municipal Councilors, T&CP Dept., Urban Development Authority (UDA), NGOs, private developers, Banksacademic: technical / research institutions, Ward committee representatives, area welfare societies, municipal councilors, Neighborhood Committees, NGOs, Women Self Help Groups, , etc. These will be approached through targeted communication interventions.

Communication Activities
Organize street plays/folk media/ drum beating/ miking
Engage with local volunteers for Interpersonal communication with families (Nehru Yuva Kendra/NCC/NSS etc.)
Wall writings/ wall paintings/Banners
Engage with communities through interactive games like snakes & ladders, cards with messages, etc.
Use innovative means such as cycle rickshaws for display of key messages on Immunization
Community mobilization and follow up with the active participation of Mahila Arogya Samitis
Use of mobiles (m-health) for communicating with families (wherever applicable/present)
Miking/mobile van/ audio video spots
Drum beaters (Duggi/munadi in urban slums)
Influencer/Ward members/Nigam member/Shopkeepers etc. Many slums may be inhabited by migrating population so labor contractors could also be looped into to motivate and allow labor to vaccinate their children.
Rural ANM adjoining urban pockets may support urban immunization and SBCC efforts as per their existing work schedule.
Constitution of Teekakaran Nigrani Committees

Activities for Tribal Population

Key Stakeholders: The key stakeholders like MoTA/Tribal Research Institutes/ Tribal Department, Key Influencers/ Sarpanch/Village Head/Priest, faith-based leaders, Local/Traditional Healers, Teachers, Eklavya/Ashram schools, etc, will be involved in implementing communication activities at the village level.

Communication Activities
Connect the messages within the cultural context of the tribal community and focus on disseminating such messages through peer-communication methods
Development and performance of folk songs/folk art forms relevant to the tribal community
Advocacy meetings with local traditional healers in tribal areas, engage with and involve them in mobilizing communities on Immunization
Community meetings to promote healthy behaviours among tribal populations through comic characters and cartoons depicting their culture (which are easily accepted among them)
Engage with local CBOs/NGOs/tribal leaders for community mobilization
Involve Tribal Van Dhan Kendra in tribal majority states to mobilize and engage tribal communities
Wall writings/ wall paintings
Miking
Drum beaters (Duggi/munadi)
Constitution of Teekakaran Nigrani Committees

Activities to reach Population in hard-to-reach areas

Communication Activities
Engage with local NGOs for community mobilization
Advocacy meetings with local traditional healers and engage with and involve them in the programme
Utilize community radio (wherever present) and innovative programming for sharing IMI messages
Organize health camps
Organize folk shows/street plays
Miking
Drum beaters (Duggi/munadi)
Engage with local influencers to mobilize families
Constitution of Teekakaran Nigrani Committees

Activities for Migrant Population

Key stakeholders: Apart from Government bodies, key stakeholder to reach out to migrant population include Workplace owners, Placement agencies, Private Medical Practitioners, Money Lenders, Dhaba owner, social and political leaders, police, elected representatives (PRIs), development functionaries, migrants, and youth forums/clubs, mandals, auto drivers' associations and traders' associations (particularly in vegetable and grain mandis, etc.)

Communication Activities
Bus panels/wall writings in relevant languages
Corner meetings where such population gather. (Language of the migrant population to be used)
Auto-rickshaw panels – language versions to be used
Transit kiosks/ canopy
Play RI spots on LED/LCD screens at transit points such as railway stations and bus stops/stations, marketplaces
Engage with local community leaders/ Labour contractors/ informers for mobilizing families
RJ mentions in FM channels in those languages specific to migrant population

4. Monitoring Plan

To be ensured at each level

1. State – MD NHM and SIO and Development partners every week and comprehensive review at the end of each round to better plan next round. (WhatsApp groups of each state of various officials would be activated to monitor the coverage and ensure smooth logistics vaccine supply)
2. Supportive supervision visits by state officials and partners (WHO, UNICEF, ITSU, JSI) to ensure supervision of the communication aspects in the app. using the standard template.
3. Block – CMO with ICDS department and ANMs

For effective monitoring it is also pertinent to ensure that regular and daily data is uploaded and the same is analyzed weekly to track the progress and shared in above monitoring meetings

Communication Matrix

Primary Audience	Messages	Channels/ Supporting IEC (to reach both primary and secondary audience)	Secondary Audience/ Supporting Partners	Innovative Activities
Urban slums Vegetable vendors Migrants working at construction sites Domestic help population Daily wage workers Factory workers	1. In last one year during COVID-19 many families skipped their children immunization putting children at direct risk of many diseases. 2. It's very important to now get every child immunized on priority following CAB 3. All vaccines under IMI 4.0 are free of cost. 4. Contact your nearest health post/ASHA/USHA/ANM/MAS member to learn about child immunization 5. There are 12 different disease which are prevented by child immunization 6. MCP card is very important it needs to be carefully kept till compete immunization i.e., 2 years. 7. Common AEFI and how to tackle them. (If your child is less than 2 years and in last one month has not received any vaccination, contact your nearest health facility for complete immunization.)	**IPC/ Mid media and mass media mix** • Wall writing • Hoarding • Standees • Auto rickshaw banner • Cinema slide • Bus stop panel • Metro panels • Street play at slums areas • Magic show with immunization messages • Rallies by school children • Posters at health facilities	• Neighboring RWA • School Children • Ward/Nigam Members • MoIC from the selected area • ANM/USHA/MAS/ASHA of the selected area • NGOs- One NGO could be assigned few slums • DM/DC/DIO/SIO • Volunteers- NYK, NCC, NSS • Hospitals /facilities where immunization is scheduled • Engaging transgender community through Targeted Intervention (TI) NGOs and SACS to create awareness about child immunization.	Teeka Mitra Tolis/ Change Champions Mobile unit for publicity and IEC distribution ANM with maximum vaccinated children at block level to be awarded cash price. Engage with secondary and primary audience with different innovative games to sensitize them on importance of immunization. Slum with maximum fully immunized children to be awarded by DM /DC in each district after IMI 4.0 completion. Ward or Nigam member of such slum to be facilitated with cash price. A pan India number where anyone can call and check about immunization. What vaccine is due, place of vaccination, common AEFI and how to tackle them.
Tribal population	1. There are 12 different diseases which are prevented by child immunization. 2. Immunization is safe and very effective. 3. Tribal head is supporting this immunization drive. 4. Village head has immunized his children (select such vill. head who have immunized their children) 5. Common AEFI and how to tackle them.	**IPC is the focus** • Folk songs and dance on immunization at weekly /local haats/market place • Culturally appropriate writings on home walls, school building etc. • Drum beating and announcement of immunization sites and dates area wise. • MCP card local language (tribal language) • Wall writing wherever possible	• ANM/MAS/ASHA of the selected area • MoIC of selected area • NGOs in the selected area • Tribal leaders (Head priest/ traditional healers) • Principles, teacher, and students at tribal schools • Tribal youth/adults – educated youth as role model and motivator. • DM/DIO/SIO	Free ration for a week for the tribal community with maximum fully immunized children. Reward for health centre team who has covered maximum tribal children during IMI 4.0

Communication Matrix				
Primary Audience	**Messages**	**Channels/ Supporting IEC (to reach both primary and secondary audience)**	**Secondary Audience/ Supporting Partners**	**Innovative Activities**
Migrant population Slum pockets Construction sites Brick making sites Agricultural Labour settlement area Factory area	1. In last one year during COVID-19 many families skipped their children immunization putting children at direct risk of many diseases. 2. Child immunization today could save family from financial burden in future incurred due to many disease 3. It's very important to now get every child immunized on priority following CAB 4. All vaccines under IMI 4.0 are free of cost. 5. Common AEFI and how to tackle them. 6. Contact your nearest health post/ASHA/USHA/ANM/MAS member to learn about child immunization 7. There are 12 different disease which are prevented by child immunization 8. MCP card is very important it needs to be carefully kept till compete immunization i.e., 2 years.	**IPC and mid media activities** 1. Standees, LCD screen and Banners at railway stations 2. Standee, LCD screen and Banners at Bus stop stations 3. Hoarding at prominent location with high migration transit pollution 4. Banner at specific city locations from where daily wage workers start their day 5. Auto rickshaw banner 6. Cinema slide 7. Wall writing 8. Bus stop panel 9. Metro panels 10. Street play at slums and at specific spots where migrants are working 11. IMI announcement on radio	• Labour Contractor • ANM/MAS/ASHA of the selected area • MoIC of selected area • NGOs in the selected area • Factory owners • DC/DM • DIO/SIO	Free bus or train ticket /pass for home town for next 6 months for families who have completed scheduled immunization and also have MCP card well kept. Free ration for a month for families with complete child immunization. One day extra wage for the parents taking their children for immunization. Fruit distribution at immunization sites for the parents coming with their children.
Hard to reach population Difficult terrain Tribal area Hilly area Naxalites effected area	1. In last one year during COVID-19 many families skipped their children immunization putting children at direct risk of many diseases. 2. Child immunization today could save family from financial burden in future incurred due to many disease 3. It's very important to get every child immunized on priority following CAB 4. All vaccines under IMI 4.0 are free of cost. 5. Common AEFI and how to tackle them. 6. Contact your nearest health post/ASHA/USHA/ANM/MAS member to learn about child immunization 7. There are 12 different disease which are prevented by child immunization 8. MCP card is very important so it needs to be carefully kept till compete immunization i.e., 2 years and thereafter as a record.	**IPC is the focus. Use technology if connectivity is good.** Street plays using local teams and culturally appropriate script 1. Wall writing by local artists 2. IMI 4.0 announcement in local print and electronic media. 3. IEC van 4. Drum beating and miking specific dates and place for immunization. 5. IMI announcement on radio	• ANM/MAS/ASHA of the selected area • MoIC of selected area • NGOs in the selected area • Tribal Leaders • Churches /other religious institutions • DM/DC • DIO/SIO	Cash or kind reward for caregivers participating and getting their children immunized in IMI 4.0 and also motivating community positively for immunization.

Chapter-9: Vaccine and logistics - supply chain management

Vaccine and cold chain management are critical components of ensuring the quality of vaccines. For IMI 4.0, the following activities are to be prioritized for effective vaccine and cold chain management:

1. District level:

a) Adequate vaccine supplies are available in stock, based on the target beneficiaries and allowable wastage rates of individual vaccines.
b) The Cold Chain Technician (CCT) should undertake an assessment of Cold Chain Equipment (CCE) functionality across all Cold Chain Points (CCPs) in the district and ensure repair or replacement of non-functional CCE.
c) Regular monitoring of stock position across all CCPs in eVIN, with the supply of vaccines to ensure adequate stock across all CCPs.
d) Ensure availability of all immunization logistics including syringes, hub cutters, waste disposal equipment, tally sheets, etc. in all CCPs

2. CCP level:

a) Timely indent of vaccines based on HCS and session plan.
b) Ensure that adequate vaccine stocks are available in time for each round.
c) Monitor the vaccine storage temperature and ensure immediate information to the district in case of non-functioning of CCE
d) Monitor and ensure the daily entry of issue and return of vaccines in eVIN
e) Ensure availability of adequate numbers of AVD volunteers for vaccine transport to session sites

3. Session site level:

a) Ensure receipt of adequate number of vaccine vials required for the session through alternate vaccine delivery system (AVDS).
b) Keep the vaccine carrier in a shaded place away from direct sunlight and open only while taking out vaccines.
c) Follow the SOPs on placing of opened vaccine vials either on or near the ice pack or on the table.
d) Cut the needle hub immediately after each injection and dispose appropriately.
e) Ensure return of all vaccines to the CCP through AVDS after the session.

Chapter-10: Monitoring and evaluation

The monitoring and evaluation component is key to ensuring effective planning, preparations and implementation of activity guided by the relevant and objective indicators.

Accountability framework at the state, district and corporation implemented through the Task Force for Immunization (STFI/DTFI/CTFI). The task forces are usually held at monthly intervals while closer to the start of IMI activity, DTFI/CTFI could be held weekly to closely track the preparedness and resolve bottle necks if any for smooth implementation of the activity.

1. Readiness Assessment checklist

A team of officials from MoHFW and with technical officers from immunization partners will visit selected districts/state for objectively assessing the readiness for IMI. The checklist will cover thematic areas on planning and coordination, capacity building (training), communication plan implementation, microplanning of sessions, human resource availability, vaccine/logistic availability, and distribution, AEFI management preparations and supportive supervision/monitoring plan.

Based on the observations on preparedness, a district if not well prepared will not be permitted to start IMI activity unless adequate level of preparation has been met.

2. Monitoring of operations

The IMI activity will be monitored at the session site for all processes required for safe and effective vaccination, and in the community for completeness of vaccination for all vaccines in use under UIP. The monitoring will be done through questionnaires on paper format/ODK based application. There are two ODK applications namely Immunization Monitoring and Analysis Software (IMAS) developed by WHO NPSP and Supportive Supervision Tool (S4 Tool) developed by NCCVMRC and UNICEF.

The Medical Officers from Government Public Health system and from Medical Colleges are encouraged to monitor the activity both at the session and in the community. Representatives from various Immunization partners are also encouraged to undertake monitoring along with your trained hired monitors.

If monitoring is done on paper-based format, ensure data is entered in the ODK application same day.

3. Session monitoring *(Refer Annexure 3 for session monitoring formats)*

The session monitoring tool captures information on session being held, reason if not held, area/session profile, high risk profile, availability of vaccine/other logistics, headcount survey and due list availability and whether it is updated for and being updated on session day, implementation of open vial policy, safe injection practices, reason why IMI session is planned, implementation of Covid-19 appropriate behavior by the vaccinator/mobilizer and caregiver, communication aspects like ANM passing key messages, IEC display, intersectoral convergence and mobilization support at the site, No. of days ANM being utilized in IMI, ANM belonging to same sub center area or have been mobilized and if yes for how many days, awareness of ANM/ASHA/AWW on incentive.

Monitor should follow the standard operating procedure for session monitoring. Medical Officer to develop a supportive supervision/monitoring plan involving medical officers/supervisory staff to priority areas with high burden of missed children, areas with migratory setting and vaccine hesitancy.

Key session indicators

- % IMI Sessions found being held of the total planned sessions
- % Session with IEC display
- % Sessions where supervisor has visited at least once
- % Sessions with updated due list
- % Sessions with all vaccine/diluents available for full immunization
- % Sessions where RVV, PCV, Td and IPV available
- % Sessions where ASHA/AWW/Link worker found working
- % Sessions with partially used vials supplied
- % Sessions with vials marked date/time of opening
- % Sessions where BCG, MR, JE (where applicable) found being used within 4 hours of opening
- % Sessions where ANM providing 4 key messages to the caregiver
- % Sessions with AEFI/Anaphylaxis kit
- % Sessions with adrenaline injection within expiry date
- % Sessions where both vaccinator and mobilizer found wearing face mask/face cover
- % Sessions with hand washing facility
- % Sessions where vaccinator washing hands while preparing for vaccination for all/some beneficiaries
- % Sessions where ANM doesn't have session wise roster plan (Rural/Urban)
- % Sessions with ANM engaged for 1-3 days only, 4 to 6 days only, 7 or more days (Rural/Urban)
- % NUHM sessions with Mahila Arogya Samitee (MAS) constituted
- % NUHM sessions with Mahila Arogya Samitee (MAS) engaged

4. House to house monitoring *(Refer Annexure 3 for H-H monitoring formats)*

The community level monitoring should be done in areas where planned IMI session has already been conducted.

The house-to-house monitoring tool captures information on area/risk profile, high risk profile, migratory/non migratory setting, reason for monitoring, children due for vaccine dose during IMI, received all/some/none of due vaccine dose, if received all due doses whether child received all age specific vaccines as per UIP schedule, and if received some/none reason for missing due IMI vaccine dose.

Key house to house monitoring indicators

- % children due for at least one vaccine due during IMI
- % Children received all / some /none of due vaccine dose
- % Children received vaccine for first time in life
- % Children completed age specific vaccination as per UIP schedule
- % Children 12-23 months achieved full immunization (1st year vaccines for FI)
- % Children above 2 years found fully immunized
- % Children above 2 years found vaccinated with MRCV2/DPT booster1/DPT booster2/OPV booster
- % Areas with 2 or more children missed one/all of the due vaccine doses
- % Reasons for child missing due IMI vaccine dose – below 1 year, 12-23 months
- No. of pregnant women vaccinated with Td
- No. of pregnant women who received2nd dose or booster of Td vaccine.

- No. Of districts where entries completed on RCH portal
- No. of new registration done
    - Children
    - Pregnant women

Chapter-11: Areas of support from other ministries / departments and Role of partners

The coordination with other ministries/departments is essential to get their support in the operational issues and challenges in social mobilization. The partner agencies and other stakeholders play a significant role in strengthening RI system.

	Role & Support of Ministries / Department and Partners	
1.	Housing & Urban Affairs	• Involvement of Self-Help groups under National Urban Livelihood Mission • increase awareness on immunization in urban areas • Complete involvement of urban local bodies to support immunization • Ownership by Municipal Commissioners of the Intensified Mission Indradhanush • Specific directions to big municipal corporations for involvement in campaign • Identification of nodal persons from urban local bodies for convergence with health department for immunization • Involvement of Zila Preraks under Swachh Bharat Mission for generating awareness on immunization • Identifying and encouraging involvement of local CSOs • Regular review by the District /City Task Force for Urban Immunization
2.	Information & Broadcasting	• Involvement of MoI & B in the development of communication strategies • Support in wide dissemination of IEC material pertaining to immunization • Coordination with Indian Broadcasting Federation, Private Radio channels and explore areas of support including CSR for private FM channels
3.	Labour & Employment	• Sharing the data of migrant population and temporary labors in the district • Support in mobilizing resistant families for vaccination • Support in IEC activities
4.	Minority Affairs	• Generating awareness on immunization in minority communities and their mobilization to ensure full coverage of all children • Inclusion of immunization details in the pre-matric scholarship forms
5.	Panchayati Raj	• Conduct community meetings for awareness on importance of immunization • Proactive involvement in communication strategies for the area • Co-ordination and supporting health department in mobilization of beneficiaries and influencing the resistant families • Review of RI activities in the area during meetings of Gram Sabha & Zila Parishads
6.	Tribal welfare	• Support in planning for IMI session in tribal areas • Social awareness and mobilization • Identifying key influencers
7.	Women & Child Development	• Sharing of data on beneficiaries with ANM/ASHA • AWW to support conducting head count surveys and assist in micro-plan development • Extra support needed from AWW in urban or other areas with no ASHAs • IPC with pregnant women for TT vaccination and child vaccination • Monitoring of AWWs by CDPOs and DPOs
8.	Youth Affairs and Sports	• Involvement of Nehru Yuva Kendra (NYK) and National Service Scheme (NSS) for generating awareness and mobilization of beneficiaries • Social mobilization & Mobilize families resistant/reluctant for vaccination

9.	Education	• Support in providing planning for IMI sessions in schools • Community awareness through schoolteachers and shiksha mitra • Support in mobilizing resistant families • Social awareness and support in communication activities
10.	Medical colleges and Nursing schools:	• The medical colleges will be engaged to conduct assessments, reviews, monitoring, and training. The staff may should be identified from medical colleges and trained to create a pool of master trainers for conducting MO and Health worker trainings • The trained staff from Nursing colleges/ANM training centers should be engaged to support immunization sessions where required • The identified officials will also monitor the various activities related to IMI.
11.	Professional bodies and CSOs	• Key state and local bodies such as IMA, IAP and CSOs should be actively involved. in critical role in awareness generation and advocacy, particularly at the local level. Participate in district and state level meetings • State and local bodies such as IMA, IAP and civil society bodies will be approached for seeking support in information dissemination and advocacy at various levels • IMA/IAP will support in creating awareness about full immunization and complete immunization. Support letters for promotion of intensified Mission Indradhanush Strategy" at various conferences conducted by them.
12.	WHO (NPSP)	• Facilitate in mapping partners, Risk prioritization • Facilitate preparatory meetings at district and blocks for developing micro plan • Develop training materials and build capacity of district trainers • Develop monitoring tools for session and house to house monitoring and accordingly modify/update the Immunization Monitoring and Analysis Software (IMAS). • Monitoring of headcount survey, micro planning, and implementation • Provide monitoring feedback during Task Force and review meetings at district, state at national level • Share daily monitoring feedback during campaign at all levels and final consolidated feedback at the end of each round
13.	UNICEF	• Support state, districts and blocks for social mobilization activities, dissemination of information and their monitoring through its social mobilization network • Provide supportive supervision for cold chain and vaccine management using standardized checklists and sharing feedback at the national, state and district levels • Participate as resource persons in training of health personnel at state and district levels • Monitoring of head-count surveys in districts • UNICEF will work collaboratively with Immunization Technical Support Unit (ITSU) to develop the dissemination plan for Intensified Mission Indradhanush at the national, state, district, and block levels
14.	ITSU	• ITSU will coordinate with state to facilitate data flow for IMI 4.0 activities, will collate and analyze data at national level • Strategic communication unit of ITSU will take a lead on communication plan activities. ITSU will formalize the communication plan with inputs and support from UNICEF, Rotary, Global Health Strategies, and other partners
15.	UNDP	• Support state, districts, and blocks for microplanning, including cold chain and vaccine logistics planning • Review of IMI micro plans in priority blocks/urban cities • Monitoring of head-count surveys in districts • Independent monitoring of IMI activities to identify issues • Monitoring of timely entries in eVIN for vaccine and logistics planning.

		• Attend regular debriefing meetings at planning unit and district level
16.	JSI	• Support state, districts, and blocks for microplanning, including cold chain and vaccine logistics planning • Monitoring of head-count surveys in districts • Independent monitoring of IMI activities for identification of issues • Attend regular debriefing meetings at planning unit and district level
17.	Jhpiego	• To provide technical support in planning and implementation of communication activities for IMI • To support in monitoring of IMI activities • Support in trainings for IMI
18.	USAID	• Coordinate with implementation partners to ensure their engagement in demand generation and communication activities specially in urban areas.
19.	Professional bodies and CSOs	• Key state and local bodies such as IMA, IAP and CSOs should be actively involved. in critical role in awareness generation and advocacy, particularly at the local level. Participate in district and state level meetings • State and local bodies such as IMA, IAP and civil society bodies will be approached for seeking support in information dissemination and advocacy at various levels • IMA/IAP will support in creating awareness about full immunization and complete immunization. Support letters for promotion of intensified Mission Indradhanush Strategy" at various conferences conducted by them.
20.	Lead partners for call to action (RMNCH+A)	• The RMNCH+A state lead partners will assist with implementation of strategies to strengthen the intensified Mission Indradhanush (IMI 4.0) in selected high-focus districts • Support monitoring of immunization drives and share feedback at block, district, and state levels • Coordinate with partners on any critical support required by the state/STFI

Chapter-12: State level activities and responsibilities

1. Steering committee meeting:

At least one meeting is convened for the members of steering committee at the state level during the preparatory stage. The steering committee ensures,

- Accountability framework through state, district, and block level task force meetings for IMI-4.0
- active involvement of other non-health departments in support of human resource mobilization, communication activities and social mobilization
- regular review of programme during preparation and implementation

Chairperson	Convener	Members
Chief secretary	Principal secretary (Health)	**Government Departments:** Health, Women and Child Development, (WCD), Panchayati Raj, Minority Affairs, Human Resource Development (HRD), Information and Broadcasting, Urban Affairs, Housing and Urban Poverty Alleviation, Defense, Home Affairs, Youth Affairs and Sports, Railways, Labour and Employment, Tribal Affairs, Rural Development, Drinking water and Sanitation and any other relevant departments. **Development partners:** WHO, UNICEF, UNDP, JSI, Rotary International, CORE, BMJF, IPE Global and other partners supporting RI in the state

2. Sensitization of District Magistrates

The Principal secretary (Health) and Mission Director (NHM) may sensitize and provide necessary directions to all concerned district magistrates about the mission through video conferencing. The guidelines and necessary directions are communicated to all the district administrations.

A review on preparedness before the mission starts and performance review following each round through video conferencing are ensured to strengthen Immunization.

3. State Task Force for Immunization:

Chairperson	Co-Chair	Members
Principle secretary (Health)	Mission Director	**Member secretary:** State Immunization Officer (SIO) **Members:** Key departments, partner agencies, CSOs, religious leaders.

The state Task Force meeting for Immunization is key role for successful launch of program ensuring maximum coverage and the quality of services at all level. At least one STFI is conducted at each month during the preparatory phase and one in between each round.

The STFI reviews,

- district framework of accountability in IMI districts; DTFI and coordination with other departments
- intersectoral coordination at state and district level

- deployment of state level health officials in each of the districts to ensure accountability, assess preparedness, and oversee the activities
- status of micro planning, stock and supply of vaccines and logistics, human resource, training/workshop
- communication strategy and ensures IEC in local language and media dissemination
- fund approval, receipt, and disbursement of funds up to the ground level
- additional fund requirement for supervision, mobility of vaccinators and mobilizers to non-resident blocks, vehicles for mobile vaccination teams, need based hiring of vaccinators in rural and urban areas/vacant sub-centers.
- plan for a meeting through video conferencing with concerned Chief medical officers (CMO), District Immunization Officers (DIO), Block Medical Officer In charge (MOiC) to review the preparedness status, identify bottle necks and resolve issues

4. State level workshop/meetings:

The state conduct workshop to train master trainers on IMI 4.0; micro planning including head count survey, due list preparation, social mobilization, communication activities, vaccine and logistics supply chain management, supervision, interdepartmental coordination, documentation and reporting and financial assistance. The timeline is shared to conduct ground-level training.

Training of Trainers for Medical officers – IMI 2022

Objective: to train the master trainers who can train and orient the district level health officials,

Participants	Facilitators	Duration	Timeline
DIO & one MO / district training officer from each district, **State:** State program manager (NHM), state IEC consultant, state ASHA Coordinators, State NHM - Cold Chain Officer, Data manager, M&E coordinator, Finance & account accounts manager, **Partners:** WHO India, UNICEF, UNDP, and others	National level officers, State Immunization Officer (SIO), **Partners:** WHO India, UNICEF, UNDP, and others	1 day	4-6 weeks prior to IMI

Media sensitization workshop – IMI 2022

Objective: to sensitize media person, media coverage, demand generation, and to resolve their queries.

Participants	Facilitators	Duration	Timeline
Media persons	**Chair:** principal secretary **Co-Chair:** MD NHM, **Facilitators:** SIO with support from UNICEF, UNDP, WHO India, Rotary International, state IEC consultant and media officer,	Half day	2-3 weeks prior to IMI and between the rounds

5. Communication activities

Ensure that a comprehensive SBCC action plan is in place at state level well in advance with clear cut demarcation of specific IEC /BCC activities to be conducted before and during IMI 4.0 at state, district, block, and village level. The state steering committee also need to ensure that there are sufficient and skilled human resources available at each level to plan and timely execute communication activities. It is equally important to have relevant and effective IEC materials designed and printed in advance for key program audiences as per the SBCC action plan and ensure their availability at each level before

actual onset of IMI 4.0. Program manager at state level also needs to ensure that all the stakeholders like 3A, NGO functionaries, development partners and key officials of different ministries are well oriented on specific activities and their respective role and IEC material to facilitate these activities.

Behavioral Insight - Ready Reckoner

A simple tool wherein all the myths and misconceptions prevalent in the state leading to VH should be listed and against each such reason health workers response should be narrated. This explanation should be based on facts and figures and specific advantages of immunization. Relevant quotes from religious books should also be taken and highlighted wherever required.

To develop this RR documentation work should start at very grass root level. Each MoIC should conduct orientation session with their respective 3A where these challenges and BIs should be enlisted and with the engagement of IEC officials and development partners suitable replies must be proposed as mentioned above.

List of Influencers /Motivators/Volunteers

Ensure that a comprehensive list of all influencers is in place as per the vaccination sites finalized for IMI 4.0. Hard to reach areas and resistant populations should be periodized while developing this list. All the influencers in the list must be well oriented about the immunization schedule, vaccine specific benefits and common side effects, how to manage side effects, in case of serious side effects whom to reach. They must also be oriented and sensitized that COVID-19 has adversely effected RI program in our country and many children have missed their routine immunization as a result they are prone to many diseases therefore, it is very important that every child must be immunized as per his/her schedule following covid appropriate behavior. (social distancing, mask, hand wash)

Social Mobilization

There should be Village level social mobilization plan highlighting how ANM/ASHA/AWW would mobilize community using PRI, local influencers, religious leaders, MAS, and other volunteers. This plan must be consolidated at block level and relevant block level stakeholders must be added to the plan with clear cut direction about how to engage these people and institution, frequency of engagement and channels of engagement. Similarly, district and state social mobilization plan should be developed and executed well in advance to ensure that we have maximum participation on the day on immunization session.

Media Engagement

To build overall positive and supportive environment for IMI 4.0, a well-designed media engagement plan must be put in place with the effective utilization of print and electronic media. Famous electronic TV and Film industry personalities, political personalities, famous people from medical fraternity should be involved for positive messaging around RI even considering COVID-19 situations following CAB. Social media plan should also be carefully designed and executed at national and state level with positive messaging and timely addressing any myth or misconception. Media engagement should be carefully planned between national and state level so that they complement each other and support and intensify each other's coverage and frequency of engagement.

6. Daily review meetings at state level during IMI

The state Immunization Officer reviews the performance of districts daily during IMI. The state level officers and partners analyze the coverage and monitoring data, and feedback from state observers and other stakeholders. The SEPIO sends necessary communication to DIOs to take corrective measures.

7. State level mid review meeting – IMI- 4.0

Objective: to review overall performance, identify poor performers and bottle necks, and plan for actions for improvements in the upcoming round.

Participants	Facilitators	Duration	Timeline
Review of districts conducting IMI	**Chair:** Principal secretary **Co-Chair:** MD NHM **Facilitator:** SIO with support of WHO India, UNICEF, UNDP, Rotary International	Half a Day	Before start of IMI and in between rounds

Chapter-13: District level activities and responsibilities

The district level activities are key for successful implementation of IMI in the district. The district Immunization officer is the nodal person for IMI 2022 in a district. The following preparatory activities are carried out in the district before IMI.

1. Meeting of District Task force for Immunization (DTFI)

The District Task Force for Immunization meets at least twice before IMI 2022 and once between rounds. The DTFI meeting helps to sensitize the stake holders, plan, review the progress, strengthen interdepartmental coordination, identify the bottle necks, and resolve the issues.

Chairperson: District magistrate / collector

Member secretary: District Immunization Officer

Responsibility: CS / Chief Medical Officer

Members: DDO/CDO, CMS from district hospital, District coordinator/nodal officer NHM/NUHM, DPO, DEO, Project Director DRDA, DPRO, MOiC, District Entertainment officer, minority community leader, IMA/IAP, representative from civil society organization, representation from WHO, UNICEF and other partners

DTFI discuss and review,

- Operational constraints and communication challenges
- Quality of headcount survey and target estimation
- Support required for additional manpower for headcount survey, social mobilization, supervision form other departments
- Review the preparedness, performance in between rounds

2. Meeting of District Task force for Urban Immunization -DTFU (I)

The District Task Force for Urban Immunization constituted in each district/city critically review the Immunization progress, identify gaps, and decide strategic actions to improve RI coverage. The DTFU meets at least twice before IMI 2022 and once between rounds. DTFU (I) meeting is highly important to rectify operational constraints and meet communication challenges.

Chairperson: District magistrate / collector

Member secretary: District Medical and Health Officer/CMO

Members: Municipal Commissioner, DIO, District coordinator/nodal officer NUHM, Medical superintendent from district hospital, District Development Officer, District Education Officer, District Project Officer ICDS, District Public Relation Officer, Municipal Health Officer,

Objective:

The objective of the meeting is to discuss and review,

- Manpower shortage for headcount survey, vaccination, mobilization, supervision,

- Communication challenges in urban especially HRAs
- Support required for mobility, supply chain management
- Support required from administration and another department
- Financial constraints
- Review the progress in preparation for IMI
- To discuss on any other issues in IMI implementation

3. District review committee:

The District Immunization Officer convenes a district review committee headed by CMO/CS. The members include nodal officers, district officials of key departments, representatives of district level partners, and CSOs. The committee is responsible overall implementation of IMI 2022 in the district and carryout decisions taken in DTFI meeting. The major role is to,

- Review micro plan, finalize areas to be covered under IMI, rationalize involvement of health workers among blocks and urban areas,
- Develop communication strategy, ensures timely availability of IEC material, review communication plan
- Ensures timely availability of reporting formats, timely reporting to state through IMI 2022 portal,
- Monitor vaccine and logistics supply chain and cold chain management and ensure that, eVIN is timely updated
- Availability and distribution of funds and logistics

4. District workshop

The DIO will prepare a training calendar in consensus with nodal officers. The schedule includes training of medical officers, data entry operators, cold chain handlers, program and accounts manager, and media person.

Training of medical officers – IMI 2022

Objective: the participants trained facilitate training of front-line health workers and other block health officials, sensitize officials from other key departments at the block.

Participants	Facilitators	Duration	Timeline
Two per block / urban planning unit (MOiC and one MO) District Program Manager (NHM), district IEC consultant, district ASHA coordinator, district cold chain handler, district data manager, district M&E coordinator (NHM), district accounts manager (NHM)	DIO, Master trainer (MO/District training officer), Master trainers from partner agencies	One day	4-6 weeks prior to IMI

Training of Program / Accounts managers – IMI 2022

Objective: to train and orient on IMI financial guideline, timeliness

Participants	Facilitators	Duration	Timeline
Block program and accounts managers and other officials handling funds from NHM	DIO, District Program Manager, Master trainer (MO/District training officer), partner agencies	One hour	4 weeks prior to IMI

Training of Data Handlers – IMI 2022

Objective: to train on IMI data collection, reporting, timeliness

Participants	Facilitators	Duration	Timeline
Data handler one per block/urban unit	DIO, District Data Manager, District M&E Manager, Master trainer (MO/District training officer) and partner agencies	Half a day	4 weeks prior to IMI

Training of cold chain handlers – IMI 2022

Objective: to train on vaccine and logistics requirement, cold chain handling, vaccine supply and documentation and reporting through eVIN

Participants	Facilitators	Duration	Timeline
Vaccine and cold chain handlers at least two per cold chain point	DIO, District Cold Chain Handler, Master trainer (MO/District training officer), partner	Half a day	2-3 weeks prior to IMI

Media workshop – IMI 2022

Objective: to orient the media person about IMI, the importance and benefits of vaccination, demand generation, and clarifying their queries

Participants	Facilitators	Duration	Timeline
Representatives / reporters from media (print / electronic)	DIO and District IEC consultant, media officer along with CMO/CS with the support of partners from WHO, UNICEF, UNDP, Rotary International. The district magistrate chairs the meeting.	Half a day	2 weeks prior to IMI and between rounds

5. Monitoring and Supervision

The state level monitor assigned for the district will monitor the preparedness and during implementation. The district will assign nodal officer for each block and urban unit. The block/urban nodal officer will monitor the quality of headcount survey, micro plan, and due list status. The partners will also monitor the training quality, headcount survey, communication activities, and the quality and completeness of micro plan. The feedback will be shared with District Review Committee for corrective actions

During IMI, the block/urban nodal officer will do session monitoring/supportive supervision daily. The partners (WHO-NPSP, UNICEF) will do session monitoring as well as community survey daily.

6. Daily review meeting

Chairperson: CMO/CS and **Convener:** DIO

Participants: nodal officers for block, urban nodal officer, any other district level supervisors, partners. Invite other departments depending on the need.

Objective:

The nodal officers/supervisors and monitors share their feedback. Any feedback given by the MoIC also taken for discussion. The meeting should include discussion on,

- **Daily coverage:** target vs coverage, antigen wise coverage to identify poor performing blocks/urban units
- **Completeness:** session planned vs held, data received from all the sessions/blocks, data entry in IMI portal and Google portal
- **Timeliness:** timeliness in vaccine and logistics distribution, timeline followed in beginning and end of session, reporting in Google sheet and IMI portal
- **Shortages:** vaccine and logistic shortage, IEC materials, manpower
- **Stock:** review the stocks available at each block for upcoming IMI sessions
- **Cold chain maintenance:** conditioning of ice packs, issues related to ILR/Deep freezer, AVD system delivery
- **Supervision:** session site supervision by district and block level supervisors and supervisory checklist shared
- **Quality of IMI:** social mobilization, due list completeness, safe injection practices, Covid appropriate behavior, four key message delivery, availability of all vaccines and logistics, etc.
- **Communication activities:** the IEC materials displayed in the field, community activities in the field
- **Interdepartmental coordination:** the support received or required from other departments
- **Community level survey:** the areas more than 2 missed children received some/no vaccines on IMI day
- **AEFI:** any AEFI reported from the field or in media

Expected output:

- Minutes of meeting prepared and discussion points shared with all blocks/urban units
- Based on discussions, necessary letter/communication shared with MoIC
- Gaps identified are rectifies and action taken report prepared and documented

7. Communication activities

Advocacy: utilize DTFI/CTFUI and advocate stakeholders and officials from supportive departments.

Orientation: conduct an orientation meeting for CSO partners, religious leaders and community influencers and get their support, media person

Capacity building of block/urban staffs on communication

Social media: utilize social media like What's App, Facebook, Twitter for sharing IMI related messages/posters/videos

IEC materials: Ensure IEC materials are received/printed and timely distributed, plan for hoardings/ posters for visibility.

Media coverage: use all media including electronic media, local radio/FM channels, Television

Chapter-14: Block level Activities and responsibilities

The block Medical Officer should take the lead in planning and implementation of the mission. The BMO is trained at the district level and receives necessary communication from DIO and the block nodal officer. The major activities at the block are: Block and Tehsil Task force meetings, City Task force on Urban Immunization meeting, Planning meeting for IMI – 2022, Training of front-line health workers, Headcount survey, Due list preparation, Micro plan preparing, Block level compilation and review of micro plan, Communication activities, Vaccine, logistics supply chain management, Conduct IMI session, Documentation and reporting, and Review of data.

1. Block Task Force (BTF) and Tehsil Task Force (TTF) meetings

Chairperson: BDO

Member secretary: Block Medical Officer In-charge

Members: ACMO/Dy CMO, Block educational officer, CDPO from ICDS dept, Representative of WHO, Representative of UNICEF,

Objective:

- To sensitize/orient all the stakeholders
- To get administrative support to resolve issues
- Get support from other departments and strengthen coordination
- Review the progress
- Discuss on communication challenges and plan for activities

2. City Task Force on Urban Immunization Meeting

City Task Force is constituted for Metro Cities where Urban Local Bodies are the implementing authority for NUHM

Chairperson: Mayor

Member secretary: Municipal Health Officer

Members: Municipal Commissioner, Chief Medical and Health Officer, DIO, Medical Superintendent from District Hospital, District Development Officer, District Coordinator/Nodal officer NUHM, District Project Officer ICDS, District Education Officer, Project Director DRDA, District Public Relation Officer, Representatives from WHO India (NPSP), and UNICEF (If available)

Objective:

- Risk prioritization to identify wards, assign senior district level officials to high priority wards/areas needing immediate intervention
- Ensure supervision and monitoring mechanism
- Ensure contingency plan for vacant areas
- Decide specific and appropriate timebound action
- Review HR allocation, fund utilization, training status, vaccine, and logistics supply chain management
- Ensures communication plan is prepared and implemented

- Create platform for coordination with all stakeholders and develop innovative solutions to identified obstacles

3. Planning meeting for IMI – 2022

The MOiC conducts a meeting within 2 days of district level training in their respective PHC. The nodal officer of concerned block/urban provide overall guidance and support the meeting.

Objective: to plan for activities and timeline, define roles and responsibility, understand bottle necks, and

Participants: medical officer from PHC, Block program manager, data entry operator, admin and finance manager, cold chain handler, Health education officer, supervisors and other staffs involved in Immunization along with partners.

Points to discuss:

- Gaps in RI and surveillance based on HMIS, monitoring data, VPD surveillance data
- High risk areas and areas that needs more focus
- HR availability to conduct headcount survey and micro plan preparation and the alternatives to conduct
- Gaps identified in the last IMI
- Roles and responsibilities of each staffs
- Timeline for training, BTF, headcount survey, micro plan preparation
- Communication challenges and plan for demand generation
- Other issues specific to the block/urban units

Expected output:

Meeting minutes are prepared and shared with DIO

- A plan of action with timeline is prepared and shared with DIO
- Listing of all the villages/ mohallas/ areas done and manpower assigned for headcount survey
- Training schedule done and communications shared with participants

4. Training of health care workers:

Objective: the participants are trained on headcount survey, micro plan preparation, duelist preparation, safe injection practices, communication, documentation, and reporting.

Training of vaccinators:

Participants	Facilitators	Duration	Timeline
ANM / any other health staff designated for vaccination/hired vaccinators	Block/urban medical officer and MO trained at district, HEO, BPM, DEO/ Admin & Finance Officer, and partners	4 hours	Within 3- 5 days following district workshop
ASHA supervisor and ASHA/AWW/Link workers	BMO/MO, HEO, BCPM, Admin & Finance officer and partners	2 hours	

Expected output:

- All the health care workers are trained, and catch-up session planned for the absentees

- Training attendance is shared with district
- The health care workers are trained on head count survey, micro planning, and other key topics

5. Supportive Supervision

Supportive supervision is an important activity for successful implementation of IMI. It is a process of guiding the field staffs to improve their work performance, identify the gaps and plan for solution.

- The MoIC is responsible to assign supervisors to all the session sites.
- The supervisors can be, MOs (including AYUSH), health supervisors, ICDS supervisors, block program managers, any other health staffs related to RI, Immunization field volunteers, etc. The supervisors are trained and oriented on IMI and supervisory plan is shared on time.
- In the block especially in urban, where there is manpower constraint, administrative support is sought at DTFI/DTFUI/BTF/CTFI for additional manpower.
- Preparatory phase: Headcount survey should be closely monitored. Special attention is needed in the high priority areas. Due list preparation and micro plan preparation at the sub-center also needs supervision
- During IMI: supervision is done at all the sites, moving independently with additional vaccines and logistics if required to replace at the session sites

6. Daily review meeting

The MoIC/Urban nodal officer conduct meeting daily during the IMI days. The supervisors, monitors, partners join the meeting and share their observations. The objective of the meeting is to identify the gaps and mid-course correction. The meeting should discuss on,

- Cold chain, vaccine, and logistics supply chain
- Quality of due list, social mobilization, and communication activities
- Safe injection practices, Covid appropriate behavior
- Documentation and reporting
- Vaccine hesitancy, turnout of beneficiaries
- Issues in high priority areas

7. Communication activities

Communication activities are important at all the levels. The micro plan includes a plan for communication.

- **Advocacy & Sensitization:** advocate the stakeholders (Block level administrative, ICDS, Education, and others)
- **Capacity building** of ANM, and ASHA, AWW and Link worker on communication
- **Social messaging:** sharing of IEC materials (Poster, messages, videos) through social media
- **Social mobilization:** plan and conduct Mother's meeting, community/Influencers meeting, VHSNC meeting for IMI, Rallies, Mosque/temple announcement, IPC session, miking, and others
- **IEC materials:** use IEC materials like posters, leaflets, etc.

Annexures -1: Immunization schedule

Vaccine	When to give	Dose	Route	Site
BCG	At birth or as early as possible till one year of age	0.1ml (0.05ml till 1 month)	Intra-dermal	Left Upper Arm
Hepatitis B – birth dose	At birth or as early as possible within 24 hours	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral
bOPV 1,2 & 3	At 6, 10 & 14 weeks (can give up to 5 years of age)	2 drops	Oral	Mouth
Pentavalent 1,2 & 3	At 6, 10 & 14 weeks (can give up to 1 year of age)	0.5 ml	Intra-muscular	Antero-lateral side of Lt mid-thigh
Rota Virus Vaccine 1,2, 3	At 6, 10 & 14 weeks (can give up to 1 year of age)	Rotavac: 5 drops (liquid vaccine) Rotasil lyophilized vaccine- 2.5 ml Rotasil Liquid- 2ml	Oral	Mouth
f-IPV 1 & 2	At 6 & 14 weeks (can give up to 1 year of age)	0.1 ml	Intra-dermal	Rt Upper Arm
PCV 1,2 & Booster	At 6, 14 weeks & Booster at 9 months age (can give up to 1 year of age)	0.5 ml	Intra-muscular	Antero-lateral side of Rt mid-thigh
Measles / MR (1st dose)	9 completed months to 12 months. (can give up to 5 yrs. age)	0.5 ml	Sub-cutaneous	Rt upper Arm
JE* (1st dose)	9 completed months-12 months (can give up to 15 year of age)	0.5 ml	Intra-muscular	Antero-lateral side of Lt mid-thigh
Vitamin A (1st dose)	At 9 months with Measles	1 ml (1 lakh IU)	Oral	Oral
DPT booster 1	16-24 months (DPT can be given up to 7 yrs. of age)	0.5 ml	Intra-muscular	Antero-lateral side of Lt mid-thigh
Measles / MR 2nd dose	16-24 months	0.5 ml	Sub-cutaneous	Rt upper Arm
OPV Booster	16-24 months	2 drops	Oral	Oral
JE -2nd dose	16-24 months	0.5 ml	Intra-muscular	Antero-lateral side of Lt mid-thigh
Vitamin A (2nd to 9th dose)	16 months with MR 2nd, Then, one dose every 6 months up to 5 yrs. of age.	2 ml (2 lakh IU)	Oral	Oral
DPT Booster-2	5-6 years	0.5 ml.	Intra-muscular	Upper Arm
Td	10 yrs. and 16 yrs.	0.5 ml.	Intra-muscular	Upper Arm

Annexures -2: List of 374 districts prioritized for IMI- 2021

Annexure- 2A: List of districts prioritized based on composite indicators			
S. NO.	State	No. Of Districts	Districts
1.	A&N Islands	1	Nicobars
2.	Andhra Pradesh	13	East Godavari, Vizianagaram, Visakhapatnam, Praksham, Chittor, Anantapur, Kurnool, Kaddapa, Guntur, Krishna, Sri Potti Sriramulu Nellore, Srikakulam, West Godavari
3.	Arunachal Pradesh	14	East Kameng + Pakke Kessang, Kamle, Kra Daadi, Kurung Kumey, Lower Subansiri, Papum Pare, Siang, Tawang, Upper Subansiri, West Kameng, West Siang + Leparada + Shi Yomi
4.	Assam	27	Barpeta, Bongaigaon, Dima Hasao, Golaghat, Karbi Anglong + West Karbi Anglong, Karimganj, Kokrajhar, Marigaon, Nagaon + Hojai, Tinsukia, Udalguri, Cachar, Sonitpur, Jorhat, Dhemaji, Chirang, Lakhimpur, Biswanath, Dibrugarh, Hailakandi, Baksa, Kamrup Rural, Charaideo, Sivasagar, Majuli
5.	Bihar	38	Araria, Aurangabad, Begusarai, Bhagalpur, Bhojpur, Buxar, Purbi Champaran, Pashchim Champaran, Darbhanga, Gaya, Gopalganj, Jamui, Katihar, Khagaria, Madhubani, Munger, Muzaffarpur, Patna, Purnia, Samastipur, Saran, Sitamarhi, Siwan, Supaul, Vaishali, Arwal, Banka, Jehanabad, Kishanganj, Lakhisarai, Madhepura, Nalanda, Rohtas, Saharsa, Sheikhpura, Sheohar, Kaimur (Bhabua_, Nawada
6.	Chhattisgarh	1	Durg
7.	Daman & Diu	1	Daman
8.	Delhi	7	East, North West, South, South East, West, Central, New Delhi
9.	Goa	2	South, North
10.	Gujarat	33	Banas Kantha, Kachchh, Ahemdabad including Ahmedabad Corporation, Surat including Surat corporation, Amreli, Anand, Arvalli, Bharuch, Bhavnagar, Botad, Chhotaudepur, Dohad, Dang, Devbhumi Dwarka, Gandhinagar, Gir Somnath, Jamnagar, Junagadh, Kheda, Mahisagar, Mahesana, Morbi, Narmada, Navsari, Panch Mahals, Patan, Porbandar, Rajkot, Sabar Kantha, Surendranagar, Tapi, Vadodara, Valsad
11.	J&K	1	Badgam
12.	Haryana	2	Mewat, Palwal
13.	Jharkhand	5	Deoghar, Garhwa, Giridih, Pakur, Sahebganj
14.	Karnataka	9	Bengaluru Urban (Including Bbmp), Davangere, Vijayapura, Bagalkot, Chickaballapur, Gulbarga, Bidar, Gadag, Bellary
15.	Kerala	9	Alappuzha, Ernakulam, Kannur, Kollam, Kozhikode, Malappuram, Palakkad, Thiruvananthapuram, Thrissur
16.	Madhya Pradesh	5	Chhindwara, Datia, Gwalior, Jabalpur, Morena
17.	Maharashtra	10	Ahmednagar, Aurangabad, Buldhana, Mumbai + Mumbai Suburban, Jalgaon, Nashik, Parbhani (Including Corp.), Pune (Including Corp.), Thane (Including Corp.)
18.	Manipur	15	Bishnupur, Chandel, Churachandpur, Imphal East, Imphal West, Jiribam, Kakching, Kamjong, Kangpokpi, Noney, Pherzawl, Tamenglong, Tengnoupal, Thoubal, Ukhrul
19.	Meghalaya	2	East Khasi Hills, West Garo Hills
20.	Mizoram	1	Lunglei

Sl No.	State	No. of Districts	Districts
21.	Nagaland	12	Dimapur, Kiphire, Kohima, Longleng, Mokokchung, Mon, Phek, Tuensang + Noklak, Wokha, Zunheboto, Peren
22.	Odisha	10	Cuttack, Ganjam, Jajapur, Jharsuguda, Kendrapara, Kendujhar, Khordha, Malkangiri, Mayurbhanj, Sundargarh
23.	Pondicherry	2	Mahe, Pondicherry
24.	Punjab	4	Faridkot, Mansa, Patiala, Sangrur
25.	Rajasthan	19	Ajmer, Alwar, Baran, Barmer, Bharatpur, Bikaner, Churu, Dausa, Jaipur, Jaisalmer, Jalore, Jodhpur, Karauli, Kota, Nagaur, Rajsamand, Sawai Madhopur, Sikar, Udaipur
26.	Sikkim	2	East District, North District
27.	Tamil Nadu	12	Kanchipuram + Chengalpattu, The Nilgiris, Thiruvallur, Thiruvarur, Karur, Krishnagiri, Villupuram, Dharmapuri, Madurai, Namakkal, Salem
28.	Telangana	29	Hyderabad, Medchal Malkajgiri, Ranga Reddy, Mahbubnagar, Gadwal, Mahabubabad, Narayanpet, Jagityal, Vikarabad, Nizamabad, Yadadri, Jayashankar Bhupalpalli, Peddapalli, Mancherial, Jangoan, Siddipet, Nagarkurnool, Sangareddy, Rajanna Siricilla, Hanmakonda, Adilabad, Nirmal, Khammam, Mulugu, Wanaparthy, Karimnagar, Kamareddy, Suryapet, Bhadradri Kothagudem
29.	Tripura	2	Khowai, South Tripura
30.	Uttar Pradesh	75	Agra, Aligarh, Prayagraj, Ambedkar Nagar, Amethi, Amroha, Auraiya, Azamgarh, Budaun, Bahraich, Ballia, Banda, Barabanki, Bareilly, Bijnor, Bulandshahr, Chitrakoot, Deoria, Etah, Faizabad, Farrukhabad, Fatehpur, Firozabad, Gautam Buddha Nagar, Ghaziabad, Ghazipur, Gonda, Gorakhpur, Hardoi, Hathras, Jalaun, Jaunpur, Jhansi, Kannauj, Kanpur Dehat, Kanpur Nagar, Kheri, Kushi Nagar, Lalitpur, Lucknow, Mathura, Mau, Meerut, Moradabad, Muzaffarnagar, Pratapgarh, Rae Bareli, Rampur, Sambhal, Shahjahanpur, Siddharth Nagar, Sitapur, Sonbhadra, Sultanpur, Unnao, Varanasi, Bhadohi, Baghpat, Balrampur, Basti, Chandauli, Etawah, Hamirpur, Hapur, Kasganj, Kaushambi, Maharajganj, Mahoba, Mainpuri, Mirzapur, Pilibhit, Saharanpur, Sant Kabeer Nagar, Shamli, Shravasti
31.	Uttarakhand	3	Bageshwar, Champawat, Haridwar
32.	West Bengal	8	24 Paraganas North, Paschim Bardhaman, Birbhum, Howrah, Hooghly, Kolkata, Purba Medinipore, Purba Bardhaman

Annexures -2B: List of districts under Azadi Ka Amrit Mahotsav	
State	**Districts**
Andhra Pradesh	Nellore, Srikakulum, Guntur, Krishna, West Godavari
Arunachal Pradesh	West Siang, East Siang
Assam	Karimganj, Nagaon, Sonitpur, Golaghat
Bihar	Katihar, Bhojpur, Nawada, Sitamarhi, Kaimur
Chhattisgarh	Bastar, Rajnandgaon, Kanker, Dhamtari
Goa	South Goa
Gujarat	Kheda, Bhavnagar, Porbandar, Bharuch, Surendranagar
Haryana	Panipat
Himachal Pradesh	Kangra
Jammu & Kashmir	Anantnag
Jharkhand	Sahebganj, Latehar, Gumla, Lohardaga
Karnataka	Dakshina Kannada
Kerala	Kannur, Kozhikode
Madhya Pradesh	Mandla, Satna, Seoni, Damoh, Sagar
Maharashtra	Nashik, Wardha
Manipur	Tamenglong
Meghalaya	East Garo Hills
Mizoram	Lunglei
Odisha	Mayurbhanj, Koraput, Sundergarh, Keonjhar, Sambalpur
Puducherry	Puducherry
Punjab	Gurdaspur, Jalandhar
Rajasthan	Dungarpur, Sirohi, Banswara, Jaisalmer, Bhilwara
Sikkim	Pakyong
Tamil Nadu	Thootukudi, Pudukkottai, Erode
Telangana	Kumuram Bheem Asifabad, Warangal, Medak, Nalgonda
Tripura	West Tripura
Uttar Pradesh	Ballia, Ghazipur, Ghaziabad
Uttarakhand	Haridwar, Tehri Garhwal
West Bengal	Midnapore, Bardhaman

Annexure-3: Micro Plan and Monitoring Formats

IMI 4.0 Sub Centre Head Count Syrvey Planning (Format HC-0)

(MO to ensure this format is filled for all sub-centres including vacant sub-centres)

Name of the District: _____ Block: _____ PHC/UPHC/ Planning unit: _____ Sub Centre:_____

Whether Sub centre has Full time ANM encircle : Full Time / Vacant/ Temporarily Vacant Name of ANM _____ Mobile No. of ANM: _____

Sl. No.	Name of Sub centre	Write Names of ALL Villages / Hamlets/ Urban localities / HRA Sites under the Sub centre separately one area in each row	Total Population	Estimated number of households	Is it a Polio High Risk Area? Yes/ No	Is this Focus Area** for Mission Indradhanush Headcount Survey Yes/No	If yes, Dates Planned to conduct Headcount Survey	Write name, designation of Mobilizer/s and designation (Write ASHA, AWW / Link Worker) who will conduct the head count survey	Contact Number of Mobilizer
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
								1. 2.	1. 2.
Total									

Focus Areas for Mission Indradhanush:

1. All villages/hamlets under vacant sub-centres (No ANM posted or absent for more than 3 months)
2.Unserved/low coverage pockets in sub-centre areas
3. Underserved and hard to reach populations (forested and tribal populations, hilly areas etc.)
4. Small villages, hamlets, field huts, etc., clubbed with another village for RI sessions and not having independent RI sessions
5. Polio High risk areas (urban slums, slums with migration, Nomads, Brick Kilns, Construction sites and other migratory populations like fisherman villages, riverine areas with shifting populations etc.)
6. All villages/hamlets with VPD outbreaks in last 2 years (Include all villages with reported MR outbreak and suspected cases of Diphtheria or Pertussis)
7. Any other areas for RI strengthening

Signature of ANM

IMI4.0 House to House Survey form

ASHA/AWW-Assessor Name/Ph No.: ________ Sub-Centre name:________ Name of ANM: ____________ **Format-HC1**

ASHA/AWW-Facilitator Name/Ph No.:______________________

Area Name: ________ Date of Visit : ……………………

First house visited today - House No. :_________	Last house visited today - House No. :________
Name: _____________ Address with landmark:__________________	Name: _________________ Address with landmark:________________________

	Family Details			Pregnant Woman	Children 0 to 2 years - (if YES , go to Annexure 2c)		
House number (as per chullah)	Name of head of family	Fathers name	How many family members are living in this house? (Include All adults & children including new borns)	Is there any woman pregnant in the family ? (If YES, go to HC2)	Is there any Newborn/child aged less than 1 month in the family (if YES , go to HC3)	Is there any child aged between 1 month and 1 year in the family (if YES , go to HC3)	Is there any child aged between 1 to 2 Years in the family (if YES , go to HC3)
A	B	C	D	E	F	G	H
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
Total		TOTAL		Total Yes	Total Yes	Total Yes	Total Yes

Signature of ASHA/assessor:____________________ Verified by ASHA Facilitator (Signature):____________________ Verified by ANM (Signature):_______________

SHEET NUMBER :________

IMI 4.0 VILLAGE/ AREA - Pregnant Women Survey Listing

Name of ASHA/AWW/ assessor: _____ **Area Name as in HC1: _____** **Format-HC2**

Name of ANM:_____

House No as in HC-1	Name of the pregnant woman	Age in years	Husbands name	Mobile / Telephone Number	MCP card Number	Expected date of delivery/ LMP	Tetanus Toxoid Vaccination			Ante Natal Check Up				FOR ANM ONLY	
							TT-1/ Td-1	TT-2/ Td-2	TT/ Td-Booster (If 2 doses of TT have been given within 3 years of the current pregnancy)	1st ANC	2nd ANC	3rd ANC	4th ANC	TT/ Td due - Y/N	ANC due - Y/N
A	B	C		E	F	G	H			I				J	
							Date / Y / N / DNK	Date / Y / N / DNK	Date / Y / N / DNK	Date	Date	Date	Date		
						TOTALS									

Signature of ASHA_____ **Verified by ASHA Facilitator (Signature):_____** **Verified by ANM (Signature):_____**

Format-HC3

IMI 4.0 Infants / children survey listing

Name of ASHA/AWW/ assessor: ____________ Area Name and No as per HC1: ____________ Name of ANM: __________________

						Vaccines at birth			Vaccines at 6 weeks					Vaccines at 10 weeks			Vaccines at 14 weeks					Vaccines at 9 to 12 months					Booster and 2nd doses of Vaccines at 16 to 24 months of age					
House No as in HC-1	Name of the child	DOB/ Age in yrs and months	Sex M / F	Name of the father and mobile number	MCP Card Number	Hepatitis B Zero dose (Witin 24 hours of birth)	OPV-Zero dose (within 15 days of birth)	BCG (At birth or upto 1 year of age and as early as possible)	OPV-1	Penta-1	fIPV1	RVV-1	PCV-1	OPV-2	Penta -2	RVV-2	OPV-3	Penta -3	fIPV2	RVV-3	PCV-2	Measles/MR 1st dose	JE 1st dose	PCV-B	Vitamin A 1st dose	For Fully Immunized (FI) child - has incentive been given to ASHA	OPV Booster	DPT Booster	Vitamin A	Measles/MR 2nd dose	JE 2nd dose	For Completely Immunized (CI) child - has incentive been given to ASHA
A	B	C	D	E	F	G			H					I			J					K				L	M					N
						Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N		Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	
																										Yes /No						Yes /No
																										Yes /No						Yes /No
																										Yes /No						Yes /No
																										Yes /No						Yes /No
																										Yes /No						Yes /No
																										Yes /No						Yes /No
																										Yes /No						Yes /No
																										Yes /No						Yes /No
																																TOTAL

Signature of ASHA/AWW/ Assessor___________________________ Verified by ASHA/AWW Facilitator (Signature):___________

IMI 4.0 SESSION DUE LIST FOR THE MONTH OF _____

HC 4 Due List

Name of the Village: Name of ASHA

Name of PHC :_____ Name of the Sub Centre : Name of the ANM:

Location of the Session Site : Name of AWW: Name of Influencer:

Date of session :_____ Date of next session to be conducted at this site :_____

Details of Pregnant Women / Children due for vaccination for RI session								After the session					
Sl. No.	MCP Card No.	Name of Beneficiary Child / Pregnant Woman	Name of Father/Husband	Mobile Number	For Children Date Of Birth / Age in Months	For Children Sex M / F	Vaccines due in this session	Vaccines administered today	4 Key Messages Given Yes/ No	If not immunized then reason (R1/R2/R3/R4/R5/R6)	*Incentive money Rs. 100 will be payable to ASHA for Full Immunization	**Incentive money Rs. 75 will be payable to ASHA under for Complete Immunisa	Is this beneficiary due for next month? Yes/ No
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
									Total amount				

Number of beneficiaries who did not come for vaccination	Number of beneficiaries who did not come for vaccination session	
Reasons	Children	Pregnant Women
R1. Out of Village or House Locked		
R2. Sickness		
R3 Already Vaccinated after the MI head count survey till the day of vaccination		
R4. Fear of AEFI		
R5 Refused vaccination		
R6. Other		
Total		

SUMMARY:	
No. of target children for the session (as per due list after head count)	
Total Children vaccinated	
No. of target Pregnant Women for the session (as per due list after head count)	
Total Pregnant Women vaccinated	

Signature of JHA(F) *Signature of ASHA*

MP 1 - IMI 4.0 Sub-centre planning (for ANM)

(MO IC to ensure this format is filled for all sub-centres including vacant sub-centres)

Name of sub centre:_____ Block:_____ Name & mobile number of ANM:_____

S. No	Name of villages, hamlet, slum, migrant area, etc.	Head count done (Y/N)	Population based on head count (Write NA if head count not done)		If yes, number of immunization sessions required	Mention reason for additional session* (Write code) 1/2/3/4/5/6/7	Location of session site(s) for additional session(s)	Name, designation & mobile no of mobilizers only for areas requiring immunization sessions (write name of ASHA, AWW/link worker)
			0–2 years	Pregnant women				1. 2.
								1. 2.
								1. 2.
								1. 2.
								1. 2.
								1. 2.
								1. 2.
								1. 2.
								1. 2.

*Code: 1. All villages/hamlets under vacant sub-centres (No ANM posted or absent for more than 3 months) 2.Unserved/low coverage pockets in sub-centre areas 3. Underserved and hard to reach populations (forested and tribal populations, hilly areas etc.) 4. Small villages, hamlets, field huts, etc., clubbed with another village for RI sessions and not having independent RI sessions 5. Polio High risk areas (urban slums, slums with migration, Nomads, Brick Kilns, Construction sites and other migratory populations like fisherman villages, riverine areas with shifting populations etc.) 6. All villages/hamlets with VPD outbreaks in last 2 years (Include all villages with reported MR outbreak and suspected cases of Diphtheria or Pertussis) 7. Any other areas for RI strengthening

MP 2 - IMI 4.0 : Block/Urban area planning

For Block/urban planning unit

(Compile information from Format MP-1)

Name of Block:_____ Number of sub-centres:_____ Number of ANMs:_____ Number of vacant sub-centres:_____

S. No	Name of sub-centre	Head count done (Y/N)	Population based on head count (Write NA if head count not done)		No of immunization sessions required	If mobile session, write "mobile". For other sessions, mention location of session site(s).	Name, designation & mobile no of mobilizers (ASHA, AWW/ link worker)	Which ANM will conduct immunization session in this area			
			0–2 years	Pregnant women				ANM of same sub-centre	ANM of other sub-centre from same block	ANM from outside block	Hired ANM
							1. 2.				
							1. 2.				
							1. 2.				
							1. 2.				
							1. 2.				
							1. 2.				
							1. 2.				
							1. 2.				

Signature of ANM

Signature of Block MO IC

MP 3 - ANM micro plan roster for IMI 4.0

For ANM

(One format for each ANM in the district)

Rou

District_____ **Block/ planning unit:** _____**AEFI management centre name & Tel no:** _____

MO IC (name & mobile): _____ **Supervisor (name & mobile):** _____

ANM (name & mobile): _____ **Sub-centre of ANM:** _____

	Description of areas selected for Indradhanush session (exclude Sundays and other govt. holidays)						
	Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**
Date							
Village/ urban area							
Reasons for area selection*							
Session site address & timing							
Name & Tel no of mobilizer							
Designation of mobilizer							
Name of Community Influencer							
Name & Tel no of AVD person							
Estimated 0–2 years beneficiaries							
Estimated pregnant women							
Estimation based on head counts	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

* Code: 1. All villages/hamlets under vacant sub-centres (No ANM posted or absent for more than 3 months) 2.Unserved/low coverage pockets in sub-centre areas 3. Underserved and hard to reach populations (forested and tribal populations, hilly areas etc.) 4. Small villages, hamlets, field huts, etc., clubbed with another village for RI sessions and not having independent RI sessions 5. Polio High risk areas (urban slums, slums with migration, Nomads, Brick Kilns, Construction sites and other migratory populations like fisherman villages, riverine areas with shifting populations etc.) 6. All villages/hamlets with VPD outbreaks in last 2 years (Include all villages with reported MR outbreak and suspected cases of Diphtheria or Pertussis) 7. Any other areas for RI strengthening

Signature of ANM Signature of MOIC Signature of Di

MP 4 - Mobile team planning for IMI 4.0

For Block/ Urban area

(Round I / II / III / IV)

(One format for each mobile team)

District: _____ **Block/planning unit: _____**

AEFI management centre name & Tel no: _____

Name and mobile no. of MOIC _____ **Supervisor_____** **ANM_____**

Day/ Date	Vehicle details		Site 1	Site 2	Site 3	Site 4
1		Timing of visit				
		Name of mobilizer				
		No. of 0–2 year old children				
		Name of influencer				
		No. of pregnant women				
2		Timing of visit				
		Name of mobilizer				
		No. of 0–2 year old children				
		Name of influencer				
		No. of pregnant women				
3		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
4		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
5		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				

Signature of ANM Signature of DIO Signature of MOIC

MP 5 - District Planning for IMI 4.0

For DIO

District: **Name of DIO:**

S.No	Name of block/urban area	Number of ANMs	ANM days available for Indradhanush (ANM*7)	No. of ANM days required based on microplan	Available ANM days utilized			Additional ANM days required (need based) from other blocks for conducting Mission Indradhanush sessions
					Within ANM's own sub-centres	In other sub-centres within same block	For supporting activity outside block	

Signature of DIO

Template for Validation of Head Count Survey (HCS) - Intensified Mission Indradhanush (IMI 4.0) 2022

State: _____ District: _____ Setting: Rural / Urban If urban - Is it NUHM City - Yes/No; Date of survey validation: __/__/__

IMI 4.0 District identified under: 1) Composite index (CI) / 2) Azadi ka Amrit Mahotsav (AKAM) / 3) Both CI and AKAM / 4) State Govt.

Name of ANM of this area: _____ Name of village/urban area or ward: _____ Migratory status: Migratory / Non-migratory

Name of Monitor: _____Organization (encircle): Govt./ITSU/WHO/UNICEF/UNDP/JSI/CORE/IPE-FM/ IPE-SMNET/IFV/Others_____

Monitor to visit 5 households (HH) randomly for assessing the quality and completeness of the head count survey (HCS) in one ASHA/Surveyor area:

S. No.		1	2	3	4	5
1	House number marked by team [UM - unmarked HH]	_____ / UM	_____ / UM	_____ / UM	_____ / UM	_____ / UM
2	Name of the head of family					
3	Mobile/landline contact number					
4	Date of visit by surveyor (dd/mm/yy), else NV [NV – Not visited]	__/__/__; NV	__/__/__; NV	__/__/__; NV	__/__/__; NV	__/__/__; NV
5	No. of children < 2 years in this HH as found by monitor					
6	No. of children < 2 years in this HH due for vaccination for age, assessed by monitor as on day of survey by surveyor					
7	Please mention names of children due for vaccination					
8	Any cluster of ≥ 3 consecutive HH not visited by surveyor/team?			Yes / No		

Try to meet the surveyor/team (ASHA/AWW/ANM/Link worker etc.) and cross-check findings from validated HH with the information in HCS format:

9	Who is doing / has done head-count survey in this area (specify if any other mobiliser_____			ASHA/ AWW/ AN / Link worker/ Other mobiliser _____		
10	Status of surveyor wearing mask / face cover			All / Some / None / Didn't meet the survey team		
11	Surveyor was following physical distance (2 Guj / ~ 2 mts)?			Yes / No / NA		
12	Status of survey as of today as told by surveyor			Completed / Ongoing / Yet to start / Not aware		
13	Surveyor aware of clearly demarcated area (boundary) for headcount survey?			Yes / No		
14	Is the surveyor (team) using standardized survey format for IMI head count survey?			Yes / No		
15	No. of children <2 years in this HH as assessed by surveyor (from survey register / record)					
16	No. of children <2 years in this HH due for vaccination, as assessed by surveyor (from survey register/ record)					
17	No. of children <2 years due for vaccination but missed by surveyor (by cross-checking names of due children under Q-7)					
18	Has the surveyor missed children <2 years due for one or more vaccines in 3 or more HH?			Yes / No		

- *Recommend repeat survey if: 1). ≥ 3 consecutive HH not visited for survey AND/OR 2). ≥ 3 HH have missed children due for one / more vaccine in survey*
- *If no survey has been done in this area, inform details at the planning unit (Medical Officer/Key person). Proceed to another planned area for survey validation.*
- *Ensure data entry in ODK tool same day/at the earliest (If paper format has been used while ODK tool is available)*

Immunization Session Site Monitoring Format

(_)__ /___ /____ / _ _/____
(Not to be filled by monitor)

Encircle applicable options. For (*) marked questions multiple responses may be applicable

State/UT: _____ District: _____ Date: __/__/__ Monitoring time: __: __ to __ : __

Block / Urban _____ Setting: Rural / Urban, If NUHM City: _____ Planning Unit: _____

Sub center/Urban Health Post: _____ Village/Mohalla/Ward: _____ Session site: _____ Session type: Fixed / Outreach / Mobile

Name of ANM: _____ Name of Supervisor: _____ Designation: _____ CMC area: Yes / No / NA

Type of Monitoring: RI / IMI / Others_____ Type of monitor: a). Govt Monitor / Mentor b). Monitor – Partner c). Both

Name of Monitor (Partner): _____ Organization: ITSU / WHO / UNICEF / UNDP / CORE / FM / SMNet / IFV / Others: _____ Designation: _____

Name of Mentor / Govt Monitor: _____ Department: _____ Designation: _____

If joint monitoring is undertaken, whether both monitors were present through-out monitoring of this session. Yes / No

Session details	1	Is the session being held? **Yes / No**
	2*	If session is not being held - select reason(s): a) Early closure as per district timings b) ANM not available at session site c) Vaccine / logistics not available d) Others
		If session not being held (Q1 – "No") note reasons in Q2; proceed with house-to-house monitoring in this session area and then proceed for planned monitoring under RI monitoring. If it is IMI monitoring – inform Medical Officer and proceed to a new IMI session / new area for house to house monitoring as per plan. Finally visit health facility to assess Q-61 – 62.
	3	Is the session being held at same location as per micro-plan? **Yes / No / Don't know**
	4*	Type of HRA/HRG a) Slum with migration b) Nomads c) Brick kilns d) Construction site e) Other migratory high risk area f) Non migratory settled slum g) Hard to reach area (tribal, forest, hilly area, riverine etc) h) VPD areas i) Refusals j) other settled HRA j) Not a polio HRA
	5	Location of the session as per micro-plan: a) District Hospital b) CHC c) PHC d) UPHC e) Sub Centre f) Urban Health Post g) ICDS Centre h) HRG site (fixed) i) HRG site (by mobile team) j) Others
	6	Vaccines / logistics delivered by? a) Alternate Vaccine Delivery b) ANM c) ASHA d) AWW e) Others: _____
	7*	Mobilizers found working today: a) ASHA b) AWW c) Link workers d) CMC e) NCC f) NYK g) NSS h) PRI i) Education Dept j) Religious leaders k) Others l) None, m) Not met
	8	Which mobilizers are same as per micro plan? a) ASHA b) AWW c) Link workers d) CMC e) NCC f) NYK g) NSS h) PRI i) Education Dept j) Religious leaders k) Others l) None, m) NA
	9	Whether Mahila Arogya Samiti (MAS) formed? Yes / No / NA (Check with ANM / ASHA / mobilizer)
	10	MAS member found mobilizing beneficiaries today? Yes / No / NA (NA for rural and urban areas not under NUHM city)
Birth Vacc	11	Birth dose vaccination being provided to all newborns delivered in the facility during the past 7 days (only for fixed session sites at health facility with delivery services): Hep B – Yes / No / Not observed / Not applicable OPV – Yes / No / Not observed / Not applicable BCG – Yes / No / Not observed / Not applicable
HCS / Due-list	12	Is record of headcount count survey (HCS in register/format/paper) available at the session site? (Look for physical record) Yes / No / Headcount survey not conducted
	13	Has ANM updated vaccination status of beneficiaries in RCH register / records following previous session? (NA when it is No / Headcount survey is not done) **Yes / No / NA**
	14	Is updated due list available [New-born may have been included, children (<2yrs)/Pregnant women rolling over for missed or next antigen after last session]? **Yes / No / Due list not available**
Vaccine and Open Vial Policy	15	Encircle vaccine/diluent available at session : BCG / BCG Diluent / bOPV / Rotavac / Rotasiil / Diluent for Rotasiil / PCV / IPV / Pentavalent / DPT / MR / MR diluent / Td JE (Live) / Diluent for JE (Live) / JE (Inactivated)
	16	Partially used vaccine vials from previous session received at session today a) bOPV b) Pentavalent c) DPT d) IPV e) Td f) PCV g) JE (Inactivated) h) None
	17	Any vials opened today had no date & time marked on them? a) BCG b) bOPV c) Rotavac d) IPV e) Penta f) DPT g) MR h) JE (Live) i) JE (Inactivated) j) Td k) PCV l) Rotasiil m) None, n) NA
	18	Any partially used vials supplied beyond 28 days of opening per date/time marked on the vial? a) bOPV b) Pentavalent c) DPT d) IPV e) Td f) PCV g) JE (Inactivated) h) None i) NA
	19	Encircle partial vaccine vial not applicable to open vial policy supplied to this session: a) BCG b) MR c) JE (Live) d) Rotavac e) Rotasiil f) None, g) No vial supplied - NA

Logistics other than Vaccine	20	A) Encircle syringes not available a) AD (0.1 ml) Syringes b) AD (0.5 ml) syringes	Rotasiil logistic available? 20 B) Adapter– Yes / No / NA; 20 C) 6 ml oral syringe – Yes / No / NA
	21	Which of the following is available at the session site? a) Paracetamol b) Vitamin-A c) Spoon for Vitamin-A, d) Red & Black bag e) ORS f) Zinc	
	22	Is the number of 5ml reconstitution syringes equal to or greater than the total number of BCG + MR + JE vials supplied? Yes / No / Don't know	
	23	Blank MCP/RI card available at the session? Yes / No (If "No" encircle "not applicable" in Q-24)	
	24	If MCP/ RI card available, does it have counterfoil for ANM for tracking missed doses? Yes / No / Not applicable	
	25	Working status of available hub-cutter a) Working b) Not working c) Hub cutter not available	
Injection practices and Supervision	26	Is ANM using any of these vaccines after 4 hours of reconstitution / opening the vial? a) BCG b) MR c) JE (Live) d) Rotavac e) Rotasiil f) None, g) NA	
	27	Observe ANMs injection practices & encircle a) not cutting syringe hub immediately b) touching the needle c) post injection–applying thumb/finger/cotton d) no unsafe practices e) not observed	
	28	a) Is anaphylaxis kit available?	a). Yes b). No
		b). If available, status of Adrenaline in anaphylaxis kit	a). Adrenaline available and within expiry date b). Adrenaline available but beyond expiry date c). Adrenaline not available
	29	Has any supervisor visited the session today: a) Health Supervisor b) Medical Officer c) Others (specify): ..... d) None	
Covid – 19 related observations	30	Vaccinator and all mobilizers present at the session site wearing face mask/ face cover - Vaccinator wearing / Mobilizers wearing / Both wearing / None wearing	
	31	Staggered approach being followed to avoid overcrowding at the session site with time slots allotted to beneficiaries? Yes, with time slot in due list / Yes, but with no time slot in due list / No due list was in use	
	32	All beneficiaries sitting at least 1-meter distance from each other in waiting area and vaccination area – Yes / No / Not Observed	
	33	Are observed beneficiaries accompanied by more than one caregiver at the session site – Yes / No / Not Observed	
	34	Hand washing facility with soap and water / alcohol-based hand sanitizer available at session site for beneficiaries and caregivers – Yes / No	
	35	Is ANM / Vaccinator sanitizing hands with an alcohol-based sanitizer / soap and water before and after vaccinating every beneficiary – For all beneficiaries / For some of the beneficiaries / For none of the beneficiaries/ Not Observed	
	36	Care givers wearing face mask/ clothed face cover during their visit to the session site - All caregivers wearing / Only some caregivers wearing / None of the caregivers were wearing / Not Observed	
	37	Disinfection of the seating space done after completion of the immunization session by the vaccinator/mobilizer/alternate staff– Yes / No / Not Observed	
IMI specific Questionnaires	38	Is this IMI session site located at the same place where RI session is held? (From RI micro-plan / interview ANM): Yes / No / Don't know	
	39	Reason why IMI session is planned?	a) Vacant sub-center / health post b) Areas with last 3 or more consecutive missed RI sessions c) Polio High Risk Areas d) Areas with low RI coverage (measles outbreaks, cases of diphtheria & neonatal tetanus in last 2 years e) Small villages, hamlets, BASAs (field huts) clubbed with another village for not having independent RI sessions f) Others .....
	40	No. of days this ANM has been assigned to work in IMI as per micro-plan / ANM duty roster? (Find out from ANMs session wise micro-plan)	a) 1 b) 2 c) 3 d) 4 e) 5 f) 6 g) 7 h) more than 7 days i) Session wise micro-plan not available with ANM / not aware
	41	Place of posting of this ANM? a) same sub center / urban health post b) different sub center / urban health post in the same block / planning unit c) different block / urban planning unit	
	42	If mobilizer (other than ASHA/AWW) is assigned to this session, ask if he/she is aware of incentive for mobilization of children @ Rs 150/= per session: Yes / No / NA	

Communication Questionnaire								
BRIDGE Training and IEC visibility	43	Status of frontline worker on BRIDGE IPC skill training: **ANM** – Y / N / Not available; **ASHA** – Y / N / Not available; **AWW** – Y / N / Not available						
	44	Did you see any of the following IEC material related to Immunization displayed at session site (multiple responses possible): **a)** Poster –RI: Yes / No **b)** Poster – IMI: Yes / No **c)** Banner –RI: Yes / No **d)** Banner – IMI: Yes / No **e)** Wall painting - RI: Yes / No **f)** Wall painting - IMI: Yes / No **g)** Any other: Yes / No, If Yes- Specify ..... **h)** No IEC material displayed						
	45	Does any of the displayed IEC material has tagline ("Paanch Saal Saat Baar"): **Yes / No** (Skip Q45 if No IEC material displayed as per Q44)						
ANM providing key messages	Observe immunization of two children and record if ANM is giving key messages		On child – 1		On child – 2			
	46	Explain what vaccine(s) will be given and the disease(s) prevented	Done / Not done / Not observed		Done / Not done / Not observed			
	47	Explain potential side effects following immunization (fever/pain/swelling, etc.) and how to deal with them	Done / Not done / Not observed		Done / Not done / Not observed			
	48	Explain when to come for the next visit	Done / Not done / Not observed		Done / Not done / Not observed			
	49	Explain to keep the immunization card safe and to bring it along for the next visit	Done / Not done / Not observed		Done / Not done / Not observed			
	50	Ask the caregivers to wait with child for 30 min after vaccination	Done / Not done / Not observed		Done / Not done / Not observed			
Interview with caregiver	Conduct exit interview with 2 caregivers		Caregiver 1		Caregiver 2			
	51	Who brought the child to the session site/ Who is caregiver?	1) Mother, 2) Grandmother, 3) Father, 4) Grandfather, 5) Uncle or Aunt, 6) elder siblings, 7) neighbor, 8) mobilizer, 9) others		1) Mother, 2) Grandmother, 3) Father, 4) Grandfather, 5) Uncle or Aunt, 6) elder siblings, 7) neighbor, 8) mobilizer, 9) others			
	52	Who visited you to invite for vaccination to the session site?	ASHA / AWW / ANM / CMC / link worker Influencer as per micro-plan / Others / None / NA		ASHA / AWW / ANM / CMC / link worker Influencer as per micro-plan / Others / None / NA			
Caregiver Interview	53	What is your source of information for immunization services? Allow caregiver to respond spontaneously for multiple responses; and then probe for remaining options and select responses accordingly.	Caregiver-1			Caregiver-2		
			ANM- Y/N	Religious leader- Y/N	Wall painting- Y/N	ANM- Y/N	Religious leader- Y/N	Wall painting- Y/N
			ASHA- Y/N	Poster/banner- Y/N	Mobile SMS- Y/N	ASHA- Y/N	Poster/banner- Y/N	Mobile SMS- Y/N
			AWW- Y/N	Radio-Y/N	Social Media- Y/N	AWW- Y/N	Radio-Y/N	Social Media- Y/N
			CMC- Y/N	Miking- Y/N	Mothers' meeting - Y/N	CMC- Y/N	Miking- Y/N	Mothers' meeting- Y/N
			Neighbors-Y/N	Rallies- Y/N	Community meeting - Y/N	Neighbors-Y/N	Rallies- Y/N	Community meeting - Y/N
			PRI- Y/N	AV show / Street play - Y/N	Others- Y/N	PRI- Y/N	AV show Street olay- Y/N	Others- Y/N
			Influencers- Y/N	TV- Y/N	None	Influencers- Y/N	TV- Y/N	None
	54	Whether you are aware of all vaccine/s which are given to your child in this visit (match responses with MCP card?	Caregiver-1			Caregiver-2		
			Yes / No / NA			Yes / No / NA		

	55	Whether you know when the next visit is due for your child (Please confirm answer through MCP card)?		Yes / No / NA	Yes / No / NA
	56	Did ANM ask you to carry MCP card during next visit?		Yes / No / NA	Yes / No / NA
	57	Did your child develop any discomfort following previous / today's vaccination? (pain, fever, rash, swelling etc)		Yes / No / NA	Yes / No / NA
	58	What all actions were taken by you in case of discomfort (Multiple response possible)	a) Gave PCM or cold sponge as instructed by ANM b) Consulted ANM/ Informed ASHA/Visited Govt health facility c) Visited Private Health facility d) Visited Quack e) did not take any action f) /Others		a) Gave PCM or cold sponge as instructed by ANM b) Consulted ANM/ Informed ASHA/Visited Govt health facility c) Visited Private Health facility d) Visited Quack e) did not take any action f) /Others
	59	How many visits are required to get your child completely immunized till 5 years age? Please tick Yes if caregiver response is seven.		Yes / No	Yes / No
ASHA Incentive	60	Is ASHA aware of incentives in RI programme? (Select "NA" when ASHA could not be interviewed)	a) Line listing of households (survey for enlisting of beneficiaries) @ Rs.100 / session		Yes / No / NA
			b) Preparation of due list of children/pregnant women for immunization to be updated on monthly basis @Rs.100 /session		Yes / No / NA
			c) Mobilization of children @ Rs 150/= per session		Yes / No / NA
			d) Full Immunization @ Rs 100 per child who has received all due doses within first year		Yes / No / NA
			e) For Complete Immunization, @ Rs 75/= per child who has received all doses due up to the second year		Yes / No / NA
At Planning unit	Meet Medical Officer in charge to ascertain reasons for monitored session not held. Respond Q-61and/or 62 as applicable.				
	61	Why ANM was not available at session site?	a) On leave b) Vacant post c) Assigned other work d) Started late e) Others (specify)		
	62	Reason for non-availability of vaccines/logistics?	a) Not issued b) Not picked up c) Picked up but not delivered d) Others (specify)		

Immunization - House to House Monitoring Format

Encircle appropriate options. For (*) marked questions multiple responses are allowed.

__ __ / __ __ / __ __ __ __
(not to be filled by monitor)

State/UT: _____ District: _____ Date: __ / __ / __ Monitoring time: __ : __ to __ : __
Block / Urban: _____ Setting: Rural / Urban If NUHM City: _____ Planning Unit: _____
Sub center/Urban Health Post: _____ Village/Mohalla/Ward: _____ Name of ANM: _____
Name of Supervisor: _____ Designation: _____ CMC area: Yes / No / NA Type of Monitoring: RI / IMI / Others_____
Type of monitor: Govt Monitor - Mentor; / Monitor – Partner; / Both; Mentor / Govt Monitor: _____ Department: _____ Designation:_____
Name of Monitor (Partner): _____ Organization: ITSU / WHO / UNICEF / UNDP / CORE / FM / SMNet / IFV / Others: _____ Designation:_____
If joint monitoring is undertaken, whether both monitors were present through-out monitoring of this village / area: Yes / No

If polio HRA, type of HRA/HRG (Both in RI or IMI)	a) Slum with migration b) Nomads c) Brick kilns d) Construction site e) Other migratory high risk area f) Non migratory (settled HRA) g) Hard to reach area (tribal, forest, hilly area, riverine etc) h) Not a polio HRA

*Reason for IMI monitoring ##: a) Vacant sub Centre / health post b) Areas with last 3 or more consecutive missed RI sessions c) Polio High Risk Areas d) Areas with low RI coverage (measles outbreaks, cases of diphtheria & neonatal tetanus in last 2 years) e) Small villages, hamlets, BASAs (field huts) clubbed with another village for not having independent RI sessions f) Others ..... :.....

		Details of the Child including age specific vaccination status. (10 houses in RI / 5 houses in IMI)	House-1	House-2	House-3	House-4	House-5	House-6	House-7	House-8	House-9	House-10
Details of the selected child	1	Name of the selected child (0-35 months in RI / 0-23 months in IMI)										
	2	Name of the mother / father of the selected child										
	3	Religion (H=Hindu; M=Muslim; O=Others)	H / M / O	H / M / O	H / M / O	H / M / O	H / M / O	H / M / O	H / M / O	H / M / O	H / M / O	H / M / O
	4	Is RI/Mother & Child Protection (MCP) card available with family?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
	5	Sex of the selected child: M=Male / F=Female	M / F	M / F	M / F	M / F	M / F	M / F	M / F	M / F	M / F	M / F
	6	Place of delivery: G) Govt – Hospital; P) Private Hospital: H) Home	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H
	7	Date of Birth (In dd/mm/yy format, if not known, write NA)										
	8	Age in completed months (Even if Date of Birth is known)										

Refer ready reckoner to ascertain vaccination status. If RI/MCP card is available, monitor must write date (dd/mm/yy) for vaccines received and "No" for missed vaccines. If card/date not available, monitor must write "Yes" for received & "No" for missed vaccines. RI Monitoring: Vaccine not received for age is considered "No or missed dose" Eg: Six months child has received only BCG is considered as missed all primary doses of OPV, Penta, fIPV, RVV and PCV if applicable. However, during MI/IMI a child received only BCG is considered due for first dose of same vaccines, but not eligible for 2nd and 3rd dose of same vaccines. Monitor must write "NA" against vaccines not due for age in RI while NA against vaccines in IMI, and for vaccines not introduced in the district/state in both RI and IMI monitoring

Birth	9A	Hep B Birth dose										
		OPV-0 dose										
At 6 weeks / OPV1 contact	9B	BCG										
		OPV-1										
		Rotavirus -1										
		IPV (fIPV1 intradermal wherever applicable)										
		PCV 1 (at OPV1/Penta1 - 6 weeks/within 1 year of age where applicable)										
		Pentavalent-1										
		DPT-1										

Ready reckoner to ascertain vaccination status of the selected child during RI / IMI monitoring

Age (Completed months)	Ideally a child should have received age specific vaccines in UIP as per National Immunization Schedule • Monitor to assess RI vaccination status of the selected child based on age eligibility [Should ignore time interval between doses and reasons for delayed or no vaccination]. • Monitor to assess vaccination status of the selected child during MI /IMI eligible for vaccine based on age, prior vaccination, and time interval between doses.										
	BCG	OPV	Hepatitis-B (Birth dose Within 24 hours)	Rotavirus (RVV)	IPV	PCV	Pentavalent/ DPT and DPT Booster-1	MCV / MR / MRCV	JE	DPT Booster-1	OPV Booster
0	BCG	OPV-0 (up to 15 days)	Hep-B Birth dose	NA	NA	NA	NA	NA	NA	NA	NA
1	BCG	OPV-0 (up to 15 days)	Hep-B Birth dose	NA	NA	NA	NA	NA	NA	NA	NA
2	BCG	OPV-0,1	Hep-B Birth dose	RVV-1	fIPV-1	PCV -1	Pentavalent-1	NA	NA	NA	NA
3	BCG	OPV-0,1,2	Hep-B Birth dose	RVV -1,2	fIPV-1	PCV - 1	Pentavalent-1,2	NA	NA	NA	NA
4 to 8	BCG	OPV-0,1,2,3	Hep-B Birth dose	RVV -1,2,3	fIPV -1, 2	PVV -1, 2	Pentavalent-1,2,3	NA	NA	NA	NA
9 to 15	BCG	OPV-0,1,2,3	Hep-B Birth dose	RVV -1,2,3	fIPV -1, 2	PCV-1, 2, 3	Pentavalent-1,2,3	MCV/ MR/ MRCV - 1	JE - 1	NA	NA
16 - 23 24 - 35	BCG	OPV-0,1,2,3	Hep-B Birth dose	RVV -1,2,3	fIPV -1, 2	PCV-1, 2, 3	DPT/ Pentavalent-1,2,3	MCV/ MR/ MRCV – 1, 2	JE - 1, 2	DPT Booster -1	OPV Booster

Any new vaccine such as RVV, IPV, PCV and Pentavalent will be administered on the first opportunity within first year (at 6 weeks/along with primary vaccine OPV/Pentavalent). These vaccines will not be administered if child has already started with OPV before or is older than one year of age. However, in case of delayed vaccination DPT can be administered in place of Pentavalent. DPT Booster-1 will be administered only at/after 16 months while ensuring a gap of six months from the third dose of Pentavalent (if started within one year) / DPT.

PCV given IM in right thigh along with OPV-1 at 6 weeks / later but within 1 year of age (PCV1), PCV2 at 14 weeks/later along with OPV3 and PCV-Booster dose at 9 months.

Assess vaccination status of the selected child during MI / IMI considering age and time interval between vaccine doses as below:

- At least 4 weeks interval between subsequent doses of Pentavalent (if started within one year)/ DPT (if started later within one year/ after one year)
- At least 4 weeks interval between two different live vaccines if not administered simultaneously (BCG/Measles/JE vaccines)
- At least 1 month between two doses of MR/MRCV, and 3 months between two doses of JE vaccines in case of delayed vaccination
- At least 3 months between two doses of JE vaccines in case of delayed vaccination
- At least 6 months gap between 3rd dose of DPT/Pentavalent and 1st DPT booster.

Annexure-4: Formats for IMI 4.0 portal

IMI 4.0 Portal Daily reporting format

Date of Activity _____

District Name: _____

S. No	Block name	Urban/Rural	No of sessions Planned for the round	No of sessions held	No. of target children for the round (as per the due lists based on head count)	No. of children vaccinated	No. of target Pregnant women for the round (as per the due lists based on head count)	No. of PW vaccinated	Saturation status for children vaccination (Y/N)	Saturation status for PW vaccination (Y/N)
1		U								
		R								
2		U								
		R								
3		U								
		R								
4		U								
		R								
		R								
7		U								
		R								
8		U								
		R								
9		U								
		R								
10		U								
		R								
Total		U								
		R								
Grand Total										

Framework for key dashboard indicators on Immunization indicator

Sl	Activity	Indicators	Numerator	Denominator	Visualization	Level	*Remarks*
1	Target entry status- children	% of blocks entered target for children vaccination	No of blocks entered target for children vaccination	No. of block where IMI is conducted	Map, graph, chart	Block, District, state, national	Automated
2	Target entry status- PW	% of blocks entered target for PW vaccination	No of blocks entered target for PW vaccination	No. of block where IMI is conducted			
3	Sessions	% of session held	No of session held	No of sessions planned			
4	Children immunized in district	% of target children vaccinated	Number of children vaccinated in IMI	Number of children to be vaccinated as per due lists based on head count			
5	PW immunized in district	% of target PW vaccinated for Td in IMI	Number of PW vaccinated in IMI	Number of PW to be vaccinated as per due lists based on head count			
6	Saturation of blocks in children immunization	% block saturated in children immunization	No. of block achieved 100% immunization of target children	No. of block where IMI is conducted			
7	Saturation of blocks in PW immunization	% block saturated in PW immunization	No. of block achieved 100% of target in PW immunization	No. of block where IMI is conducted			
Social media indicators							
1	Number of IMI 4.0 districts posting updates on State Facebook page	in numbers	District	Once in every round	Hard and soft copies of communication plans	District, state, national	Automated
	Number of IMI 4.0 districts with positive articles/opeds on Immunization printed newspapers / magazines / dallies	in numbers	District	Once in every round	Hard and soft copies of printed articles / opeds		

Sl	Ministry/Department	Activity/ Data element (Entry Option (Yes / No))	Visualization	Level
1	Ministry of Human Resource Development	Awareness generation sessions conducted in schools	Map, Chart	District, State, National
		Mobilization drives conducted by Bulawa Toli		
		Organizing Children Day week (by organizing painting, drawing competition)		
2	Ministry of Housing & Urban Poverty Alleviation	Awareness generation sessions conducted by Self Help Groups in urban areas		
3	Ministry of Panchayati Raj	Participation of PRI/ SHG members in VHSNC		
		IMI sessions attended by PRI/ SHG members for mobilization		
4	Ministry of Rural Development	Awareness generation sessions conducted by SHG members		
		IMI sessions attended by SHG members for mobilization		
5	Ministry of Urban Development	Review of IMI activities by Municipal Commissioners		
		Participation/ involvement of Self-Help Groups and local CSOs in rallies/ drives in urban areas		
		IMI sessions attended by Self Help Groups and local CSOs		
6	Ministry of Women & Child Development	Involvement of AWW in conducting head count surveys and micro-plan development		
		Mother's meeting conducted by AWW for mobilization		
		IMI sessions attended by AWW for mobilization		
7	Ministry of Youth Affairs and Sports	Participation/ involvement of NYKS/NSS members in rallies/ drives		
		IMI sessions attended by NYKS/NSS members for mobilization		

Annexure-5: Reporting Format

T3: State/UT target format for Mission Indradhanush

State/UT Name: _____

S. No	State/UT name	Urban /Rural	No. of target children - total for the round (as per the due lists based on head count)	No. of target pregnant women - total for the round (as per the due lists based on head count)	No of sessions planned (total for the round)
1		U			
		R			
2		U			
		R			
3		U			
		R			
4		U			
		R			
5		U			
		R			
6		U			
		R			
7		U			
		R			
8		U			
		R			
9		U			
		R			
10		U			
		R			
11		U			
		R			
12		U			
		R			
13		U			
		R			
14		U			
		R			
15		U			
		R			
16		U			
		R			
17		U			
		R			
Total		U			
		R			
Grand Total					

Please note that the total target for children, pregnant women and session needs to be entered based on the headcount done before the start of the activity

U= Urban, R=Rural

RF4: State daily reporting format for Mission Indradhanush

Date of Activity _____

State/UT Name: _____ Round: I / II / III

For State/UTs

S. No	District Name	Urban/Rural	No of sessions Planned for the day	No of sessions held during the day	No. of target children for the day (as per the due lists based on head count)	No. of children vaccinated	No. of children vaccinated for the first time in life		No. of target Pregnant women for the day (as per the due lists based on head count)	Pregnant Women			No. of PW vaccinated	Record number of vaccinations for each antigen																	Full immunization achieved				Record number of vaccinations									Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed	Total no of beneficiaries that could not be vaccinated	Reason for beneficiaries not vaccinated																						
							0 - 11 mo	12 - 23 mo		TT-1	TT-2	TT- B		BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	Measles/MR-1	JE-1	PCV-B	Vit A-1	Male	Female	Male	Female	DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	Measles/MR-2	JE-2	Vit A-2						House locked		Out of village		Sickness		Fear of AEFI		Not aware of vaccination / campaign		Refused vaccination		Already Vaccinated after the head count survey in MI till the day of vaccination		Others	
																															9 - 11 months		12 - 23 months																	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women
1		U																																																															
		R																																																															
2		U																																																															
		R																																																															
3		U																																																															
		R																																																															
4		U																																																															
		R																																																															
5		U																																																															
		R																																																															
6		U																																																															
		R																																																															
7		U																																																															
		R																																																															
8		U																																																															
		R																																																															
9		U																																																															
		R																																																															
10		U																																																															
		R																																																															
Total		U																																																															
		R																																																															
Grand Total																																																																	

- Children less than 1 year should not be given DPT-1/Hep B-1, start schedule with pentavalent vaccine only.
- As per guidelines, subsequent doses of Pentavalent vaccine can be given to a child more than one year only if the child has started with Pentavalent vaccination within one year. Give subsequent dose in the next possible contact. Do not start Pentavalent vaccination beyond one year of age.
- Children more than 1 year of age coming to session site for the first time (without any vaccination) should be given DPT and not pentavalent vaccine. Other missed vaccination should be given as per guidelines.

RF2: Block daily reporting format for Mission Indradhanush

For Block/ Urban Cities

Date of Activity ___________

Block/ planning unit: ________________________________ Round: I / II / III

S. No	Name of ANM	Urban/Rural	No of sessions Planned for the day	No of sessions held during the day	Session site address	No. of target children for the day (as per the due lists based on head count)	No. of children vaccinated	No. of children vaccinated for the first time in life		No. of target Pregnant Women for the day (as per the due lists based on head count)	Pregnant Women			No. of PW vaccinated	Record number of vaccinations for each antigen																		Full immunization achieved				Record number of vaccinations								Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed	Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated															
								0 - 11 mo	12 - 23 mo		TT-1	TT-2	TT- B		BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	Measles/MR-1	JE-1	PCV-B	Vit A-1	9 - 11 months		12 - 23 months		DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	Measles/MR-2	JE-2	Vit A-2					Children	Pregnant Women	House locked		Out of village		Sickness		Fear of AEFI		Not aware of vaccination / campaign		Refused vaccination		Already Vaccinated after the head count survey in MI till the day of vaccination		Others	
																																	Male	Female	Male	Female															Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women
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Grand Total																																																																	

- Children less than 1 year should not be given DPT-1/Hep B-1, start schedule with pentavalent vaccine only.
- As per guidelines, subsequent doses of Pentavalent vaccine can be given to a child more than one year only if the child has started with Pentavalent vaccination within one year. Give subsequent dose in the next possible contact. Do not start Pentavalent vaccination beyond one year of age.
- Children more than 1 year of age coming to session site for the first time (without any vaccination) should be given DPT and not pentavalent vaccine. Other missed vaccination should be given as per guidelines.

RF3: District daily reporting format for Mission Indradhanush

Date of Activity _____

For District

District Name: _____ Round: I / II / III

S. No	Block/ Urban City name	Urban/Rural	No of sessions Planned for the day	No of sessions held during the day	No. of target children for the day (as per the due lists based on head count)	No. of children vaccinated	No. of children vaccinated for the first time in life		No. of target Pregnant women for the day (as per the due lists based on head count)	Pregnant Women			No. of PW vaccinated	Record number of vaccinations for each antigen																	Full immunization achieved				Record number of vaccinations									Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed	Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated																	
							0 - 11 mo	12 - 23 mo		TT-1	TT-2	TT - B		BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	Measles/MR-1	JE-1	PCV-B	Vit A-1	Male	Female	Male	Female	DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	Measles/MR-2	JE-2	Vit A-2							House locked		Out of village		Sickness		Fear of AEFI		Not aware of vaccination / campaign		Refused vaccination		Already Vaccinated after the head count survey in MI till the day of vaccination		Others	
																														9 - 11 months		12 - 23 months																	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women
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		R																																																															
Grand Total																																																														

- Children less than 1 year should not be given DPT-1/Hep B-1, start schedule with pentavalent vaccine only.
- As per guidelines, subsequent doses of Pentavalent vaccine can be given to a child more than one year only if the child has started with Pentavalent vaccination within one year. Give subsequent dose in the next possible contact. Do not start Pentavalent vaccination beyond one year of age.
- Children more than 1 year of age coming to session site for the first time (without any vaccination) should be given DPT and not pentavalent vaccine. Other missed vaccination should be given as per guidelines.

RF4: State daily reporting format for Mission Indradhanush

For State/UTs

Date of Activity ____________

State/UT Name: ____ Round: I / II / III

S. No	District Name	Urban/Rural	No of sessions Planned for the day	No of sessions held during the day	No. of target children for the day (as per the due lists based on head count)	No. of children vaccinated	No. of children vaccinated for the first time in life		No. of target Pregnant women for the day (as per the due lists based on head count)	Pregnant Women			No. of PW vaccinated	Record number of vaccinations for each antigen																		Full immunization achieved				Record number of vaccinations								Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed	Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated															
							0 - 11 mo	12 - 23 mo		TT-1	TT-2	TT- B		BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	Measles/MR-1	JE-1	PCV-B	Vit A-1	9 - 11 months		12 - 23 months		DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	Measles/MR-2	JE-2	Vit A-2							House locked		Out of village		Sickness		Fear of AEFI		Not aware of vaccination / campaign		Refused vaccination		Already Vaccinated after the head count survey in MI till the day of vaccination		Others	
																																Male	Female	Male	Female													Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women
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Grand Total																																																															

- Children less than 1 year should not be given DPT-1/Hep B-1, start schedule with pentavalent vaccine only.
- As per guidelines, subsequent doses of Pentavalent vaccine can be given to a child more than one year only if the child has started with Pentavalent vaccination within one year. Give subsequent dose in the next possible contact. Do not start Pentavalent vaccination beyond one year of age.
- Children more than 1 year of age coming to session site for the first time (without any vaccination) should be given DPT and not pentavalent vaccine. Other missed vaccination should be given as per guidelines.

RF5. Daily vaccine and diluents utilization reporting format

For Vaccine and Cold Chain Handlers

State / District / Block / Urban Area (encircle the applicable option)

Day	BCG	BCG Diluent	OPV	Penta	RVV	IPV	PCV	Measles/ MR	Measles/ MR Diluent	DPT	TT	JE	JE Diluent	Vit A	AD Syringes 0.1ml	AD Syringes 0.5ml	5ml Reconst-itution Syringes
Day 1																	
Day 2																	
Day 3																	
Day 4																	
Day 5																	
Day 6																	
Day 7																	
Day 8																	
Day 9																	
Day 10																	

Signature of MOIC

Name and signature of cold chain handler

Annexure- 6: Formats for Communication activities

CMM 1 :Sub-center level communication plan for MI

Name of the district		Name of the facility-CHC/ PHC			Name of sub-center /health center	Name of ANM:			Name of ASHAs and AWWs:				
S. No.	Name of Village/ Urban Area/ School	Social mobilization activities							Mid-media activities				
		Mother's meeting	Community/ Influencer's meeting	VHSNC meeting for IMI		Mosque/ Temple announcement	IPC sessions	Others (specify)	Posters in community		Leaflets for community		Any other activity
1		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....		Numbers.....		
2		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....		Numbers.....		Numbers.....
3		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....		Numbers.....		Numbers.....
4		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....		Numbers.....		Numbers.....
5		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....		Numbers.....		Numbers.....
6		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....		Numbers.....		Numbers.....
7		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....		Numbers.....		Numbers.....
Total No.													

Note: This template needs to be filled-up by ANM with the help of her ASHA/AWW and MOIC. ANM should compile all her ASHA templates and keep one copy with her and submit one copy to the MOIC before the Block Training for MI

CMM 2 Health Facility /PHC level communication plan for MI

Name of the District:		Name of PHC/Planning unit:				Name of I/C MO:					
	BTF meeting for MI campaign	Date–				Date --					
Advocacy meetings	MI microplanning meeting (for communication and planning)	Date -- Responsible person ----									
	Coordination meeting with CSO/NGOs, key religious leaders/influencers at block level	Date--- Responsible person ----		Date22/09/17 Responsible person……				Date…… Responsible person……			
	Sensitization meeting with block-level officers from government line departments	Date08/09/17 Responsible person MO i/c				Date…… Responsible person……					
	Any other activity Tribal promoters & Forest People	Date -- Responsible person----		Date…… Responsible person……				Date…… Responsible person……			
Capacity Building	Orientation of ANMs on BRIDGE (For MI communication/planning)	Date--- Responsible personL--				Date ----- Responsible person ---					
	Orientation of ASHAs/AWWs on BRIDGE (and MI campaign communication)	Date …. Responsible person ….				Date …. Responsible person ….					
Social Media	WhatsApp messaging (in coordination with District Social Media committee)	Members …… Nos Frequency……				Members …… Frequency ……					
	Other										
		PHC/Planning unit	SC-1	SC -2	SC-3	SC-4	SC-5	SC-6	SC-7	SC-8	Total
Social Mobilization activities	Mother's meetings										
	Community/ Influencer's meeting										
	VHSNC meeting for MI										
	Mosque/Temple announcement										
	IPC sessions										
	Miking										
	Others (specify										
Mid media activities	Posters in community										
	Leaflets for community										
	Leaflets for ANMs										
	Leaflets for ASHAs/AWWs										
	Leaflets for MOs										
	Any other activity										

Note: This template needs to be filled by BEE/IEC consultant (person responsible for IEC) in their absence MOIC needs to fill this format with consultation with his/her ANM/ANM supervisors/ASHA facilitators. This needs to be submitted to person in-charge for IEC at district before the district training on MI and carry one copy at PHC level for record and monitoring.

IMI 4.0 CMM 3 District level communication plan for MI

Name of the state:		Name of District:		District IEC/ Media officer:
Advocacy meetings	DTFI meeting	Date……	Date……	Date……
	Orientation of IMA/IAP members	Date……	Date……	Date……
	Orientation of CSO partners, including religious leaders and community influencer groups)	Date…… Responsible person……	Date…… Responsible person……	Date…… Responsible person……
	District Media orientation workshop	Date……		
	Any Other	Date……	Date……	Date……
Capacity Building	Training of block level health officers	Date…… Responsible person……		
Social Media	Constitution of social media committee	Members…… Frequency……		
	WhatsApp messaging	Members…… Frequency……		
	Facebook messaging	Members…… Frequency……		
	Any other	Members…… Frequency……		

		District	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Total
Advocacy	BTFI meeting for MI										
	MI microplanning meeting (For communication planning and operation)										
	Meeting with key CSO, religious leaders/influencers at block level										
	Sensitization meeting with govt. line department staff i.e. ICDS, Edu., Agri, DFP										
	Any other										
Capacity Building	Orientation of ANMs on BRIDGE and Microplanning review										
	Orientation of ASHAs/AWWs on BRIDGE										
	Orientation of ASHAs/AWWs on mobilization for MI										
Social Mobilization	Mother's meetings										
	Community/Influencer's meeting										
	Community meetings (VHSNC, SHGs, Mahila mandals for MI campaign)										
	Mosque/Temple announcement										
	IPC sessions										
Mid media	Posters in community										
	Hoardings										
	Leaflets for community										
	Leaflets for ANM, ASHA and AWW										
	Leaflets for MOs										
	Milking/Local announcements										
	Any other activity										

Note I–This template will be completed by District MPHO/IEC officer/consultant. If there is no one dedicated for IEC activity, then District Immunization Officer will be responsible to compile with consultations of Block MOIC/BHE/IEC consultant. One copy needs to be with concerned person who is responsible for IEC/communication and one copy needs to be submitted to Chief District Medical Officer/CMO/CDMO before the District Training start on MI.

IMI 4.0 CMM 4 State-level Communication Plan for MI

Name of State:				State IEC/Media officer:
Advocacy	STFI meeting	Date..... Responsible person.....	Date..... Responsible person.....	Date..... Responsible person.....
	Orientation of IMA/IAP members	Date..... Responsible person.....	Date..... Responsible person.....	Date..... Responsible person.....
	Orientation on MI of state officials from other departments (ICDS, Edu, Agri, PRI, Urban, Sports and Youth, HR, Railways, Tribal, DFP, etc)	Date..... Responsible person.....	Date..... Responsible person.....	Date..... Responsible person.....
	Formation of Core Group for media management including crisis communication	Date..... Responsible person.....	Date..... Responsible person.....	Date..... Responsible person.....
	Orientation of Heads of CSO partners (Development partners, Rotary, Lions Club, any other), religious leaders or key influencers	Date..... Responsible person.....	Date..... Responsible person.....	Date..... Responsible person.....
	Media Sensitization workshop	Date..... Responsible person.....		
	State-level media workshop on MI	Date..... Responsible person.....		
	Any Other	Date..... Responsible person.....	Date..... Responsible person.....	Date..... Responsible person.....
Capacity Building	State ToT for district officials on MI operationalization, including communication planning, and communication monitoring	Date..... Responsible person.....		
	State Media Spokespersons Training/AEFI Committee training on media	Date..... Responsible person.....		
Social Media	Constitution of Task Force for Social Media	Members..... Frequency.....		
	WhatsApp messaging	Members..... Frequency.....		
	Facebook messaging	Members..... Frequency.....		
	Any other	Members..... Frequency.....		

		District 1	District 2	District 3	District 4	District 5	District 6	District 7	District 8	District 9	Total
Advocacy	DTFI meeting I										
	DTFI meeting II										
	Orientation of IMA/IAP members										
	Orientation meeting of CSO partners at district level (Rotary, Lions Club, any other), religious leaders or key influencers										
	Media sensitization workshop										
	Any Other										
Capacity Building	TOTs for block level health officials										
Media	District media sensitization workshop										
Social Media	Task force/Social media in-charge										
	WhatsApp/Facebook messaging specific to district to be fed to State Task Force for Social media										

Note 1: This is the responsibility of the Communication In-charge/SEPIO to collect information from district and compile the State Plan. She/he needs to submit this template to STFI/Director Health Services/Mission Director (NHM).
Note 2: This template needs to be discussed at the State ToTs and will be the basic tool for communication planning at state level.

Annexure-7: Standard Operating Procedure for eVIN

	Particular	Action
1	Stock out	Inform DVS, use eVIN to check if vaccine is available in nearby CCP. With Approval from District arrange replenishment either from DVS or from Nearby CCP.
2	Stock status is at re-order point (Less Than Minimum Stock)	Inform DVS, arrangement replenishment within timeline.
3	Excess Stock (Greater than maximum stock)	Inform DVS, use eVIN to check if any other CCP is under stock out or at less than minimum. Perform Load balancing.
4	Temperature Breach – Above 8 degree	Inform Cold Chain Technician, arrange shifting of vaccines to another Cold Chain equipment if problem persists.
5	Temperature Breach – Below 2 degree	Inform Cold Chain Technician, arrange shifting of vaccines to another Cold Chain equipment if problem persists.

Zindagi Indradhanush Banayein