NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Ministry of Health & Family Welfare
Government of India

G20 भारत 2023 INDIA

A BIG LEAP
TOWARDS MEASLES & RUBELLA
ELIMINATION

MISSION INDRADHANUSH 5.0
Be Wise!
Get your child fully immunized

INTENSIFIED MISSION INDRADHANUSH 5.0

OPERATIONAL GUIDELINES

INTENSIFIED MISSION INDRADHANUSH 5.0

OPERATIONAL GUIDELINES

डॉ. मनसुख मांडविया
DR. MANSUKH MANDAVIYA

सत्यमेव जयते
आज़ादी का अमृत महोत्सव

मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार
Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India

MESSAGE

I am writing to you with great enthusiasm and optimism as we embark on Intensified Mission Indradhanush (IMI) 5.0, to take a BIG LEAP towards achieving measles and rubella elimination in India. Many new vaccines have been introduced under the programme against deadly childhood diseases in the last few years. The periodic immunization intensification drives conducted under the Universal Immunization Programme (UIP) as Mission Indradhanush & Intensified Mission Indradhanush, are vibrant examples of our constant zeal for striving to ensure that no child is left unprotected. IMI 5.0 demonstrates how India is leveraging the learnings from one of the world's largest COVID-19 vaccination drive, to strengthen routine immunization. The scope and scale of the country's COVID-19 vaccination drive has given us confidence in carrying out the country's biggest vaccination catch up campaign across all the districts of the country. The successful experience of the digital platform of CoWIN has guided us to develop U-WIN, the electronic Immunization registry that will be scaled up to capture vaccination events under the UIP and the campaign.

The objectives of IMI 5.0 are crystal clear: we must identify all children up to 5 years of age who have missed their doses, register them on U-WIN, and vaccinate them during specially planned IMI sessions. This task is of utmost importance, requiring your dedication, expertise, and unwavering commitment. IMI 5.0 presents us with a unique opportunity to bridge the immunization gaps exacerbated by the COVID-19 pandemic and address the existing inequities through proper planning and community engagement.

I have complete faith in your abilities to rise to the occasion and make IMI 5.0 a resounding success. Your tireless efforts and dedication are commendable. I am confident that, together, we will achieve our goal of eliminating measles and rubella by 2023. Let us motivate and support one another, working as a cohesive team, to make IMI 5.0 a remarkable success story.

24 July, 2023
New Delhi

(Dr. Mansukh Mandaviya)

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राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण
भारत सरकार
**MINISTER OF STATE FOR
HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA**

Message

Mission Indradhanush is the flagship programme of the Government of India focused to ensure that no child is left without the benefit of vaccines.

The periodic drives of Mission Indradhanush & Intensified Mission Indradhanush, over the last nine years, had shown a positive impact on the immunization coverage of children and pregnant women as evident in the National Family Health Survey (NFHS 5). However, the devastating impact of COVID-19 pandemic has offset the immunization gains made in the past. This, coupled with other reasons like migration, lack of awareness and misinformation, further accentuated during Covid-19 pandemic, has aggravated the immunization gap. These cohorts of partially and unvaccinated children and pregnant women are most vulnerable to disease outbreaks.

To reverse the declines in childhood vaccination recorded in India since the pandemic, Intensified Mission Indradhanush (IMI) 5.0 is the "Big Catch-up" campaign being undertaken across the length and breadth of the country. IMI 5.0 translates India's Global commitment of reaching Zero Dose children and eliminating Measles and Rubella by 2023, into action. IMI 5.0 also aims at strengthening the country's immunization systems by establishing the Electronic Immunization Registry- U-WIN.

I commend the sincere efforts of officers of MoHFW and all the development partners who have contributed to develop this document. I hope these guidelines will be very helpful for the state in having a clear vision for planning, implementation and monitoring of the Intensified Mission Indradhanush 5.0.

The health team has made the country proud through their efforts for Covid-19 Vaccination. Your unwavering commitment to public health goes beyond mere statistics; it saves lives and improves the well-being of our nation. I extend my heartfelt wishes for success in all your endeavours and eagerly look forward to celebrating our collective triumph against vaccine preventable diseases.

(Prof. S.P. Singh Baghel)

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आज़ादी का अमृत महोत्सव

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स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Message

The comprehensive framework of Intensified Mission Indradhanush Guidelines represents our collective efforts to address one of the most critical interventions in public health: ensuring universal immunization coverage for every child and pregnant woman in our Country.

Immunization is the cornerstone of preventive healthcare, safeguarding the health and well-being of our population, especially the most vulnerable among us. Recognizing its importance, the Government of India launched Mission Indradhanush, an ambitious initiative aimed at reaching every left out and dropped out children and pregnant woman with life-saving vaccines. Through this Mission, we have set our sights on achieving full immunization coverage and progress eliminating vaccine-preventable diseases from our society. IMI 2023 is targeted to provide the big impetus to eliminate Measles and Rubella from the country by ensuring that no child up to 5 years of age is left without both doses of MR vaccine. Moreover, IMI 2023 is special as we are covering all districts for first time and it is the first time that the platform of U-WIN will be utilized to register all due beneficiaries.

Successful implementation of the COVID Vaccination drive in the country, made us realize that dedication and collaborative efforts of all stakeholders for success of any initiative is fundamental. Therefore, I urge healthcare administrators, professionals, civil society organizations, and the community at large to come together, shoulder to shoulder, to ensure the effective implementation of this mission.

Oversight of the State leadership and regular review through State Steering Committee and State & District Task Force is critical for complete planning, clear directions and mid-course corrections.

I am confident that with the support and active participation of all stakeholders, Intensified Mission Indradhanush 2023 will bring us closer to our goal of universal immunization coverage and subsequently, attaining SDG-3.

Date : 24th July, 2023
Place : New Delhi

(Rajesh Bhushan)

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Foreword

I take pleasure to present the Intensified Mission Indradhanush 2023 Guidelines, which marks a significant milestone in our relentless pursuit of comprehensive immunization coverage across India. As the Additional Secretary & Mission Director of NHM, I do witness the transformative impact that Mission Indradhanush has had on our nation's healthcare approach.

Immunization is a powerful tool that not only saves lives but also paves the way for a healthier future. Further, the Intensified Mission Indradhanush represents our commitment to reach the unreached and ensure that no child or mother is left without the protection offered by life-saving vaccines.

Intensified Mission Indradhanush 2023 places a renewed emphasis on areas with low immunization coverage, urban slums, and hard-to-reach populations. By leveraging innovative approaches, intensifying outreach activities, and strengthening routine immunization services, we aim to accelerate progress and reduce the burden of zero-dose children in the country. The communities with zero dose children are the missed communities which the immunization systems have not been able to reach.

Moreover, some parts of the country have reported measles outbreaks which are a threat to the health and well-being of our children. Recognizing the urgency to address this challenge, Intensified Mission Indradhanush places special emphasis on intensifying efforts to eliminate measles and reduce its burden on our population. MR has lifelong debilitating effects on child health, schooling and performance in sports.

The guidelines also underscore the importance of data-driven decision-making, robust monitoring, and evaluation mechanisms to assess progress and identify areas for improvement. With IMI 2023, U-WIN is also being scaled up nationwide to register every child from birth.

Earmarked funds are available under the NHM along with flexibility for engaging mobilizers & supervisors during the campaign to ensure seamless implementation.
I am confident that IMI 2023 will achieve its objectives, making India a nation where every child and mother is protected from vaccine-preventable diseases. Let us join hands, united in our pursuit of a healthier and brighter future of children.

(L.S. Changsan)

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Dr. P. Ashok Babu, IAS
Joint Secretary

Preface

I am delighted to present the Intensified Mission Indradhanush 2023 operational guidelines, filled with great enthusiasm, aimed at recovering from the losses suffered during the challenging times of the COVID-19 pandemic. As we move forward, it is crucial that we refocus our efforts the reach of vital immunization benefits.

Intensified Mission Indradhanush 5.0 is essential to reverse this immunity gap emerged due to the pandemic and Measles and Rubella (MR) Elimination. This endeavour is of utmost importance for India, as the country has set the goal of MR elimination by 2023.

It is crucial to capitalize on this opportunity and work diligently towards achieving this milestone as well as increasing coverage of recently introduced vaccines (RVV, PCV & fIPV) in Universal Immunization programme. Considering the pan India rollout and scale of UWIN, IMI activities are to be carried out in a heightened manner in all 756 districts of India but not to lose focus on high priority districts.

I have full confidence that the guidelines outlined in this document will provide a comprehensive roadmap for the successful implementation of Intensified Mission Indradhanush 2023. These guidelines are the result of extensive research, collaboration, and the combined expertise of our committed immunization community. Let us embrace these guidelines as a unified force and work tirelessly to achieve our shared vision of a world free from vaccine-preventable diseases.

In conclusion, I want to express my sincere appreciation to all the healthcare workers, policymakers, and partners who have wholeheartedly supported the cause of immunization. Your relentless dedication and unwavering determination have been instrumental in our progress so far and I am confident that, working together, we will overcome any challenges that may come our way.

Now is the time for us to take advantage of this opportunity and create a lasting effect, ensuring that no child is left behind and that every child receives the essential and life-saving vaccines they are entitled to.

With determination and hope,

(Dr P. Ashok Babu)

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From Additional Commissioner (Immunization)

Mission Indradhanush (MI) has brought focus to ensure that no child is left without the protection of the vaccines since its inception in 2014. The program has yielded remarkable results by annually reaching out to all under-vaccinated children and pregnant women. The NFHS-5 (2019-21) reports also inform a substantial increase in the full immunization coverage (76.4%) as compared to NFHS-4(2015-16, 62%).

However, the relentless onslaught of the COVID-19 pandemic has disrupted immunization services and to bridge the immunization gaps and reinvigorate our commitment to protect vulnerable populations, the next phase of Intensified Mission Indradhanush 2023 (IMI 2023) is planned. This year the focus is to reach all unvaccinated and partially vaccinated children up to age of 5 years and pregnant women, register them on the digital platform **U-WIN**, and record all vaccination done.

To ensure the success of this intensified campaign, several key priorities need to be emphasized. These include conducting comprehensive headcount surveys and registering each beneficiary on U-WIN, implementing meticulous and digital micro planning, registering beneficiaries on U-WIN, mobilizing every child to vaccination sessions through IPC and through a vibrant Communication strategy put in place, enforcing rigorous monitoring and supervision, and maintaining accurate recording and reporting on U-WIN, which will serve as the primary and trustworthy source of information. By prioritizing these essential steps, we can maximize the effectiveness and impact of the campaign.

As we move ahead with IMI 2023, we must address the deep-rooted inequities in immunization based on factors such as wealth, education, and the urban-rural divide. Moreover, the recent upsurge in measles cases has unearthed the pockets of low immunization coverage highlighting the areas of high risk. Such vulnerable areas are to be identified and new sessions if needed are to be planned in these areas.

The immunization partners have been our important stakeholder and their strength on ground needs to be used effectively

With unwavering resolve let us embark on this transformative journey that would be a big leap for the country for MR elimination and initiation of digitalization of UIP Services for the beneficiaries. .

(Dr. Veena Dhawan)

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ABBREVIATIONS

AD	Auto Disable
AEFI	Adverse Event Following Immunization
ANM	Auxiliary Nurse Midwife
ANMOL	ANM online
ASHA	Accredited Social Health Activist
AVD	Alternate Vaccine Delivery
AWW	Anganwadi Worker
BMGF	Bill and Melinda Gates Foundation
BRIDGE	Boosting RI Demand Generation
BTFI	Block Task Force for Immunization
CAB	Covid Appropriate Behaviour
CBO	Community Based Organization
CCE	Cold Chain Equipment
CCT	Cold Chain Technician
CIF	Case Investigation Form
CMO	Chief Medical Officer
COVID-19	Corona Virus 2019
CoWIN	Covid Vaccine Intelligence Network
CRF	Case Reporting Format
CS	Civil Surgeon
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
CTFI	City Task Force for Immunization
DIO	District Immunization Officer
DM	District Magistrate
DPT	Diphtheria, Pertussis and Tetanus
DTFI	District Task Force for Immunization
ESI	Employees State Insurance
eVIN	electronic Vaccine Intelligence Network
FIC	Full Immunization Coverage
FLW	Front Line Worker
GSA	Gram Swaraj Abhiyan
HCS	Head Count survey
HMIS	Health Management Information System
HR	Human Resource
HRA	High-Risk Area
HRD	Human Resource Department
HW	Health Worker
IAP	Indian Academy of Pediatrics
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
ILR	Ice Lined Refrigerator
IMA	Indian Medical Association
IMAS	Immunization Monitoring and Analyzing Software
IMI	Intensified Mission Indradhanush
IPC	Inter-Personal Communication
ITSU	Immunization Technical Support Unit
JE	Japanese Encephalitis
JSI	John Snow Inc.
MAS	Mahila Arogya Samitis
MCP	Mother and Child Protection

MCV	Measles Containing Vaccine
MI	Mission Indradhanush
MO	Medical Officer
MO I/C	Medical Officer in Charge
MoHFW	Ministry of Health and Family Welfare
MP	Micro Plan
MR	Measles & Rubella
NCC	National Cadet Corps
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHSRC	National Health System Resource Centre
NMNR Rate	Non-Measles Non-Rubella Rate
NPSP	National Public Health Surveillance Project
NUHM	National Urban Health Mission
NYK	Nehru Yuva Kendra
ODK	Open Data Kit
PCV	Pneumococcal Conjugate Vaccine
PHC	Primary Health Centre
PIP	Program Implementation Plan
PW	Pregnant women
RCH	Reproductive & Child Health
RI	Routine Immunization
RVV	Rotavirus Vaccine
SACS	State AIDS Control Society
SBCC	Social and Behaviour Change Communication
SEPIO	State EPI Officer
SIO	State Immunization Officer
STFI	State Task Force for Immunization
Td	Tetanus and adult Diphtheria
TRIFED	Tribal Co-operative Marketing Federation of India
UHND	Urban Health and Nutrition Day
UIP	Universal Immunization Program
ULB	Urban Local Body
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UPHC	Urban Primary Health Centre
USAID	United States Agency for International Development
VHSNC	Village Health Sanitation and Nutrition Committee
VoD	Vaccination on Demand
VPD	Vaccine-Preventable Disease
WCD	Women and Child Development
WHO	World Health Organization
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage

EXECUTIVE SUMMARY

India launched its flagship programme, Mission Indradhanush (MI), a periodic immunization intensification drive in December 2014, with an aim to strengthen Routine Immunization. The mission was further intensified in 2017 with increased focus on urban areas with better interdepartmental coordination. Over the last nine years, routine immunization intensification activities have shown a positive impact on immunization coverage. India achieved the highest ever DPT-3 coverage of 91% in 2019 (WUENIC estimates). The NFHS-5 (2019-21) reports also showed a substantial increase in the full immunization coverage (76.4%) as compared to NFHS-4(2015-16, 62%).

However, globally and in India, the achievements made in the past have been hindered by the COVID-19 pandemic. This coupled with other existing inequities in immunization as a result of socio-economic status, education level, urban-rural setting, etc., have further contributed to the immunization gap. As the cohort of partially and unvaccinated children and pregnant women increases in an area/pocket, the risk of disease outbreaks also increases.

Thus, to catch up on gaps that might have emerged due to the COVID-19 pandemic, Intensified Mission Indradhanush 5.0 has been planned across the country, to reach the unvaccinated and partially vaccinated children and pregnant women. The objective of IMI 5.0 is to identify all children up to 5 years for missed doses, register them on U-WIN and vaccinate them in specially planned IMI sessions. Three rounds of Intensified Mission Indradhanush will be conducted in 2023 as per the following schedule:

1 **Round 1:** 7 - 12 August 2023	2 **Round 2:** 11 - 16 September 2023	3 **Round 3:** 9 - 14 October 2023

Each round of IMI 5.0 will be spread over 6 working days i.e., including RI days.

Unique Features of IMI 5.0

1. **Scope:** All districts of the country
2. **Target beneficiaries:** All children up to 5 years of age and pregnant women who have missed any of their due doses
3. **Headcount survey (HCS):** Headcount surveys will be conducted for all the districts across the nation. The HCS survey format has been revised to include children of the 2-5 years age group.
4. **Session timings:** Flexible session timings will be followed. "On demand vaccination timings" would be fixed in consultation with the community to ensure a better turn-out of beneficiaries.
5. **U-WIN roll out:** Building on the successful roll-out and implementation of eVIN, a tool for strengthening the vaccine supply chain and Co-WIN, for beneficiary management, recording and reporting of Covid-19 vaccination, U-WIN has been build as a 3rd pillar based on the existing 1st (eVIN) & 2nd (Co-WIN) pillars for registering beneficiaries, recording and reporting of Universal Immunization Program. This digitalization effort through U-WIN would target the beneficiary cohorts of pregnant women and children upto 5 years of age. U-WIN portal will be used for all data recording and reporting for IMI 5.0.

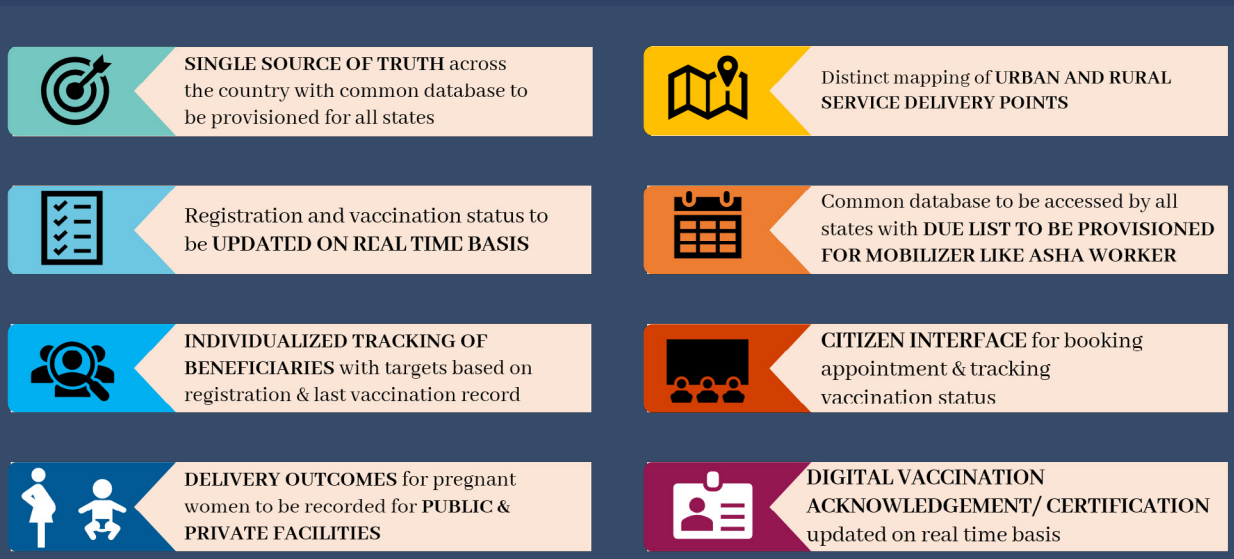


Figure E.1: Rationale for developing U-WIN

CHAPTER-1: INTRODUCTION

India's Universal Immunization Program (UIP) is one of the largest public health programs in the world. At present, UIP targets nearly 2.67 crore newborns and 3 crore pregnant women per year. About 1.36 crore routine immunization (RI) sessions are planned annually, with vaccines stored across ~29,000 cold chain points.

Since its inception, the program has evolved tremendously wherein several new vaccines have been introduced and a plethora of initiatives have been undertaken to strengthen immunization systems in the country. Presently, UIP provides free-of-cost vaccines against 11 Vaccine Preventable Diseases (VPDs) nationwide and Japanese Encephalitis (JE) in endemic districts. The list of vaccines currently being provided under UIP, along with their schedule is given in Annexure- 1. With regard to system strengthening initiatives too, UIP of India has advanced over time. Today, India has one of the most comprehensive and efficient cold chain systems, digitized vaccine and logistic supply chain management systems- Electronic Vaccine Intelligence Network (eVIN), and a nationwide vaccine preventable disease (VPD) surveillance network, among others.

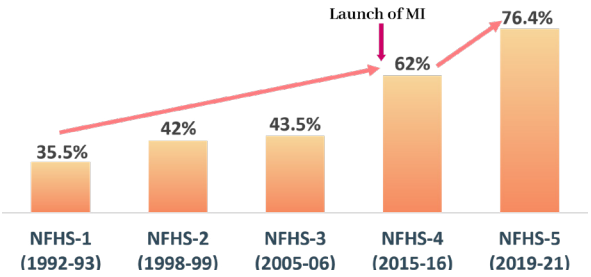
UIP was successfully leveraged to carry out the world's largest Covid-19 vaccination drive. CoWIN was established, by utilizing the eVIN platform, for the registration and tracking of beneficiaries for Covid-19 vaccination, which proved to be critical for the successful implementation of the National COVID-19 Vaccination programme. Based on the learnings from eVIN and CoWIN, the U-WIN portal, which is the electronic immunization registry for RI, has been developed and piloted in 65 districts. Following the National Workshop on U-WIN held on 8th and 9th June 2023, the platform is being scaled-up in all districts across the nation.

Mission Indradhanush (MI): India launched Mission Indradhanush in December 2014, to further strengthen routine immunization coverage. The flagship programme targets unvaccinated and partially vaccinated children and pregnant women, who were missed and dropped out from routine immunization. The mission leverages accountability frameworks at all levels for meticulous planning, effective training, communication and social mobilization and robust implementation.

To date, a total of eleven phases of Mission Indradhanush have been completed covering 701 districts across the country. During the various phases of Mission Indradhanush, a total of 4.45 crore children and 1.12 crore pregnant women have been vaccinated.

As a result of consistent efforts through routine immunization across the country and focused interventions in high risk and low coverage areas through MI/IMI, India has been able to achieve full immunization coverage (12 to 23 months age) of 76.4% in 2019-21 (NFHS- 5). As compared to NFHS-4 (2015-16), when FIC was 62%, there is an overall increase of 14.4 percentage points in FIC (Graph 1.1). It is also noteworthy that 30 of the 36 States/UTs have shown an increase in FIC as compared to NFHS-4.

India's FIC was as low as 35.4% in 1992-93 (NFHS-1), which has now progressed to 76.4% (NFHS-5).



Graph 1.1: Progression of Immunization Coverage (FIC%) [NFHS]

Rationale for IMI- 5.0

Despite the progress made, many children and pregnant women still remain partially vaccinated or unvaccinated. As per

UIP has also significantly contributed to reduction in morbidity and mortality due to VPDs which has resulted in a decline of Under 5 Mortality Rate (U5MR) for the country from 45 per 1000 live births in 2014 to 32 per 1000 live births in 2020 (Data Source -Sample Registration System)

NFHS-5 reports, 3.8% of the children are unvaccinated and the remaining 19.8% are partially vaccinated. 6.4% of the children did not receive the 1st dose of DPT-containing vaccine within 1 year of age, defined as Zero Dose children. These partially vaccinated and unvaccinated children are at increased risk of morbidity and mortality due to vaccine preventable diseases (VPDs).

The factors limiting vaccination coverage usually include large, mobile, and isolated populations that are difficult to reach, low demand from under-informed or misinformed populations and fear of side effects after vaccination. By focusing on such populations where these programmatic challenges exist, MI/IMI drives target to vaccinate these left out and dropped out children and eligible pregnant women who were missed in Routine Immunization activities.

Additionally, gaps in Head Count Survey (HCS), proper microplanning and unavailability of human resource for regular RI sessions further pose challenges in improving immunization coverage. Although the provisions for addressing these issues are available under PIP.

Presently, with the overall goal of improving vaccination coverage and equity and the specific objectives of reducing the immunity gap that might have emerged due to the impact of COVID-19 pandemic on Routine Immunization (RI), reduction in the burden of Zero Dose (ZD) children and resuscitating the measles and rubella elimination plan, IMI 5.0 is planned. The following section gives a macro level analysis of the rationale for conducting IMI 5.0.

Impact of COVID-19 pandemic on RI: COVID-19 pandemic has adversely impacted immunization coverage across the globe. As per WUENIC (WHO and UNICEF Estimates of National Immunization Coverage), globally, the number of zero-dose children (not received even a single dose of DPT containing vaccine by one year of age) was 13.3 million in 2019, which increased to 16.5 million in 2020 and 18.2 million in 2021[1].

In India too, Covid-19 pandemic disrupted RI services that resulted in a fall in immunization coverage. As per WUENIC-2019, national DPT containing vaccine-1 (Penta-1) coverage was 94%, which translates to ~1.6 million zero dose children. The number of Zero Dose children in the country doubled in 2020 to 3.4 million. Even though Routine Immunization was identified as an essential activity during the Covid-19 pandemic, the restricted movement in the year 2020, compounded by fear of exposure/contracting COVID-19 infection limited access to services. There was some recovery in 2021 and the number of zero dose children reduced to around 3.2 million in 2021.

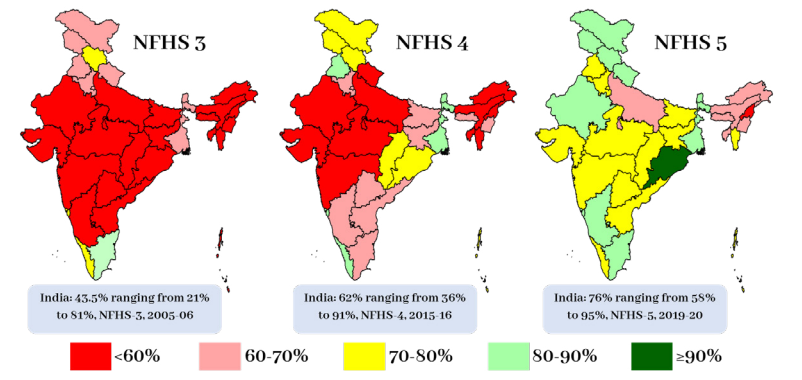


Figure 1.1: FIC% among children aged 12-23 months, India (NFHS)

1 *Morbidity and Mortality Weekly Report 1396 MMWR / November 4, 2022 / Vol. 71 / No. 44 US Department of Health and Human Services/Centers for Disease Control and Prevention Routine Vaccination Coverage — Worldwide, 202. Audrey Rachlin, PhD1,2; M. Carolina Danovaro-Holliday, MD3; Padraic Murphy, MPH4; Samir V. Sodha, MD3; Aaron S. Wallace, PhD2*

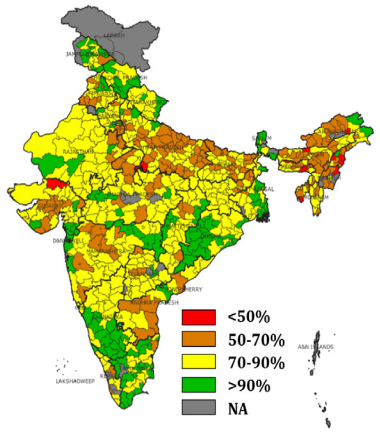
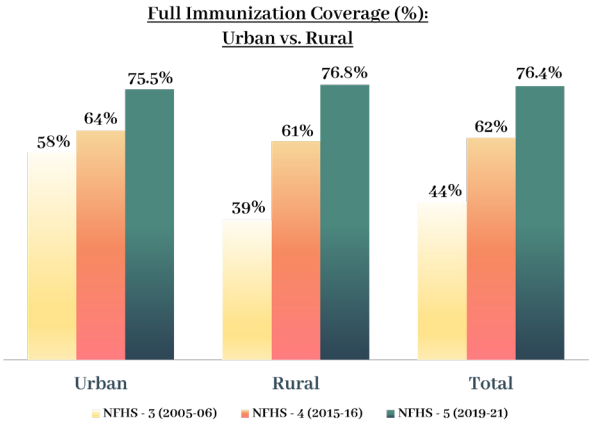


Figure 1.2: District-wise distribution of FIC% (NFHS-5)



Graph 1.2: Distribution of FIC% - Urban vs Rural (NFHS-5)

Inequities in Immunization: Inequities in vaccination coverage exist due to geographical, social/cultural/demographic variance etc. Some of these are as follows:

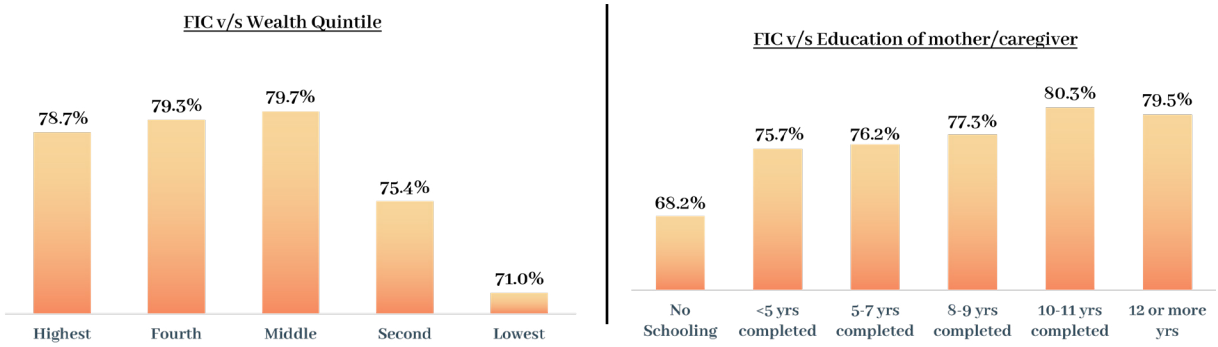
- **Intra and inter-state variations in immunization coverage:** The past NFHS rounds have shown overall progress in immunization coverage, however, the progress is not uniform across states and districts. The Full Immunization coverage in different states ranges from as low as 58% to as high as 95 % in 2019-21. (Figure: 1.1)

  District wise data of NFHS-5, shows that there are around 125 districts with FIC of more than 90%, but around 383 districts still have FIC<70%. Of these 383 districts, 12 districts have FIC< 50%. It is also noteworthy that 10 out of 12 districts having FIC less than 50% belong to the north-east region (Figure 1.2).

- **Rural/ Urban variations:** The progress in immunization coverage is not uniform in urban and rural areas. The vaccination coverage was lower in rural areas at 39% than in urban areas (58%) in 2005-06 but in 2019-21, the rural areas have shown higher coverage at 76.8% as compared to 75.5% in urban areas. Between 2005-06 (NFHS 3) and 2019-21 (NFHS-5), the coverage gain is 37.8 percentage points (39% to 76.8%) in rural whereas it is only 17.5 percentage points in urban (58% to 75.5%) areas (Graph: 1.2). The challenges in improving urban immunization coverage are multiple, including high migration, rapid urbanization, health manpower shortage, sub-optimal infrastructure, and vaccine hesitancy.

- **High Dropout rates:** India still has a significant number of partially vaccinated children. In NFHS-4, the dropout rate for BCG-MCV1 was 12.8%; for OPV1-OPV3, 19.7%; and for Penta-1 to Penta-3, 12.4%. Although the dropouts decreased considerably in the NFHS-5 survey, the dropout rates reported were 8.6%, 12.9%, and 7.4% for BCG-MCV1, OPV1-OPV3, and Penta 1- Penta 3 respectively.

  According to NFHS-5, the dropout rate for BCG-MCV1 was the highest in Assam (12.0%); OPV1-OPV3 showed the highest dropout in Nagaland (23.8%), followed by Manipur (20.7%). The highest dropout rate for Penta 1-Penta 3 was observed in Nagaland (15.0%)



Graph 1.3: Distribution of FIC% based on Wealth & Education - India (NFHS-5)

and Manipur (12.9%), followed by Kerala (11.0%) and Uttar Pradesh (11.05%).

- **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 1.3)

Measles-Rubella Elimination by 2023: India is committed to eliminating Measles and Rubella by 2023. For achieving this elimination goal, one of the key strategies is to achieve and maintain high population immunity with atleast 95% vaccination coverage of two doses of measles and rubella containing vaccine in every district of every state of India.

However, as per NFHS-5, national coverage of MR-1 is 87.9% only. Further, recent reports of upsurge in measles cases and outbreaks have unearthed pockets of low immunization coverage. Thus, to realign the country's progress on the roadmap to measles and rubella elimination, and as a recommendation of the 5th MR IEAG meeting held on 13 and 14 June 2023, the country is prioritizing more than 95% coverage of two doses of measles and rubella containing vaccine at the district level through IMI 5.0. IMI 5.0 provides a big opportunity for the country to identify all the children between 2-5 years of age who have missed MR doses, thus, preparing the country to move towards MR Elimination.

IMI 5.0: The Big Catch-Up

IMI 5.0 is the Big Catch up opportunity to address the negative impact that COVID-19 pandemic had on life-saving vaccination efforts, prevent surges in vaccine preventable diseases and address pre-existing gaps in healthcare services exposed by the pandemic.

It provides additional opportunity for children who have missed

1. Pentavalent and DPT vaccines, thereby reducing mortality and morbidity due to diphtheria, pertussis and other VPDs
2. OPV and fIPV doses, thereby improve the immunity against Polio viruses, which is critical to maintain polio-free status of India and prevent emergence of VDPVs.
3. Pneumococcal Conjugate Vaccine (PCV), which has been expanded nationwide recently
4. Measles & Rubella (MR) vaccine doses to ensure measles and rubella elimination
5. Any vaccine dose of other antigens, to alleviate the immunity gap.

CHAPTER-2:
STRATEGY FOR IMI 5.0

Key Features of IMI 5.0

- To be conducted across the country
- All children upto 5 years of age and Pregnant women due for vaccination to be vaccinated.
- Operationalization of IMI 5.0 through U-WIN
  - » Registration of eligible beneficiaries
  - » Session planning and management
  - » Real time recording of vaccine doses administered
  - » Issuing of e-Vaccination certificate to beneficiary
  - » AEFI reporting
  - » Cumulative real time reports for Program managers

Target Beneficiaries:

- Children between 0 to 2 years (0 – 23 months) who are left out or dropped out of age-appropriate doses,
- All children between 2years -5 years who have missed MR 1 & MR 2, and booster doses for DPT & OPV.
- Unvaccinated/partially vaccinated pregnant women

Note:

- The target children include all those **born on or after 6th August 2018** and due for one or more vaccines.
- If a child has not received even a single dose of Pentavalent vaccine by 1 year of age, the primary schedule is to be completed with DPT vaccine, followed by a booster dose after 6 months.
- Pregnant women target includes all those women who are pregnant on the day of the headcount survey and due for vaccination either with primary or booster dose for Td.

Timeline for IMI

Three rounds of IMI 5.0 are to be conducted, one each in August, September and October 2023 as below:

- » Round 1: 7th -12th August 2023
- » Round 2: 11th -16th September 2023
- » Round 3: 9th -14th October 2023

Each round of IMI 5.0 will be spread over 6 working days i.e. including RI days.

Note: For any deviation in working days, DIO should seek approval from the State Immunization Officer, and also of MoHFW.

Geographical Prioritization

While IMI 5.0 will be held all across the country, special focus should be on high-risk districts/ blocks/ areas identified by the state. These high focus areas include:

1. Areas with a high number of zero dose, left out and drop out children;
2. High Risk areas for Measles;
3. Areas with low coverage of new vaccines that have been introduced under UIP
4. Areas which have reported a large number of vaccination sessions as not held, against planned and areas with vacant sub centres.
5. High Risk Areas (HRAs) both migratory and non- migratory (settled) HRAs;
6. Urban areas with a special focus on slums and peri urban settlements
7. Areas with recent measles, diphtheria and pertussis outbreaks in 2022-23
8. Areas with hesitancy/ reluctance/ avoidance for vaccination

Based on the immunization related data from various sources, 270 districts across India have been identified as High Risk Districts (Annexure 11). The criteria used for selecting these districts includes the following:

- Recent outbreaks of Measles
- Areas with low Immunization coverage
- Areas with sessions missed
- Areas with vaccine hesitancy
- 143 High Priority districts selected under India Gavi partnership

It is important that activities like Head Count Survey validation, Supervisory visits, regular reviews (STFI, DTFI) with increased focus on microplanning, etc. are prioritized for these areas.

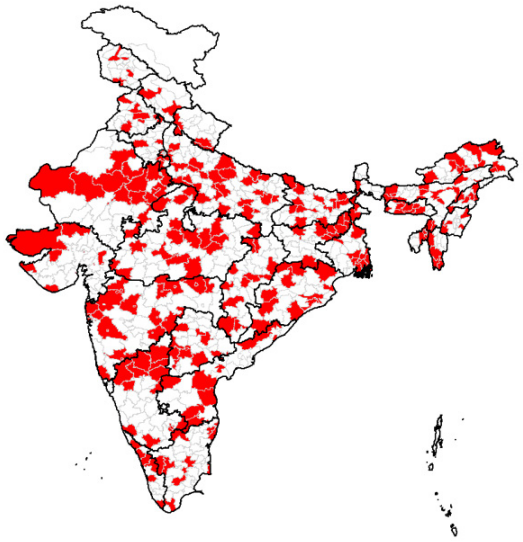


Figure 2.1: High Risk Districts

Furthermore, 120 districts have been identified as having vaccine-hesitant areas (Annexure 11). These districts need to ensure intensification and innovative community mobilization activities. Certain examples of such activities are mentioned in Chapter 8.

Note: HRA prioritization does not mean that IMI activity is to be conducted only in these selected districts only.

Session Planning

During IMI, vaccination sessions should be planned at all identified RI fixed session sites, if there are children to be vaccinated. Special additional sessions may be organized on non-RI days in high focus areas, even if the number of due beneficiaries is low.

Pre-requisite of session site:

- Accessible to the target beneficiaries
- Acceptable to the community
- Site should be highly visible to people.
- Site should be comfortable and under shade to ensure vaccines are not exposed to sunlight

Types of sessions:

1. **Fixed Sessions:** Provision for vaccination could be made on all IMI days at all existing RI fixed session sites, if there are children to be vaccinated.

2. **Outreach sessions:** It is crucial to identify a place near to the target beneficiaries for maximum achievement.

   - **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/ FBOs, Panchayat hall, religious places etc., are more acceptable and convenient for all the beneficiaries. These sites should be selected in consultation with influencers/ community leaders.

   - **In urban areas**, urban health and wellness centers, family welfare centers, private hospitals, Hospitals of CGHS, Railways and ESI, premises of NGOs/professional medical associations/ Ward councils/ Community halls etc. can be utilized.

   - **In high-risk areas** like brick kilns, nomadic sites, hamlets etc., a clean, convenient, comfortable shaded place should be selected. Support of CSOs/ FBOs/local resources to create kiosks to attract residents for vaccination may be elicited.

3. **Mobile sessions:** Mobile sessions are especially effective in areas where the number of target beneficiaries is small, the area is scattered, hard to reach, areas with temporary settlements or migratory population.

- The mobile team can cover two or more sessions on the same day that are far apart and have a small number of target beneficiaries. If the mobile teams are covering two sessions, they should have two vaccine carriers with vaccines (i.e., no. of vaccine carriers = no of sessions), to minimize the risk of using reconstituted vaccines beyond 4 hours

*All efforts should be made to plan sessions as per community demand i.e. '**Vaccination On Demand**'.*

Detailed SoPs for undertaking Vaccination On Demand are placed at Annexure 2.

- Vehicles may include Teeka express, Government/hired vehicles, boats, etc.

- DTFI should discuss the mobile session plan to get support from other departments

- The block medical officer should plan for a mobile session in mobile team planning format MP- 4 and publish it on U-WIN, well in advance (~15 days)

- The MoIC should ensure that the mobile van reaches at all these sites on the scheduled date and time, with sufficient manpower for vaccination and mobilization

- MoIC should also ensure that the information about the mobile session is conveyed to the community and the mobile session is conducted under close monitoring and supervision.

Session Timings

- IMI sessions may be conducted from 9 AM to 2 PM, however timings are flexible and subject to local requirements. Initial hours of the session (eg. Evening sessions with prolonged working hours) can be used for the preparation and registration of beneficiaries on U-WIN.

- After completion of the session, ANM should stay back at the session site for at least an hour to ensure reporting and management of any AEFI, updating the records and supporting monitoring activities. This time may also be utilized for mobilizing beneficiaries who did not turn up for the session, on the basis of due list prepared prior to the session.

- Health workers should engage with the leaders/ local influencers of the community to identify an appropriate date, venue, and timing of the session (flexible timings), if required, especially in areas where the target population (such as daily wages, factory workers, nomadic population, etc.) may not be available during regular session time.

- District administration can utilize flexible session timings to reach and maximize vaccination of such high-risk populations.

Session Planning and Management on U-WIN by Health Facility Manager

- **All Session Planning and Management is to be done on U-WIN**

- The Health Facility Manager will be responsible for the Creation and publishing of IMI Campaign Sessions as per the microplan.

- Any new session sites identified for IMI to be added on U-WIN by Health Facility Managers. Similarly, any additionally hired vaccinators are to be added online and mapped to relevant session sites.

- UIP Vaccination Session Sites tab will be used for creating sessions -
  - » Session type to be selected as IMI Campaign, Dates from the calendar for the planned upcoming sessions can be entered for up to next 3 months.
  - » Start time and End time for the session and the Total Beneficiary Capacity for the planned session should also be entered

- UIP Vaccination Sessions tab will be used for viewing the ongoing, scheduled, cancelled, and completed vaccination sessions.

CHAPTER-3:
MEASLES AND RUBELLA ELIMINATION

Measles and Rubella are highly contagious viral diseases that have been a significant global health concern for many years. Both diseases can have severe consequences, including complications and mortality, particularly in vulnerable populations such as young children and pregnant women.

Measles is caused by the measles virus and spreads through respiratory droplets, making it highly contagious. The incubation period for measles is usually 10–14 days (range 7–21 days) from exposure to symptom onset. Common symptoms include high fever, cough, conjunctivitis, a characteristic maculo-papular rash and bluish white Koplik's spot in the oral mucosa. Measles can lead to complications such as otitis media, diarrhoea, pneumonia, encephalitis (inflammation of the brain), and even death.

Measles is a tracer of the strength of the immunization system. It is often described as the "***canary in the coalmine***" for other disease outbreaks that might occur in areas of low vaccination coverage. These areas may therefore report increased outbreaks of measles and other vaccine preventable diseases resulting in high morbidity and mortality, especially among young, malnourished children.

Rubella, also known as German measles, is caused by the rubella virus and can have severe consequences if contracted by pregnant women. If a woman becomes infected during the early stages of pregnancy, rubella can cause congenital rubella syndrome (CRS) in the fetus, leading to birth defects, including hearing impairments, eye abnormalities, and heart defects. Therefore, preventing rubella transmission is crucial, particularly to protect pregnant women and their unborn children.

Under Universal Immunization Programme, 2 doses of Measles and Rubella Vaccine (MRCV) are administered at 9-12 months and 16-24 months of age. Vaccination protects the individual and also contributes to community protection through herd immunity if MR vaccine coverage is >95%.

What is MR elimination?

Measles elimination: Defined as the absence of endemic measles transmission in a defined geographical area > 12 months. It is verified after it has been sustained for at least 36 months in the presence of a high-quality surveillance system.

Rubella elimination: Defined as the absence of endemic rubella virus transmission in a defined geographical area for >12 months and the absence of CRS cases associated with endemic transmission in the presence of a well-performing surveillance system.

This goal can be achieved only when

- Vaccination coverage with both doses of Measles and Rubella Vaccination is >95% among the children upto 5 years of age group.
- Non Measles Non Rubella Discard Rate is >2/1,00,000 population
- Zero transmission of Measles/Rubella virus

Why 2 doses are important:

Around 95% children seroconvert only after two doses of MR vaccine. The peak antibody response occurs after 6-8 weeks of MR vaccine but the immunity conferred by vaccine persists for life. Thus at least 2 doses are required to protect an individual from the diseases and curtail the transmission.

Why is the elimination important?

India is signatory to WHO- South East Asian Region resolution of Measles and Rubella Elimination by 2023.

- The country has recently reported upsurge in Measles outbreaks even in areas with high vaccination coverage with both doses of MR vaccine as per the HMIS.
- The disease is particularly fatal in children with malnutrition who fall prey to severe measles and more complications.
- Complications due to measles such as diarrhea and pneumonia are major contributor to Under 5 mortality.

How to eliminate MR:

The 4th India Expert Advisory Group meeting for Measles and Rubella (IEAG-MR) in 2022 strongly recommended that the country urgently develop a "Roadmap to Measles and Rubella Elimination." Accordingly, the MR elimination roadmap was developed and

disseminated by Government of India (GOI) to all States/UTs for its implementation in September 2022. The roadmap envisages and has enabled the District Task Force for Immunization (DTFI) chaired by District Magistrates/ Deputy Commissioners at the district level, to set goals towards achieving at least 95% MRCV- 2 coverage by age 2 years, or at the latest age 5 years. The roadmap also emphasizes on the importance of achieving and maintaining sensitive fever and rash surveillance with a minimum of Non-Measles-Non-Rubella (NMNR) rate of 2 per lakh population. The roadmap provides clear guidance on the elimination process by including measurable goals and timelines.

The MR Elimination roadmap has been adopted and implemented by all States/UTs. The District Task Force have been closely reviewing the action plans along with the key performance indicators on monthly basis, so that MR elimination can be achieved.

Recently held 5th IEAG-MR, recommended the following strategies for immunization strengthening in view of MR Elimination target by 2023.

- Continue implementing the roadmap and strengthen routine immunization activities
- Utilize the opportunity of Intensified Mission Indradhanush to ensure all children under five years of age that missed MR vaccines complete two doses of measles and rubella vaccine
- Focus on high-risk districts
- Intensified multi-sectoral coordination, participation and monitoring [Indian Academy of Paediatrics (IAP), Rotary, Lions, Panchayati Raj, urban local bodies]
- Ensuring urban immunization activities are intensified in all urban areas

Best practices followed by the States for effective implementation of MR elimination:

Administrative/Operational

- Delhi utilized the MCD/NDMC and Govt. bodies for coordination during the campaign while Telangana is ensuring Interdepartmental convergence with Self Help Groups, school management and ASHA/ANM for Hyderabad Corporation area.
- Activities are reviewed at highest administrative level (Principal Secretary-Health) in Gujarat
- Urban immunization being strengthened in Gujarat and Karnataka with the help of Urban Task Forces and **Namma Clinics** respectively
- Re-prioritization and re-categorization of districts with identification of poor performing blocks at State level in Jharkhand, Kerala, Uttar Pradesh based on the local measles epidemiology.
- Sub district planning strategies for MR elimination activity in Gujarat and Karnataka (Gram Panchayat involvement)
- Uttar Pradesh has leveraged the MR strategy through Health and Wellness sub-centre by training CHOs and rationalizing posting of ANMs for filling up positions in vacant sub-centres specially in the areas reporting outbreaks
- Telangana has engaged separate field monitors for NHM from Mandal and Ward level activities.

Communication

- Bihar has prepared a communication strategy in microlevel dialect and organizes Nukkad Naataks, videos along with line departments – SDO/SHO/Local Mukhiyas.
- Gujarat has formed local SBCC teams at District and Taluka level along with influencers and partners for IEC in identified areas to increase demand generation.
- Religious leaders/influencers have been involved in Kerala and Karnataka
- Maharashtra has identified the Link between malnutrition and severity of cases for effective communication about the significance of MR vaccine.
- Maharashtra is also involving partners and local NGOs for effectively tackling vaccine resistance.

Way forward:

- >95% coverage of both doses of Measles and Rubella Vaccine (MRCV) with special focus among areas with high proportionate children with Zero doses, areas with high drop out between Measles and Rubella vaccine 1st dose and 2nd dose, areas reporting Measles /Rubella outbreaks and among children with partial vaccination history or unknown vaccination history, far flung areas and tribal districts.

- Putting all efforts in Intensified Mission Indradhanush with special focus on urban pockets which is like an Achilles Heel in achieving the elimination.

- Escalate the implementation of sub-districts/sub-divisional plan. Inclusion of within ministry and beyond ministry departments (ministry of tribal affairs, WCD etc.) to deliver a MR free State.

- More regular and intensive reviews of MR activities should be planned with every fortnightly review at DTFI level.

- Continuous and sustained Fever and Rash surveillance in Districts/ sub-districts/ taluks and mandals

- Multi-stakeholder approach / Whole of Government approach- involving Panchayati Raj, Urban Development, Women Self Help Groups, religious leaders, members of IMA, IAP, Rotary, Lions etc. for MR related activities.

- Ensuring the availability of MCP card with every parent/caregiver to verify the Vaccination status of the child since most of the measles cases have reported to have unknown vaccination status.

- Demographic analysis of Outbreaks in districts reporting outbreaks for forming strategies and communication material accordingly to tackle vaccine hesitancy.

CHAPTER-4:
PREPARATORY ACTIVITIES

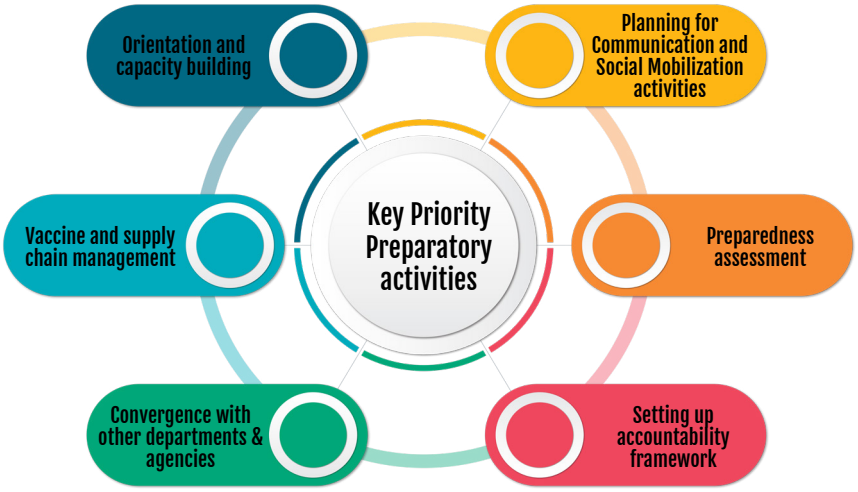


Figure 4.1: Key preparatory activities for IMI 5.0

Based on past experience, sufficient preparatory time is very critical for the successful implementation of IMI. Adequate time needs to be dedicated to activities like head count survey, microplanning, capacity building etc. Please refer to the Gantt chart, placed in Annexure 3, which guides the preparatory activities.

Orientation and Capacity Building

Training of all the front-line health workers and support staff including program manager, supervisors, mobilizers. ASHAs etc., is necessary to ensure the quality of service delivery, communication, documentation and administrative support. The standard training material shared by MoHFW is to be used (after local translation, if required) for training of all the staff involved in the activity.

Training components:

1. Conduction of head count survey and beneficiary due list preparation using revised formats.
2. Importance of high-risk areas and how to focus on such areas
3. Preparing micro plans, including communication activity planning
4. Planning & conducting sessions
5. **New initiatives: Enhanced focus on training on the following U-WIN modules:** (Figure 4.2)
   - » Registration an scheduling module
   - » Administrator module
   - » Vaccinator module
   - » Delivery point module
   - » Mobilizer module
6. Recording and Reporting
7. Advocacy and social mobilization activities
8. AEFI surveillance, management and reporting
9. Bio Medical Waste Management

The key trainings to be undertaken at various levels are shown in Table 4.1 as follows:

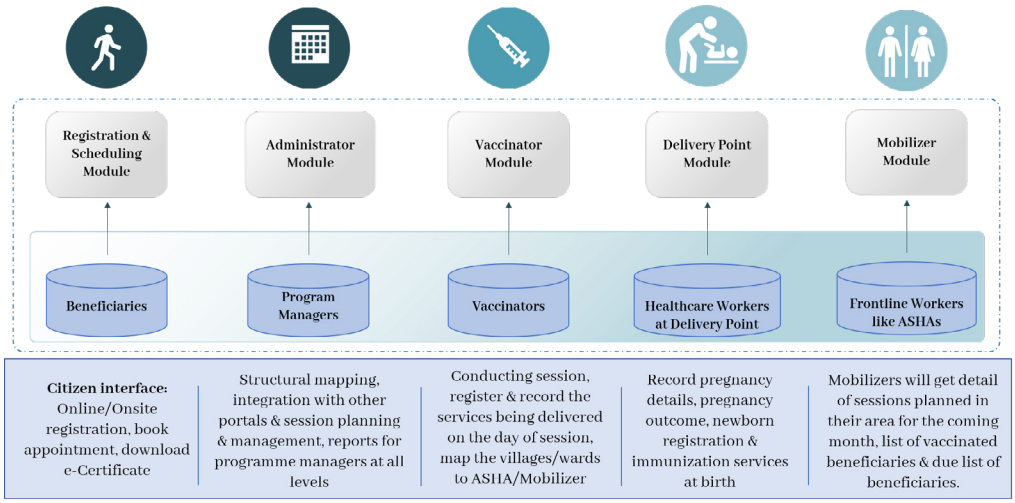


Figure 4.2: U-WIN modules

Table 4.1: Key trainings to be undertaken at various levels

S. No.	Training	Trainees/ Participants	Trainers/ Facilitators	Training Duration	Timeline	Key Focus
State level workshops						
1	State workshop on IMI	DIO and one MO from each district (two persons per district). Also includes representatives from development partners, district coordinators, State- Program managers (NHM), IEC consultants, ASHA coordinators, cold chain officers, data managers, M&E coordinators (NHM), finance & accounts managers (NHM). The states with big Municipal corporations, should ensure their participation in the state level workshop	National level officers, SIO with support from state cold chain officer, State demo graphic officer (in charge of data), IEC officer and partners such as WHO India NPSP, UNICEF, UNDP, JSI and others	One-day workshop	4th week of June 2023	Train and orient the district level health officials, on conduction IMI activities and operationalization of U-WIN
2	State media sensitization workshop on IMI	Media Persons	Chair: Principal secretary Co-Chair: MD NHM Facilitators: SIO with support from partners, state IEC consultant and media officer.	Half-day workshop	At least 1 week prior to the launch	Media briefing kit to be shared prior to the Media sensitization highlighting the key focus areas for the IMI campaign and expected support from Media to make the campaign successful.
District level workshops						
3	District IMI Workshop	All MOs from block / urban planning unit 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). Representatives from various line departments (Education, ICDS, PRI, etc.)	DIO, Master trainer (MO/ District training officer), Master trainers from partner agencies	One day	4 weeks prior to IMI	Participants trained to facilitate training of FLWs and other block health officials, sensitize officials from other key departments at the block.

S. No.	Training	Trainees/ Participants	Trainers/ Facilitators	Training Duration	Timeline	Key Focus
Block level workshops						
4	Training of Program / Accounts managers	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	To train and orient on IMI financial guideline, timelines, U-WIN
5	Training of Data Handlers	Data handler one per block or urban unit	DIO, District Data Manager, District M&E Manager, Master trainer (MO/District training officer) and partner agencies, VCCM	Half a day	4 weeks prior to IMI	To train on IMI data collection, reporting, timelines, U-WIN
6	Training of cold chain handlers	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	3 weeks prior to IMI	To train on vaccine and logistics requirement, cold chain handling, vaccine supply and documentation and reporting through eVIN
7	Media workshop	Representatives / reporters from media (print / electronic)	DIO, District IEC consultant, media officer along with CMO/ CS and District Information Officer, with the support of partners. The district magistrate chairs the meeting.	Half a day	2 weeks prior to IMI and between rounds	To orient the media person about IMI, the importance and benefits of vaccination, demand generation, and clarifying their queries. District Media briefing kit to be shared prior to the Media sensitization highlighting the key focus areas for the IMI campaign and expected support from Media to make the campaign successful.

S. No.	Training	Trainees/ Participants	Trainers/ Facilitators	Training Duration	Timeline	Key Focus
Block level workshops						
8	Training of vaccinators	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	1 day	Within 3- 5 days following district workshop	Headcount survey, registration on U-WIN, micro plan, preparation, duelist preparation, safe injection practices, communication, documentation, capturing the vaccination event on U-WIN and reporting. IPC/Community engagement kit for Community mobilisers.
9	Training of mobilizer	ASHA supervisor and ASHA/AWW/ Link workers	BMO/MO, HEO, BCPM, Admin & Finance officer and partners	½ day		

Note:

- Clear training calendar to be prepared on the day of National training
- All trainings should be intensively monitored for quality and attendance and findings should be shared at all review platforms.
- DIO and Nodal officer in the urban area should prepare a training calendar for each type of district-level training and share the same in the DTFI meeting. Also, they should guide the BMOs/ MOs to prepare a training plan at the block and planning unit level, who then prepare a training calendar for each type of Block level training and share the same in the BTFI meeting.
- DIO should identify 2-3 trainers per block with the support of partners and ensure that cascaded trainings are conducted at the block and planning unit level for frontline workers and supervisors.
- Progress on training status at each level should be shared with the state immunization officer.
- Financial support to trainings/ workshops is through NHM
- Suggested draft agenda for the trainings is placed at Annexure 4
- Trainings on U-WIN: In addition to the workshops mentioned above, Workshop for Nationwide Scale-up of U-WIN was held on 8-9 June for States/UTs and Partner agencies. The cascade trainings at State, District and Sub-district levels are being conducted in the 2nd/3rd week of June onwards to aim for all districts to go LIVE on U-WIN in the lead up to IMI round-1.

Vaccine & Supply chain management

An efficient vaccine and supply chain management is to be ensured for the effective implementation of IMI 5.0. eVIN to be utilized for ensuring the availability of vaccines, forecasting and indentation for the required doses. **The states/UTs need to estimate the vaccine and logistics requirement for IMI and intimate the requirement of additional vaccines and logistics by 2nd week of July 2023 to Immunization Division, MoHFW.** To ensure proper planning and visibility, status of vaccine availability should be updated on eVIN at all levels

Convergence with Ministries, other departments & agencies

During earlier phases of IMI, inter-ministerial and inter departmental coordination has been critical for the effective implementation of IMI activities. In this phase of IMI, the focus is on MR elimination, for which States may coordinate and seek support from the concerned departments as per local requirement. Coordination with the Department of Medical Education at the state level is required for the involvement of medical colleges in the supervision and management & reporting AEFIs. Convergence of medical college representatives, professional bodies such as the Indian Medical Association (IMA), Indian Academy of Pediatrics (IAP), representatives at the district level, developmental partners including WHO, UNICEF, UNDP, BMGF, JSI, CHAI, Jhpiego, 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. Central Bureau of Communication through its Regional Outreach & Field Outreach Bureaus and State media agencies needs to be optimally utilized during the campaign. These can be involved in organizing and overseeing all communication and public relations' (PR) activities to ensure effective communication with stakeholders, media and the public at the state and district level.

Communication strategy

Effective pre-publicity using all relevant media like mass media, mid media, digital media and on ground IPC is essential in the identified populations with a focus on migrants, urban slums, hard to reach populations and clusters with high vaccine hesitancy. This could effectively be done by engaging with influencers and proper display of relevant IEC material, mass media campaign, digital messaging along with door to door campaigns with key messages highlighting the benefits of immunization and preparing the community for common /minor AEFIs and their management. It is very important to communicate and sensitize all beneficiaries and key programme stakeholders on the timely administration of scheduled immunization and the importance of complete vaccination.

Prior to IMI round, the mobilizer should ensure that all the beneficiaries, including guardians of missed children of 2-5 years, are well informed through IPC and various community engagement activities. The ASHA/AWW should check the due list and may prepare an invitation card (Bulawa Parchi), writing the date and time of the IMI session and due vaccines for each beneficiary. The cards are to be issued to all the due beneficiaries at least a day prior to the IMI session.

Immunization Invitation card (State name :2023-24)	Immunization Invitation card (State name :2023-24)
Counter Foil	
District ----------	District ----------
Block/Urban area ----------	Block/Urban area ----------
ASHA/ Mobilizer Name ----------	ASHA/ Mobilizer Name ----------
Place & Date/ Time of Immunization ----------	Place & Date/time of Immunization ----------
Pregnant woman/Child Name ----------	Pregnant woman/Child Name ----------
Husband/ Father's Name ----------	Husband/ Father's Name ----------
Phone no. ----------	Phone no. ----------
Due Dose 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 1/2/3	MR 1/2	JE 1/2	PCV 1/2/B	RVV 1/2/3	DPT B 1/2	Td 10/Td 16

Figure 4.3: Model Invitation Card for Due Vaccination

Extensive Information Dissemination campaigning on U-WIN features of:

- Self-registration of eligible beneficiaries by citizens,
- At home registration by Vaccinators & ASHAs,
- Facilitated registration by other staff,
- Vaccination e-certificate and reminder SMS for next visit on registered mobile number.

Beneficiaries to carry photo ID and registered phone number to session sites for registration on U-WIN.

Assessment of Preparedness

It is crucial to assess the IMI preparedness for the success the programme. The various domains of assessment will be conducting task force meetings, AEFI committee meetings, status of implementation of communication activities including mass media, involvement of key stake holders and plan of supportive supervision and assignment of monitors, training status, progress in micro planning activities, sensitization of medical colleges and large hospitals for reporting of AEFIs, U-WIN cascade training progress and operationalization.

Preparatory assessment of States will be done from National level while the States will undertake the assessment of districts and share the status with MoHFW on a weekly basis. The states and districts may prioritize assessment activities in high focus areas.

Accountability framework

Strong ownership of district administration and the health department is key for the successful implementation of the mission. Accountability is strengthened through task force at national, state, district, city and block. State and district AEFI committees should take ownership to ensure that steps are taken to report AEFIs from medical colleges and large hospitals and investigated and managed on time.

MoHFW to provide overall guidance and review	National
Inter Departmental Coordination	
Training/Orientation of state health officials	
Communication to state administration & other concerned departments	
Communication strategy, prototype of IEC materials	
Steering Committee ensures accountability framework	State
STFI for overall guidance and monitoring	
Inter Departmental Coordination	
State review committee to review progress,	
State level training of all district level trainers	
Coordination with other departments & partners	
Oversee Communication activities, funds allocation, and supply chain	
DTFI/CTFI to support in planning, interdepartmental coordination, and resolving issues	District/ City
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	
Timely Trainings to be conducted	
Adequate Human Resource	
Communication Planning	
Distribution of funds, vaccines, IEC materials Logistics to blocks/Urban units	
BTFI headed by BDO to support in planning, coordination and resolving issues	Block
Identification of HRAs	
Special Strategy to be developed for underserved people	
Adequate Human Resource	
Timely Trainings to be conducted	
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

Key activities for Planning for IMI session

1. Master listing of all areas and Head Count Survey (HCS)
2. Registration on U-WIN & Due list preparation
3. Microplanning
   - » Sub-center/ ANM area level micro planning
   - » Block level micro planning (includes Manpower and vaccine, logistics planning)
   - » District level planning & HR distribution

The IMI 5.0 strategy is to immunize the missed children up to five years of age and pregnant women across all districts. The Head Count Survey (HCS) is to be conducted accordingly. All efforts should be made to encourage registration of beneficiaries by vaccinators, self-registration by citizens, and facilitate registration by healthcare workers and other support staff to ensure the availability of online records for all eligible beneficiaries (0-5 year old children and pregnant women). Based on head count survey, additional sessions during IMI are to be planned at High-Risk Areas (HRA), at vacant sub-centres, VPD outbreak areas and for other district / area priorities like flood affected areas, security compromised areas etc. All vaccination sessions conducted during IMI weeks would be considered as IMI sessions. All IMI campaign sessions will be planned and conducted on U-WIN including adding additional session sites and hired vaccinators.

Steps of IMI planning process:

1. Master listing of all areas and head count survey
2. Preparation of due list of beneficiaries
3. Microplanning - IMI sessions; vaccine and logistic estimation; manpower planning; communication plan

Master listing of all areas and Head Count Survey (HCS)

Master listing of all areas and planning of HCS should be undertaken by ANM wherein she enlists all the areas (village/ hamlet/ tola/ mohallas/ ward) including HRAs (in a separate row refer below classification) in the Sub-centre / ANM area, in Form HC-0.

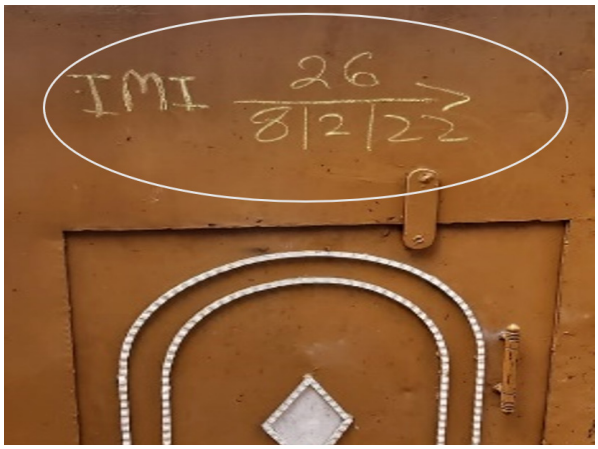


Figure 5.1: House Marking for Headcount Survey. Encircled marking on the HH signifies presence of eligible beneficiary

The objective of the headcount survey is to reach the entire population and list out all the pregnant women and all the children up to 2 years as well as children between 2-5 years of age with missed vaccine dose, in an area. The formats for HCS have been revised (Annexure 5) to capture information that is essential for the registration of the beneficiary on U-WIN. Additionally, a new HCS format, Form HC 3A, has been developed to capture information of 2-5 years aged children who are found due for any vaccination. Based on the HCS, unvaccinated and partially vaccinated children will be identified for each area and listed for coverage under IMI.

Key features of HCS are as follows:

- All workers deputed for HCS, involving ANM and supervisors, should be oriented on the methodology of HCS, revised formats and process of registration on U-WIN.
- HCS plan should be made in a way that ASHA/AWW/Link workers/volunteers complete the activity in the entire district as

Formats to be used for HCS:

- Form-HC-1- House-to-House survey form
- Form-HC-2- Pregnant women survey listing form
- Form-HC-3- Infants/children survey listing form
- Form HC-3A: Survey Listing form for Children between 2-5 years of age due for vaccination

per the timeline i.e., July 2023. HWs should conduct surveys on non-RI days and to complete them within 7-10 days for an area. On each day, 25-30 houses shall be covered.

- The trained ASHA/AWW/Link worker/ volunteers should be assigned to their respective village/ Mohalla /Area for headcount survey and provided with adequate number of hard copies of HCS formats and other logistics.

- The survey should cover all the households in the area in a systematic way, using a polio micro plan or any other possible way and marking each house visited. Support from other departments should be sought to identify link workers or volunteers that can undertake HCS in urban areas where ASHA is not present.

- Support from the ICDS department is to be sought for relevant information of all the target beneficiaries available on Poshan Tracker, to facilitate inclusion of all households.

- During HCS, details of children up to two years along with pregnant women are to be enumerated as per prevailing practice i.e., in paper-based format. In addition, during HCS, the worker should also elicit information from each household on children of 2-5 years of age. If there are children of this age group in the house hold, their vaccination status would be verified through a card or through an interview (this is to be reiterated during HCS training). **If the 2-5-year old child is found to be due for any vaccine, details of such a child are to be taken in the HCS format (HC 3A) and they are to be considered as eligible beneficiaries for the upcoming IMI 5.0.**

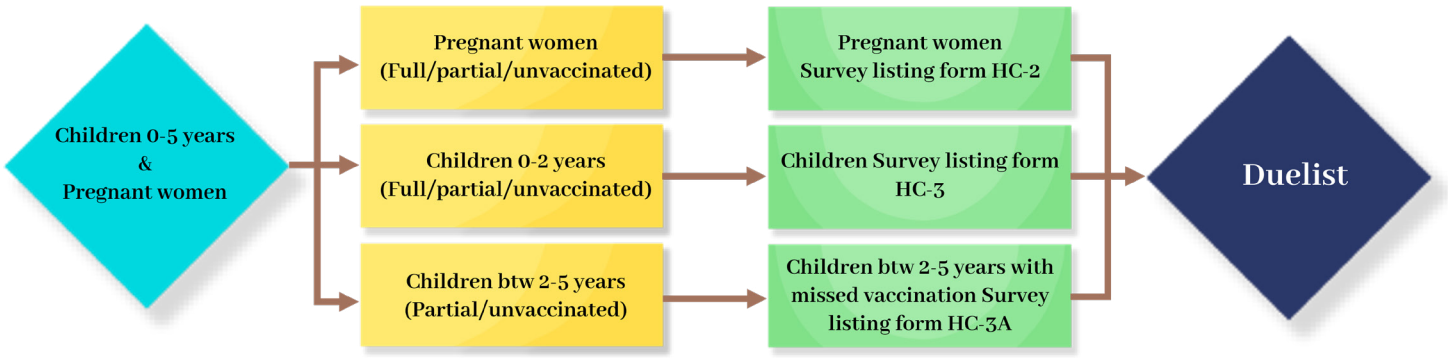
- The trained ASHA/AWW/Link worker/ volunteers can pre-register the beneficiary on U-WIN by capturing basic details like Name, Gender, Date of Birth, Photo ID type and mobile number.

- The Co-WIN database is to be leveraged, where the vaccinator can on-site search for already registered female citizens in Co-WIN with registered mobile number/ Reference ID/ Photo ID numbers and tag them as Pregnant women.

- All the 0-5 year old children are to be registered afresh and linked to the record of the Mother/Father/Guardian.

- At the end of HCS, the formats are to be submitted to respective ANMs, who in turn would prepare the due list of beneficiaries- which should include beneficiaries up to 2 years, beneficiaries of 2-5 years who had missed their due doses and pregnant women.

- All these identified beneficiaries are to be registered in U-WIN which will be an ongoing process. Encourage all efforts for registration of beneficiaries by vaccinators, self-registration by citizens, facilitated registration by healthcare workers and other support staff to ensure online records of all eligible beneficiaries (0-5-year old children and pregnant women). Additionally, for the beneficiaries not registered before the session there will be



Flowchart 5.1: Headcount Documentation in formats

IMI SESSION DUE LIST (for ASHAs/ Mobilizers)
(Prepared by ANM)

Due list

Block / Urban : _____ PHC / UPHC Planning Unit: _____ Name of Sub-Centre / ANM area: _____ Name of Session Site : _____

Name and Ph no of ASHA:_____ Name and Ph no of AWW / Mobilizer:_____ Name and Ph no of Influencer:_____

Name and Ph no of ANM :_____ Date of Session: _____ Date of next session at this site: _____

Details of Pregnant Women / Children upto 5 years due for vaccination for IMI session											After the IMI session (to be filled by ANM)					
Sl. No.	MCP Card UWIN No.	Name of Child / Pregnant Woman	Date of Birth (for Child) / Expected date of Delivery (for PW)	Age in years and months (completed)	Gender (M / F)	Name of Father / Mother/ Husband with contact number	Vaccines due in this IMI session									
							Mention name of ALL due vaccines	Is child >=1 yr & not recieved Penta-1 (Y/N) *NA if pregnant woman*	Child >1 yr due for MR-1 (Y/N) *NA if pregnant woman*	Child >2 yrs due for MR-2 (Y/N) *NA if pregnant woman*	Did the pregnant woman / child arrive today? (Yes / No)	If yes, vaccines administered today to pregnant woman / child	Has vaccination status updated in U-Win	If not vaccinated then reason (R1/R2/R3/R4/R5)	When to come for next vaccination? (date)	What vaccines is/are due next session?
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1			__/__/__								Y / N		Y / N		__/__/__	

Figure 5.2: Specimen Due List Format

a provision for on-site registration by the vaccinator during the IMI session recording the vaccine doses administered.

- As the IMI activity is focused towards and is critical for MR elimination, there is a need for an intense monitoring and supervision plan, especially in the high focus areas. The supervision teams should visit and validate these areas and households. The head count survey validation format is placed in Annexure 6. The assigned supervisor will cross check 5 houses, and provide hands-on training to rectify issues observed. The suggested list of indicators for Headcount survey (HCS) validation are as below:

- For children below 1 year of age:
  - » % Children below 1 year due for one/ more dose missed in HCS
  - » % Children ≥ 6 weeks without Pentavalent-1 identified in HCS
  - » % Children below 1 year due for Penta-1 dose missed in HCS
- For children between 1-2 year of age:
  - » % Children 12-23 months due of one/ more dose missed in HCS
  - » % Children 12-23 months without Penta/ DPT-1 missed in HCS
- For children between 2-5 year of age:
  - » % Children 24-59 months due any DPT dose missed in HCS
  - » % Children 24-59 months due for MR1/ MR2 dose missed in HCS

- HCS Process
  - » % Surveyor that were trained for conducting HCS
  - » % Surveyor using standardized format for HCS
  - » % Areas where surveyor has missed children due for one/more vaccine(s) in ≥2 HH
  - » % Cluster of ≥3 HH not visited by surveyor

Repeat survey if: 1). ≥ 3 consecutive HH not visited for survey AND/OR 2). ≥ 2 HH have missed children due for any due vaccine dose(s) in HCS.

Registration of beneficiaries on U-WIN

All the children and pregnant women captured during head count survey are to be registered on U-WIN. The Vaccinator module of U-WIN will be used to register surveyed population through:

- **At home registration**- Based on the information collected by the ASHAs/other mobilizers during the headcount survey, there will be a provision for ASHAs to pre-register beneficiaries at time of head count survey or the Vaccinators (mainly ANMs) can collect this data from the ASHAs/ other mobilizers in hard copy format and pre-register the beneficiaries and update their previous vaccination history in the Vaccinator module.

- **Self-Registration**- The citizens can be motivated to self-register the eligible beneficiaries on U-WIN.

- **On Spot Registration**- Beneficiaries coming to the session site will be checked for existing record on U-WIN through their mobile number/photo ID number. Alternatively, existing Co-WIN database (linked with U-WIN) can also be utilized to tag a beneficiary as pregnant woman or Mother/Father/ Guardian of an infants/children. If unregistered, vaccinator would be able to register beneficiaries who report to the session site directly as walk-ins.

- U-WIN registration of all the children who are in the due list and do not turn up for vaccination, should also be ensured by the vaccinators, mobilizers and other support staff.

Registration on U-WIN & Due list preparation:

- Once the head count survey is completed, ASHA/AWW/Link worker will prepare the due list with the support of ANM in the sub-centre/ ANM area. The due pregnant women, and children under the age of 5 years who are due for any vaccine as per age are enlisted. The number of due beneficiaries is to be shared with ANM/ vaccinator. The source of duelist is form HC-2, 3 & 3A. Specimen of Due List format is shown in Figure 5.2.

- The ASHA/AWW/Link worker and ANM in the sub-centre need to ensure U-WIN registration of all the children and pregnant women captured in the head count survey.

- The previous vaccination history of all the children aged 0-5 years along with dates of the vaccine doses received on the last visit is to be updated by the Vaccinators (mainly ANMs) while doing the registration in U-WIN.

- The ANM can plan updating the information on U-WIN at any convenient time or provide special slots to beneficiaries to visit the sub centre to get their details updated on U-WIN.

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

- 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

- Villages/areas with Vacant sub centers, two or more consecutive missed routine immunization sessions.

- Hard to reach areas

- Areas with vaccine hesitancy

- Urban/ Peri-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.

Vaccination and U-WIN registration of children who were delivered at home should be ensured.

IMI Session Planning and Management on U-WIN by Health Facility Manager - All the sessions planned for IMI week are to created and published online by each planning unit. Ideally 15 days prior to the session date.

- The new session sites identified for IMI and the session which are being planned for IMI are to be tagged on U-WIN by Health Facility Managers.
- **UIP Vaccination Session Sites** tab will be used for creating sessions -
  - » Session type to be selected as **IMI Campaign**, dates from the calendar for the planned upcoming sessions can be entered for up to next 3 months.
  - » Start time and End time for the session and the Total Beneficiary Capacity for the planned session should also be entered
  - » All vaccinators including hired vaccinators should be added online and mapped to relevant session sites.

Microplanning:

Overall success of the program depends on the quality of micro plans. The district should follow a bottom-up approach in planning for IMI. ANM will prepare the micro plan at the sub-centre/ ANM area based on the headcount survey and identified high risk areas, and share it with the planning unit, UPHC or block. 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-centre.

The medical officer in charge will collect micro plans from the sub-centers, and compile them to prepare a block micro plan. The medical officer reviews, finalizes, and shares the block micro plan with the DIO. The block and district should focus on rationalized work distribution among ANMs, managing additional HR, and other requirements. The Health Facility Manager will be responsible for the creation and publishing of IMI Campaign Sessions.

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. Plan for validation of HCS is to be developed at the district level and to be carried out during HCS activity.

A. Sub-center/ ANM area level micro planning

Responsible person: ANM/assigned staff (In vacant sub-centres, ANM in-charge should prepare the microplan and implement IMI activities)

Process:

- **Data collection:** ANM to conduct a meeting with ASHA/AWW/ Link workers in the sub-center and collect survey form- 2, 3, &3A and due list.
- **Data Verification:** The collected data must be checked for quality and completeness. All the due children up to 5 years and pregnant women for the upcoming IMI should be listed.
- **Data entry:** List out all the villages/Mohalla including High Risk Areas (HRAs) and the number of due children in each area. The entry of all the children and pregnant women captured during HCS is to be ensured on U-WIN Portal, either before, during or after the sessions.
- **Selection of area for IMI sessions and session site:** ANM in discussion with ASHA, AWW/Link worker to decide on the places in need of IMI sessions. The team should select a session site that is most:
  - » Accessible to beneficiaries,
  - » Acceptable by all communities,
  - » Available on the day of IMI
- **Selection of Mobilizers:** In discussion with the team, ANM to identify mobilizers (ASHA & local influencer) for each of the area/ session sites.
- **Mapping of mobilizers on U-WIN:** In the vaccinator module, the ASHA workers or mobilizers will be added and the villages/ wards will be mapped to them. All the details are entered in Sub-Center micro planning format (MP- 1)
- Each ANM will prepare a roster using microplanning format MP-3 for additional sessions in her own subcenter area in consultation with the Block MOIC. If there is a requirement for a mobile session, MOIC in consultation with ANM should plan for mobile teams in microplanning form MP-4.

B. Block/ planning unit (PHC/ UPHC) Area planning

The block review committee will review the micro plan received from all the sub-center,

IMI session planning at Sub-centre / ANM area - IMI 5.0 (for ANM) — MP-1

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

District/ Corporation:_____ Block/urban area:_____ PHC/ UPHC:_____

Name of sub centre/ Health Facility :_____ Name & mobile number of ANM:_____

S. No	Name of villages, hamlet, Urban localities, slum, migrant area, etc.	Is this a High Risk Area (HRA)? Yes/No	If HRA-Yes, mention code*	Head count done (Y/N)	Due Beneficiaries			Number of immunization sessions required	Location of session site(s) including *additional session(s)	Name & mobile number of vaccinator conducting session	Name, designation & mobile no of mobilizers only for areas requiring immunization sessions	Name and mobile number of local influencer
					Children 0–2 years	Children 2-5 years	Pregnant women					
												1. 2.

Figure 5.3: Sub-center Micro Plan Format MP-1

Block/Urban area planning: IMI 5.0 MP-2

For Block/PHC/urban planning unit

(Compile information from Format MP-1)

District/ Corporation:_____ Block/urban area:_____ PHC/ UPHC:_____

Number of sub-centres/ANM Areas:_____ Number of ANMs:_____ Number of vacant sub-centres/ANM areas:_____

S. No	Name of sub-centre	Name of areas requiring IMI session(s)	Is this a High Risk Area (HRA)? Yes/No	If HRA, mention code 1-5 & 6A-6F	Head count survey done (Y/N)	Due Beneficiaries			No of immunization sessions required			For IMI sessions (excluding mobile), mention location of session site(s). If mobile session, write "mobile"	Name, designation & mobile no of mobilizers (ASHA, AWW/ link worker)	Which ANM will conduct immunization session in this area			
						Children 0–2 years	Children 2-5 years	Pregnant women	IMI session *(exclude mobile sessions)*	Mobile session	Total sessions			ANM of same sub-centre	ANM of other sub-centre from same block	ANM from outside block	Hired ANM
													1. 2.				

Figure 5.4: MP-2 format for Block/Urban Area Planning

One local influencer should be assigned for each session, especially in the vaccine hesitant areas.

and compile it in Block/urban micro plan format MP-2.

- The location and number of vaccination sessions should be planned as per the number of target beneficiaries and injection load. The MoIC should plan for necessary fixed, outreach and mobile sessions in the block. The RI session plan should not be disturbed, and additional sessions should be planned in high risk areas not covered by RI.

- **Manpower requirement**
  - The MoIC is responsible for assigning vaccinators to all the sessions. Ensure that RI sessions are not disrupted and all 6 working days of ANMs are utilized.
  - **Team Composition:** One vaccinator and one mobilizer for each IMI session for an injection load up to 50.
  - For a higher injection load, an additional vaccinator can be added. The additional vaccinator for a session could be ANM from the same sub-center/sub-center of the same block or another block in the district or a hired vaccinator.
  - The plan for engaging additional vaccinators should be discussed with DIO, who can then assign ANM from other blocks based on the available resources.
  - If there is still a manpower shortage, vaccinators can be hired through NHM. The hired vaccinators can be retired ANM/trained staff, vaccinators from NGOs, private nursing homes/hospitals/ medical colleges, ANM/Nurse training institutes, ESI, central government health facilities including Railways and Military, Urban development agencies, health staff from corporations, and community-based organizations, or any other trained vaccinator as per the state policy (including CHOs).
  - The hired vaccinators should be well-trained before IMI on the immunization schedule, safe injection practices, AEFI management and use of injection adrenaline to manage suspected anaphylaxis at session sites, documentation, reporting, and communication.

- **Vaccine & Logistic Planning:** A week prior to conducting every round of IMI, the CCH should ensure:
  - Availability of vaccines in sufficient quantity and indent for the requirements. The vaccines expiry dates and stage of VVM should also be checked.
  - Availability of all logistics like syringes, vaccine carriers, ice packs, tally sheet, hub cutter, colour-coded bags for waste management, in sufficient quantity and indent for the requirements.
  - Availability of sufficient cold chain space and functioning of ILR/Deep freezer.
  - Contingency plan for power failure and availability of enough ice packs in deep freezer
  - Availability of copy of final IMI micro plan and vaccine distribution plan
  - Alternate Vaccine Delivery (AVD)/ Vehicles' mechanism is placed and the person is well informed on IMI micro plan and route plan

C. District level planning & HR distribution

- The micro plan received from the blocks are compiled at the district.
- The district review committee will review the completeness and quality of each micro plan.
- The committee will analyze the number of ANM days available at each block against planned sessions.
- DIO will look for a requirement of additional HR in any block/urban area and assign them in a rational manner, if required.
- The details will be 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 7. The communication plans must account for :

1. Identification of areas/pockets with vaccine hesitant families/communities.
2. Mapping of influencers who can support in convincing and mobilizing such families/communities, also account for capacity building/orientation and briefing of such influencers . Plan to give them standardized key messages.
3. Mapping of local resources like CSOs and CBOs who can support frontline workers and their capacity building on community mobilization on immunization. The CSOs/ CBOs which supported the COVID-19 vaccination program can be engaged. Plan to give them standardized key messages.
4. Mapping of available platforms such as local melas, haat bazaars, places with high footfall that can be used for message dissemination. Places that have provisions that can be capitalized for display of AV materials or making announcements.
5. Plan for strengthening inter department convergence and seeking support of frontline workers of other departments such as Education, ICDS etc.
6. Plan for production of IEC materials – what will be produced, how will it be distributed upto the village level and disseminated/displayed in best possible way.
7. Plan for media engagement, having media briefings; constituting a small group for social media dissemination and monitoring.
8. Plan for group and IPC sessions by frontline workers. Consider including special meetings for male involvement in immunization.
9. Have a robust plan to document the communication activities through stories, photographs and video documentation.
10. Supportive supervision is key- plan for supervisory visits to monitor and mentor ASHAs and ANMs in execution of communication microplans.

Note: All sessions, whether fixed, outreach or mobile, should ensure robust planning for AEFI Management:

- Identification & Designation of health facilities staffed with a MO in government/ private sector as an AEFI management centre.
- Each health facility should prepare a list of such centres dispersed geographically in their jurisdiction area so that in the event of an AEFI, the beneficiary can be quickly referred and managed.
- Microplan of each session should include the name and contact details of the MO of the AEFI management centre.
- All the MOs of the designated AEFI management centres should be trained in standard AEFI management and reporting procedures.
- Each vaccination team to have information (address and contact number) of the nearest designated AEFI management centre.
- Arrangements to be made for immediate transportation of any person suffering an AEFI to the designated AEFI management centre.
- All AEFI management centres should be provided with AEFI treatment kits and AEFI case reporting forms (CRFs).
- Availability of anaphylaxis kit with the vaccinator should be ensured *(Note that the Adrenaline vials have a short expiry date, therefore ensure that the adrenaline vials are within expiry date.)*

CHAPTER-6:
ORGANIZING IMI SESSION

Key steps for Organizing for IMI session

1. Ensuring vaccine and logistics supply chain management
2. Communication activities
3. Management of vaccination session
4. AEFI management and reporting
5. Documentation and reporting through vaccinator module (UWIN)
6. Closing the session

Leveraging U-WIN platform for organizing and conducting IMI session

Vaccine, logistics supply chain management

The cold chain handler (CCH) is responsible for vaccine, logistics and supply chain management and should receive training at the district. On IMI days, the CCH, should ensure the following:

Morning:

- Conditioning of ice packs and packing of vaccines and diluents in zipper bags
- Transportation of vaccine carrier and logistics to session sites through AVD system
- Recording of the supply of vaccines and other logistics in the register and eVIN

Evening:

- Ensure all the vaccine carriers with unused and used vaccines (with open vial policy) reach the cold chain point through AVD.
- Stock entry of returned vaccines and timely reporting on eVIN
- Disposal of returned immunization waste as per BMW management guidelines

Communication activities

- **Display of IEC material at the session site:** Relevant IEC material on the benefits of immunization, vaccination schedule, timely vaccination, AEFI reporting and management, Registration on U-WIN etc. should be displayed prominently in the respective local language.

- **Mobilizing beneficiaries:** On the day of IMI, the mobilizer should keep a copy of the due list in hand and actively mobilize all the beneficiaries with the support of local influencers. Mobilization teams (prachar toli), influencers, or volunteers can be used to reach families who do not turn up for vaccination reminder calls. ***The mobilizer can use the mobile number collected during HCS and call the beneficiary to vaccination session site.***

- ***The mobilizer should inform the beneficiaries to carry an identity card &/ or phone with a registered mobile number along with the MCP card, to the vaccination session. This will be essential for getting the beneficiary registered on U-WIN, if not one on prior basis.***

- **Community engagement:** The Local influencer can be requested to Inaugurate the session and ensure announcements from nearby religious institutions for effective community mobilization

Management of Vaccination Session

- Before starting a session, the ANM should verify the availability of:
  - » All the vaccines and diluents in sufficient quantity and in good condition i.e. within the expiry date and VVM in a usable stage.
  - » Correct diluent with the vaccine
  - » Adequate quantity of syringes, Syrup Paracetamol, anaphylaxis kit (adrenaline within expiry date), tally sheet, hub cutter, immunization waste disposal bags.

- The ANM should ensure that the mobilizers and local influencers are available and mobilizing the beneficiaries. An updated due list should be made available to the mobilizers.

Data entry on U-WIN:

The ANM should start the session on U-WIN. Once the session is initiated, the ANM will be able to see the list of pre-registered beneficiaries, beneficiaries who have

Table 6.1 – Upper Age Limit for Vaccination Under UIP

Upper age limit for vaccination under UIP		
Vaccine	**Upper Age Limit**	• If a child has crossed 1 year and not received any dose of Pentavalent, s/he to be given 3 doses of DPT at an interval of 4 weeks each followed by a booster dose after 6 months. • If the child has already received one or two doses of Pentavalent, OPV and RVV before one year of age, do not repeat the previous dose, vaccinate the missed one with a gap of 4 weeks in between doses and complete the immunization schedule • If the child has already received one or two doses of PCV and fIPV before one year of age, do not repeat the previous dose, vaccinate the missed one with a gap of 8 weeks in between doses and complete the immunization schedule • In case MR-1 is delayed beyond 16 months of age, MR-2 should be given after a gap of 4 weeks.
Hepatitis B (Birth dose)	24 hours	
OPV Zero dose	15 days	
BCG	1 year	
Penta, fIPV, PCV, Rota (1st dose)	1 year	
OPV	5 years	
Measles/MR	5 years	
DPT	7 years	
JE	2 years *	

booked online appointments and will also be able to do on-site registration for walk-in beneficiaries.

The Vaccinator Module of U-WIN will be used to register and record the services which are being delivered on the day of session. Key steps at the session site level would include –

1. Identity verification
2. Update previous vaccination history
3. Record the vaccine administered in present visit, after vaccinating the beneficiary
4. Generate e-Vaccination Certificate

In case of any offline session, data may be entered on U-WIN by 5 pm on the next day of the session.

Vaccinating the beneficiaries:
It should be ensured that all eligible children and pregnant women are vaccinated, which includes:

- All due beneficiaries in the due list
- Any due beneficiary not in the due list/ direct visit to the session site
  - » The pregnant women or children who have recently shifted to the area
  - » The relatives of the residents, visiting the

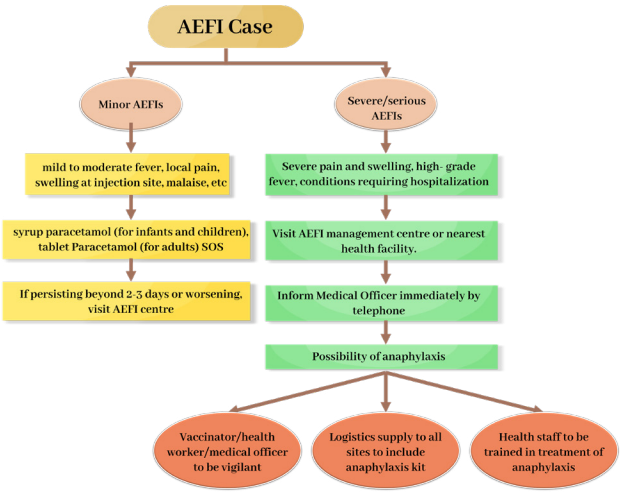
Table 6.2: Schedule for vaccinating children of > 1 yr of age who have not received any vaccine

Vaccinating children of > 1 yr of age who have received no vaccine before 1 yr of age	
1st dose	**Follow up vaccination**
DPT- 1	DPT- 2 & 3 at 4 weeks interval; Booster after 6 months
OPV- 1	OPV-2 & 3 at 4 weeks interval; Booster after 6 months
MR- 1	4 weeks between MR-1 & 2 (2nd dose 16-24 months)
JE- 1	4 weeks between JE-1 & 2 (2nd dose 16-24 months)
Do not give BCG, PCV, RVV, fIPV, Penta	

*For IMI 5.0

Vaccinator should ensure the following:

- Adherence to Safe Injection Practices, Open vial policy (wherever applicable), guidelines on biomedical waste management.
- Reconstituted vaccines (BCG, MR) must not be used after 4 hours of reconstitution.
- **Delivery of Four 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.



Flowchart 6.1: AEFI Management and Reporting

area
  - » Anyone missed/not included in headcount survey
  - » Recently migrated to the HRAs

- Vaccinate beneficiaries even if they do not have MCP card, identity card, mobile number, etc. There will also be a provision for registering the beneficiaries who do not have an identity card or mobile no.

- Any child with no MCP card should be provided with a new MCP card and entries should be updated. Incomplete entries in partially filled MCP cards should also be updated.

- If a child has taken vaccines in the private sector and is due for any vaccine/s, and willing to take/continue under UIP, register and vaccinate them as per UIP schedule. Follow up with these children in the subsequent IMI rounds and/or RI sessions till complete immunization.

Vaccination schedule:
National Immunization schedule should be adhered to (Annexure- 1). In case of delayed vaccination, the rules as displayed in Table 6.1 and Table 6.2 are to be followed.

- The order of administration of multiple vaccines should be such that oral vaccines are administered before injectable vaccines. Follow the sequence: - OPV, Rota, fIPV, PCV, Pentavalent/DPT.

AEFI management and reporting

Most vaccine reactions are minor and settle on their own. Severe and serious reactions are rare. All healthcare personnel must have a humane, responsible, sensitive and empathetic approach in dealing with AEFI cases. Timely attention and management of AEFIs can prevent serious clinical consequences and helps in maintaining the confidence of the community. A continuous dialogue must be maintained with the family and the community while managing AEFIs.

For reporting of AEFIs occurring during IMI, all the processes, formats, and timelines as in the current national AEFI surveillance operational guidelines are to be followed. Two major changes are that reporting and recording of all AEFIs will be done through U-WIN. Minor AEFIs will also be recorded in U-WIN. Any AEFI (minor, serious, severe), if observed, can be reported on U-WIN by the vaccinator, health facility manager, block MO and DIO. There will be a provision for reporting of AEFIs from U-WIN and sharing of data and information between U-WIN and SAFE-VAC. For managing AEFIs, the guidelines on the use of injection adrenaline by vaccinators at the session site and guidelines on the use of syrup paracetamol for fever, pain, and swelling at the injection site should be adhered to.

Management of AEFIs
Health workers and medical officers must be vigilant so that AEFIs can be prevented,

detected timely, and managed. Health workers or vaccinators should follow the guidelines as mentioned below:

- Ensure recipients wait for 30 minutes at the session site after vaccination and monitor the health condition of the recipient

- After vaccination, inform the vaccine recipient about any minor events which may occur.

Minor AEFIs: Management of adverse events such as mild to moderate fever, local pain and swelling at the injection site, malaise, etc. using syrup paracetamol (for infants and children) or tablet Paracetamol (for adults) SOS with a minimum interval of 4-6 hours between two doses. The recommended dose of Paracetamol is 10-15mg/kg body weight every 4-6 hours with a maximum dose of four doses in 24 hours. Ask the beneficiary to visit the AEFI management centre or nearest health facility, if minor adverse events persist beyond 2-3 days or worsens.

Severe/serious AEFIs: In case of adverse event/discomfort/illness, other than minor events, the beneficiary should visit the AEFI management centre or nearest health facility. Vaccinator/health worker should support and facilitate the process.

- Inform Medical Officer immediately by telephone about serious/severe AEFIs
- The vaccination team should have emergency numbers (102, 108, etc.) for transporting cases to the AEFI management center / higher health facility.

Management of anaphylaxis

Vaccinator/health worker/medical officer at the vaccination site must be vigilant for the possibility of anaphylaxis. Anaphylaxis is a very rare but severe and potentially fatal allergic reaction. The logistics supply to all the sites should include an anaphylaxis kit. Every health facility should have health staff trained in the treatment of anaphylaxis and should have rapid access to an anaphylaxis/ AEFI kit with adrenaline. They should be familiar with its dosage and administration. Adrenaline has a short expiry life, so monitor the expiry date on a regular basis. Guidelines on the use of inj. Adrenaline by health workers for initial management of anaphylaxis can be referred to for more details on this.

Documentation and reporting

- After vaccinating a beneficiary, details of the vaccine doses administered are to be entered / updated on the U-WIN portal.
- The beneficiary would receive the vaccination e-certificate through an SMS link on a registered mobile number or can be downloaded from the self-registration portal of U-WIN.

- The ANM should also continue recording into the tally sheet and RCH register as per existing practices. 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***)

- ***Left-out:*** *Child who has not received any vaccine under UIP (unimmunized).*
- ***Zero-dose:*** *Child who has not received first dose of pentavalent vaccine by one year of age.*
- ***Drop-out:*** *Child who has received one or more UIP vaccine/s but did not complete the schedule as per the age (partially immunized).*
- ***Full Immunization:*** *Child who has received BCG, 3 doses of OPV, 3 doses of pentavalent and MR-1 by one year of age.*
- ***FIC plus:*** *Child who has received all the vaccines given as per National Immunization schedule (NIS) by one year of age.*
- ***Complete Immunization:*** *Child who has received all the vaccines given as per National Immunization schedule (NIS) by two years of age.*

Closure of IMI session

Even if all the due beneficiaries have been vaccinated, ANM should not close the session early. The session should be closed at the scheduled time, so that walk-in beneficiaries (if any) are vaccinated. This will also help in reducing vaccine wastage. After updating the data of the vaccinated beneficiaries in the session, the vaccinator MUST end the session on U-WIN also. Though the online entries must be updated in real-time, but there would be a provision to allow updation of pending entries till 5 pm on the next date of the session. After this deadline the session if not ended by the vaccinator, would be auto-ended by the system.

ANM/ASHA/AWW/Link workers will together prepare the due list for the upcoming round referring to the current duelist, Tally sheet, and Headcount survey.

There will also be a provision in U-WIN for the vaccinator and mobilizer to see the details of the sessions planned in their area, see the list of vaccinated beneficiaries in previous rounds, download and see the name wise due list of beneficiaries for the next round (including the beneficiary wise e-vaccination certificate).

CHAPTER-7:
RECORDING AND REPORTING

Key features of Reporting & Recording for IMI 5.0:

- Immunization coverage under IMI 5.0 will be reviewed utilizing the U-WIN Portal
- Details of beneficiaries vaccinated under IMI should be reflected on HMIS also.
- Reporting in standardized formats and on google sheet will be continued.

Collection of accurate data and timely reporting is important for data analysis and undertaking mid-course corrective measures. Recording and reporting data of vaccination during Intensified Mission Indradhanush 5.0 rounds will be done on:

1. Tally sheet
2. RCH register
3. U-WIN portal
4. Monthly progress form for uploading on the HMIS portal
5. Google sheet

IMI Portal is being discontinued.

Recording and reporting through hard copy and Google sheet

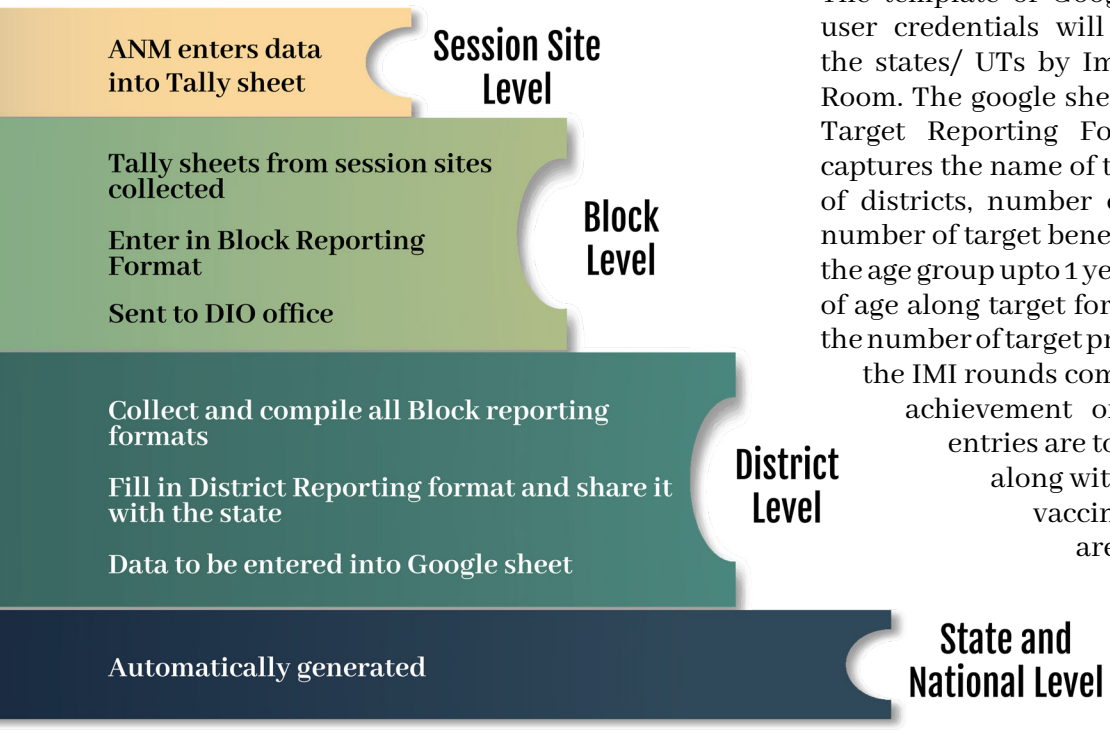
- ANM will enter the details of beneficiary wise vaccines given in a standardized format. The tally sheet will be sent to the block along with the vaccine carrier through AVD or supervisors will collect and share them in the evening meeting. Format of the tally sheet is placed at Annexure 9.

- Before the start of every IMI round, the number of target beneficiaries are to be entered into the Google sheet and shared by all states & UTs.
- During the IMI rounds, the DIO should ensure that the data is collected and shared to state through Google sheet daily in the evening as per timeline.

- **Block**: The person assigned for reporting will collect Tally sheet from all the session sites, compile and enter in Block Reporting Format (Annexure 9) and send it to DIO office

- **District**: The data handler/person assigned for reporting will receive Block reporting format from all the blocks/urban units, compile them in District Reporting format (Annexure 9) and share it with the 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.

The template of Google sheet along with user credentials will be shared with all the states/ UTs by Immunization Control Room. The google sheet for target, i.e., the Target Reporting Format (Annexure 9) captures the name of the state and number of districts, number of sessions planned, number of target beneficiaries identified in the age group upto 1 year, 1-2 years, 2-5years of age along target for MR-1 and MR-2 and the number of target pregnant women. Once the IMI rounds commence, to report the achievement of IMI, antigen wise entries are to be done in the sheet along with the reason for non-vaccination. All the details are to be captured for urban and rural areas separately.



Flowchart 7.1: Recording and reporting through hard copy and Google sheet

- **National**: The data collected through Google sheets will be analyzed to assess the achievement under IMI. Regular feedback will be shared with the states and UTs for relevant action. Templates of all Reporting & Recording formats are placed in the Annexure 9.

Reporting on U-WIN

A. Vaccinator Module:

Real-time data entry will be done by Vaccinators at the IMI Campaign session sites updating all the vaccine doses administered to each beneficiary. The Vaccinator module will be used to register and record the services which are being delivered on the day of the session for Children and Pregnant Women.

1. Registration:

- **At home registration of beneficiaries by Vaccinators** - Based on the information collected by the ASHAs/other mobilizers during the headcount survey, there will be a provision where the Vaccinators (mainly ANMs) can collect this data from the ASHAs/ other mobilizers in the hard copy format and pre-register the beneficiaries and update their previous vaccination history in the Vaccinator module. Additionally, a provision for ASHAs to pre-register beneficiaries at time of head count survey is also available.

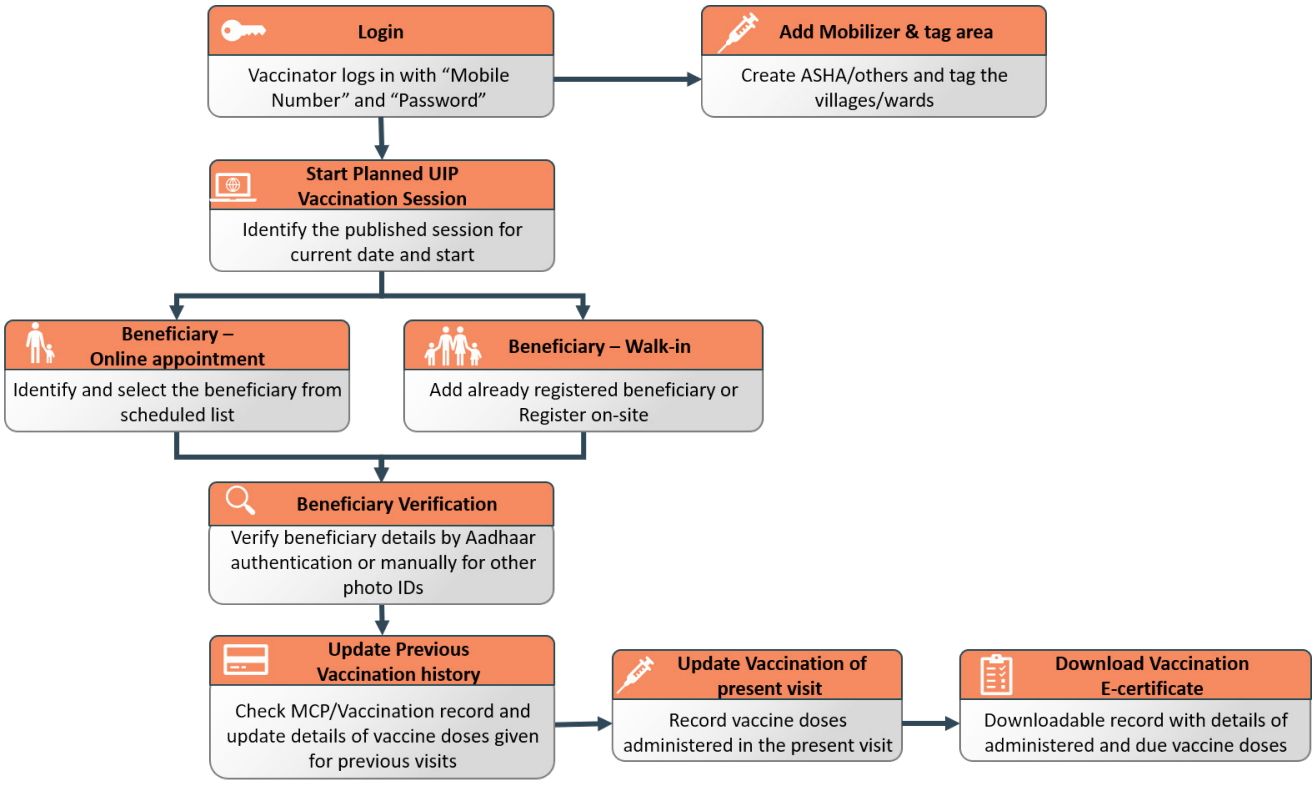
- The Co-WIN database will be leveraged, where the vaccinator can on-site search for already registered female citizens in Co-WIN with registered mobile number/ Reference ID/ Photo ID number and tag them as Pregnant woman.

- All the 0-5 year old children will be registered afresh and linked to the record of the Mother/Father/Guardian

- **On-Site Registration of beneficiary**- Vaccinator would be able to register beneficiaries who report to the session site directly as walk-ins or those mobilized by the ASHA/other mobilizers.

2. Conducting Vaccination Sessions

- Once the health care worker starts the session s/he will be able to see the list of the beneficiaries who have booked online appointments and will also be able to add on-site registered (walk-in) beneficiaries.



Flowchart 7.2: Workflow – Vaccinator Module

- Key steps at the session site level would include –
  i. Identity verification
  ii. Update previous Vaccination History
  iii. Record vaccine administered in present visit
  iv. Generate digital e-Vaccination certificate

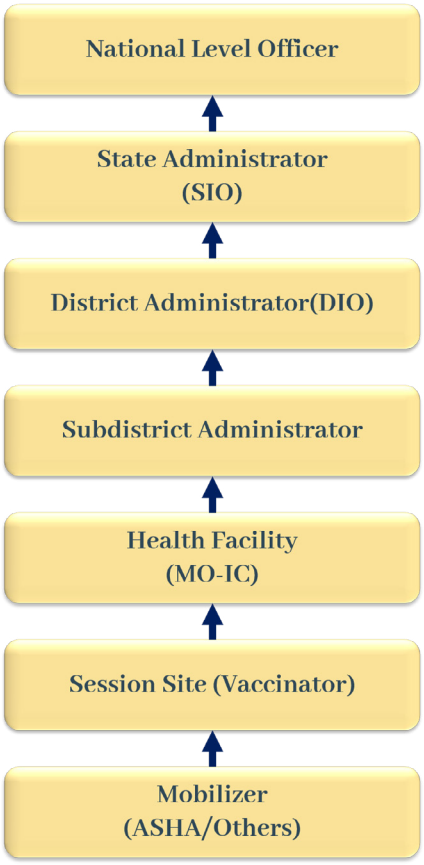
3. Generate digital e-Vaccination certificate.

Note: The vaccinator must end the session on U-WIN after updating entries of all the vaccine doses administered to beneficiaries during the session. Though the online entries must be updated real-time, there would be a provision to allow the updation of pending entries till 5 pm on the next date of the session. After this deadline the session if not ended by the vaccinator, would be auto-ended by the system.

B. Reports Module:

The various levels which have access to U-WIN are summarized below:

There will be a drill down option (National<State<District<Sub-district<Health Facility<Session Site) at each level based on the level of login. These reports can be downloaded in Excel format. There will be an option in the reports to get data of the following duration – Today (present date), Cumulative (from initiation to present date), and Date Range (max 1 month). The various reports that can be generated from U-WIN are:



Flowchart 7.3: Levels with U-WIN access

1. IMI Campaign Session Sites & Sessions Status

Session Sites - Data points are entered in the session site creation form by the Health Facility Manager and the up-mapping of information is done (State, district, sub-district, Health facility, eVIN CCP). This is updated every 24 hours.

Session Status - The created IMI campaign sessions could be categorized under 3 groups – completed, ongoing and scheduled. This report will have line-list of all published sessions with the timing of planned session, actual time when session was started and ended by vaccinator and name of the vaccinator assigned for the session. This report is updated every 3 hours.

Upcoming sessions - This report will have details of future, upcoming sessions planned for next 15 days/30 days/90 days and published by the Health Facility Managers as per the micro-plan.

2. Registration Report:

This report on the Registrations will be available to program Managers. It has data of the fresh registrations done (online and on-site) in 3 categories - Pregnant women, 0-1, 1-2, and 2-5 year old children. This report is updated every 2 hours and session-site wise registration reports will also be available for download.

3. Coverage Report

The aggregate of all the vaccine doses administered to each beneficiary will be reflected in the Coverage report which can be accessed at all levels from the National Administrator to the Health Facility level. This report is updated every 2 hours and the coverage report will have the following data elements -

i. Sessions Planned and Sessions Held
ii. Number of Pregnant women, infants, 0-1 year, 1-2 year and 2-5 year old children vaccinated.

iii. Antigen wise and dose wise coverage data for all vaccines.
iv. No. of left out, missed out or zero dose children vaccinated.

Recording and Reporting of AEFI

- All AEFIs (minor, serious and severe) should be recorded and reported through U-WIN by the vaccinator, health facility manager, block MO and DIO.

- The data of all reported AEFIs in U-WIN will be transferred to SAFE-VAC automatically and will be visible to DIO as line-list.

- DIO will check the line-list of reported AEFIs in SAFE-VAC at least once a day and will verify the categorization (minor/severe/serious) in the application.

- **Daily AEFI-related reporting during the IMI rounds:** At the end of the session, details of the number of doses of adrenaline used during the session to manage suspect cases of anaphylaxis and number of vaccine recipients sent to hospital after vaccination is to be captured in the session tally sheet reporting format. At the block & district level, these indicators will be compiled in the Block reporting format and District reporting format, respectively. At the district level, in addition to the compiled figures related to use of adrenaline doses and hospitalizations during the session on that day, the DIO will also report in the District reporting format, the number of deaths reported through UWIN-SAFEVAC or informed to the DIO through the media or medical colleges or hospitals in the public and private sector irrespective of the date of vaccination as long as the vaccines are administered during the IMI round.

- The DIO will raise and submit CRF of severe/serious AEFIs in SAFE-VAC.

- The DIO and AEFI committee will follow up on the case and will conduct its investigation using the CIF. All investigation documents will be uploaded on the SAFE-VAC by DIO.

- All the timelines for reporting, investigation and causality assessment will remain the same as mentioned in AEFI operational guidelines.

- Similarly, all the formats (CRF, CIF, CA, verbal autopsy) are the same as those being used in AEFI surveillance.

- The AEFI will also be reported in HMIS as per the current guidelines and practice.

Detailed steps of AEFI Reporting on U-WIN

- Vaccinators can view the list of beneficiaries in vaccinator module of the U-WIN. From the list, vaccinator can report AEFI of identified beneficiary through the option “Report AEFI” against each beneficiary.

- After completing the form and filling information in all mandatory data fields the form can be submitted. After submission, a confirmation message will appear on the screen and the data will be submitted and transported to SAFE-VAC through APIs and an AEFI ID will be reverted to U-WIN from SAFE-VAC for reference.

- Health Facility Manager (HFM)/DIO can view details of all the beneficiaries in their jurisdiction and can search for any particular beneficiary.

CHAPTER-8: COMMUNICATION STRATEGY FOR IMI 5.0

Key features of Communication Strategy for IMI 5.0:

- Customizing the communication strategy to the target popoulation
- Messaging with focus on U-WIN, MR Elimination and vaccine hesitancy
- Activities
  - » Awareness Generation
  - » Community Engagement
  - » Tailored communication for urban areas and tribal population
  - » Media advocacy
  - » Utilization of digital media, influencers
- Monitoring of communication activities
- Documentation of communication activities

1. Objectives of IMI Communication Strategy

The objectives of IMI communication strategy is to mobilize pregnant women and caregivers of children up to the age of five years to vaccinate with all due vaccines. The campaign will have the following specific objectives:

- **Identify specific communication challenges** and the reasons for vaccine hesitancy and tailor the communication strategy.
- **Position IMI 5.0 as an opportunity** to protect children against various VPDs and empower the communities and caregivers through timely, accurate information about vaccination.
- **Strengthen the network** of relevant regional local influencers/ supporters/ vaccine advocates/ leaders/ media for and creating an enabling environment for immunization.
- **Encourage both the parents and other family members** in ensuring full vaccination of the child/children in the family and community.
- Create awareness about the ease and **utility of U-WIN** and build the capacity of community groups to facilitate pre-registration of beneficiaries on U-WIN

Target population

- Pregnant women and care givers of children up to five years of age, with a special focus on:
  - » Urban slums, Tribal population, Migrant population, families hit by natural disasters
  - » Population in hard-to-reach areas
- Local Influencers/ leaders/ volunteers
- Health Care Workers and frontline workers

2. Messages

2a. Overarching Messages

- ALL children need to receive ALL vaccine doses in a timely manner, as per the National Immunization Schedule, to stay protected.
- Vaccines are safe and life-saving
- The child/ children must be immunized timely and completely to develop immunity and stay protected against all Vaccine Preventable Diseases (VPDs)
- All doses of vaccines are available free of cost at the nearest Government Health Facilities.
- If you are not sure about the immunization status of your child, do visit the nearest health facility or talk to the health care worker in your area.
- Ensure that all children under five years of age in your family or community complete their doses during special immunization sessions being organized as part of Intensified Mission Indradhanush 5.0.
- Keep your child's immunization card safe and show it to the health care provider when requested to.

Key Communication Proposition
"***Vaccination is SAFE and it only SAVES LIVES***"

2b. U-WIN Specific Messages

- Self-registration of eligible beneficiaries by citizens, at home registration by Vaccinators & ASHAs, facilitated registration by other staff.
- E-vaccination certificate will be available on U-WIN.
- When you go to the immunization session, carry government photo ID of the guardian and registered mobile number used for registration in U-WIN (Aadhaar Card, Voter ID, Passport, Driving license, Ration Card with Photo, Pan Card, Pension Passbook, NPR Smart Card, Unique Disability ID). Using Aadhaar Card will facilitate in the generation of ABHA ID.
- Ease of vaccination process through U-WIN (like the Co-WIN portal) including the steps of verification, vaccination, and generation of vaccination certificate.
- Beneficiaries will get a reminder SMS for :
  - » One-time registration acknowledgement message
  - » Their next due visit for vaccination
  - » Vaccination acknowledgement (including the link for e-vaccination certificate) message after each vaccination visit.

2c. Considerations when communicating with Vaccine Hesitant Care Givers

- Highlight the risks of not vaccinating or incomplete vaccination and reinforce the benefits of vaccination for children and pregnant women.
- Address specific reasons for their vaccine hesitancy
- Every fourth child in India is at the risk of life-threatening diseases, because she/he is not fully immunized.
- Reinforce the message about the safety and efficacy of the vaccines and highlight the positive examples of vaccination from nearby areas
- Highlight the economic and social impact of not vaccinating and benefits of vaccinating:
  - » High financial cost of not vaccinating-child at the risk of contracting diseases, resulting in significant expenses in treatment.

Communication Activities for High Risk Areas:

- Involve local influencers like MLAs, faith-based leaders, community leaders to counsel vaccine hesitant families
- Organize folk media based edutainment campaigns emphasizing benefits of vaccination, with support from Bureau of Communication
- On the day of the session organize 'Bullawa Toli' a rally of children to take a round of the village and call everyone for vaccination.
- Identify role models from within the community (those who have accepted vaccination), seek their support in mobilizing hesitant families.

  - » Chances of impact on the physical and cognitive development of the child, thereby affecting productivity and resulting in low economic growth and prospects.
  - » High quality vaccines provided by the government, free of cost, 6 out of 10 children globally receive a Made in India vaccine.

2d. Messages related to MR Elimination

- Let us come together to make India Measles and Rubella Free.
- Measles is a viral disease, which is highly contagious and affects mostly children. It spreads through the air when an infected person coughs or sneezes.
- Symptoms of measles includes high fever, rash, cough, runny nose and conjunctivitis.
- It is a highly contagious disease, and some cases may develop serious complications.
- Two doses of MR vaccines provide long-term protection against Measles and Rubella. All children under 2 years of age must receive 2 doses of MR vaccine.
- Measles and rubella can lead to pneumonia, diarrhoea, permanent brain damage even death. Rubella leads to blindness, deafness, mental retardation and congenital heart defects.

- Measles is more severe in malnourished children. It weakens a child's immune system leading to other infections which can be fatal.

- Vitamin A supplementation (every 6 months) to every child from 9 months to 5 years reduces the risk of complications like diarrhoea and pneumonia following measles infection.

3. Proposed Activities

360-degree communication approach will be required to achieve the end goal of covering every unimmunized or partially immunized child and pregnant woman.

- Communication planning and implementation must commence in June-July 2023, and be further intensified closer to the dates of IMI each month/ round.

- Planning should also consider that there may be rains/floods/drought/seasonal migration during the period.

- Communication activities also need to be designed in a way that they can sustain over a period to strengthen routine immunization. Broadly the activities can be divided into four categories- awareness generation; community engagement; media and social media engagement and advocacy with policy makers and local influencers

3a. Awareness Generation:

- **IEC Materials and Activities:** To disseminate Information, Education & Communication (IEC) material like wall paintings, banners and posters may be displayed at prominent places, bus panels, rickshaw panels, railways stations, cinema slides, press adverts, etc. Audio-Visual spots may be played on LED/LCD screens at transit points such as airports, metro coaches/ stations, railway stations and bus stops/stations, and marketplaces and social media platforms like Facebook, Twitter & Instagram. The scroll on the dates of IMI can be displayed on local TV channels for which support maybe sought from district information officers. IMI 5.0 stickers may be pasted at frequently visited places like provision stores, chemist shops, PDS shops. Vehicles used for vaccine delivery can de used to display posters. In urban areas, standees/photo booths may be put up at marketplaces, mall, etc.

- **Collaboration/Partnerships with Other Government Programmes:** Collaborations with Govt service providers/vendors such as milk distribution schemes/booths, cooperative societies, LPG cylinder vendors, PDS shops, common service centers, and markets frequented by public in urban as well as rural areas can be used to spread the message and create awareness about the IMI programme. These partners can use stickers or logos or messages on their receipts/letter heads/slips etc. The dates of the campaign can be put on the prescription slips of prominent Paediatricians/ Medical practitioners/ Gynaecologists.

3.b.i Community Engagement:

- **Creating an enabling environment for vaccination in communities with the help of Teekakaran Mitra Tolis**: Constitute a 'Teekakaran Mitra Toli' comprising a group of volunteers who can assist the FLWs in identifying beneficiaries and mobilizing them to access services. *These tolis may include acceptor parents, youth, adolescents, SHGs, PRI/ULB members, NCC/NSS Volunteers, FBO leaders etc.* These 'tolis' can also be entrusted to make the vaccination experience better for the parents for example:

Involvement of CSOs and Development Partners

- For identifying and mapping communities with partially vaccinated and unvaccinated children, using community engagement techniques

- Identification and capacity building of local influencers as immunization ambassadors

- Support in rationalizing distribution of workload among the FLWs and building their capacities to enable positive people-centred interaction and experience during contact sessions.

- Facilitate involvement of PRIs / ULBs/ VHSNCs/CBOs/SHGs/MAS for community mobilization and identification of any demand and supply side bottlenecks.

- Arrange for seating, drinking water etc.
- Create a small play area for accompanying older children
- Accompanying mothers who are reluctant to visit vaccination center.
- Make the session site festive- draw traditional rangoli, alpana (floor patterns), and sprinkle lime along the roads/passage leading to the vaccination site- as is done to welcome a VIP in the community.
- Some members may also be made responsible for tracking the status of immunization of the children.

- **Build Child to Parent Communication**: Partner with the education department wherever feasible- a flyer/note in the diary or a verbal message can be conveyed from children to parents for vaccination of any younger children in their house. Children can carry out a rally in the village to mobilize people to come to vaccination sessions. They can create charts/posters and support with wall paintings etc.

- **Use of folk media**: Folk media play can be organized a day or two before the IMI session highlighting the importance of immunization. The venue and timing of the performance should be meticulously planned, so that maximum people can watch.

- **Faith Leaders/Traditional Leaders Engagement** for identified pockets (Minority / Northeast/ tribals etc.) Activities may include their sensitization on the importance of vaccination, mobilizing them to issue public appeals, motivating communities, and organizing announcements from places of worship.

3.b.ii Tailored Communication for Urban Areas

Urban communities present unique opportunities as well as challenges both from the point of view of programme implementation and communication. Tailor communication to the needs of the audience, using available platforms such as municipal corporations, urban development authorities, Housing Boards, Resident Welfare Associations, Neighbourhood Committees, NGOs, Women Self Help Groups, etc. Some urban specific activities suggested below may also be planned:

- Students' networks like Scouts and Guides and NCC/NSS can lend support for house listing or mobilizing the due list beneficiaries to sessions.

- Involve common public: Use social media/ radio/press ads etc. to involve the general public. For example, messages can be developed around- reminding your friend to get his/her child vaccinated; helping your employee get his/her child vaccinated etc.

- Mahila Arogya Samitis may be involved in supporting the house to house surveys, identifying beneficiaries and ensuring community mobilization.

- Partner with Nagar Nigam waste collection truck service – use their Public Announcement System to play immunization jingles and public service announcements.

- Meetings with Influencers/Ward members/ Nigam members/Shopkeepers/ labor contractors etc.

- Make session sites attractive- Putting up Photo booths/back drops/ cutouts of the IMI Logo, etc. at session sites will be attractive to parents who can take pictures and upload them on their social media and in turn be beneficial to message carriers.

- Special activities for migrant population/ Nomadic groups: Corner meetings where the migrant community gathers – bus stands, railway stations and nomadic settlements etc. (Language of the migrant population to be used and their community leaders may be engaged)

3.b.iii Tailored Communication in Tribal Areas

Just as in the urban population, communication activities will also need to be tailored to the specific needs, beliefs and culture of the tribal communities. These may need to be planned in collaboration with TRIFED, Tribal Research Institutes/ Tribal Department, Key Influencers/ Sarpanch/ Village Heads/Priests, faith-based leaders, Local/Traditional Healers, Teachers, Eklavya/ Ashram schools, etc. Tribal communities have strong beliefs and practices related to birth, death and marriage. These need to be studied for each tribal group and linked with the benefits of immunization as applicable.

- Engage with local CBOs/NGOs/tribal leaders for community mobilization

- Connect the messages within the cultural context of the tribal community and focus on disseminating such messages through peer-communication methods. Use their traditional arts and cultural symbols as applicable.

- Advocacy meetings with local traditional healers in tribal areas, engage with and involve them in mobilizing communities on Immunization.

- Organize Tribal cultural shows and performances like folk songs/folk art forms relevant to the tribal community involving the communities themselves, using their own artists where possible.

- Wall writings/ wall paintings/ Miking/ Drum beating (Duggi/munadi) in local languages and dialects.

- Involve Tribal Van Dhan Kendra to mobilize and engage tribal communities

3 c. Media Advocacy

3.c.i Print and Electronic Media:

Media engagement will play a critical role in creating awareness and addressing misinformation related to immunization and IMI 5.0. This will involve activities at the national, state and district levels; customized for different audience segments in the three phases – pre-IMI introduction, during, and post IMI roll-out.

Key Stakeholders

- Media houses including online news media at the national level
- News channels, print, radio and digital media at national, state and regional levels
- Senior editors and health, education and business journalists;
- Media from regional dailies and local dailies
- IEC/ BCC Officers
- Policy makers/parliamentarians/legislators

Key Actions: Print and Electronic Media

Media has been an enabler in fighting misinformation, busting myths and educating the general public on health issues especially during the COVID-19 pandemic and UIP programmes like Polio and MR vaccinations. It is therefore advised to plan media engagement well in advance.

- Pre-launch media engagement to amplify key messages.

- Provide media with a fact sheet about the IMI programme, Universal Immunization Programme, and how it has been a contributor to improved health indicators globally and in India.

- Providing state, district specific data on Full Immunization Coverage, IMR, MMR etc. will also be relevant for media stories.

- Ensure that media is updated on a regular basis on the IMI 5.0 programme and its progress.

- Pitch Op-eds/ Editorials of subject matter experts and MoHFW officials on IMI and including U-WIN.

- Development of success stories and testimonials from parents/ caregivers.

- Feature stories showcasing efforts of healthcare and frontline workers in hard-to-reach areas.

- #AskTheDoctor series wherein readers, TV/ Online viewers and radio listeners could be encouraged to ask questions on childhood immunization.

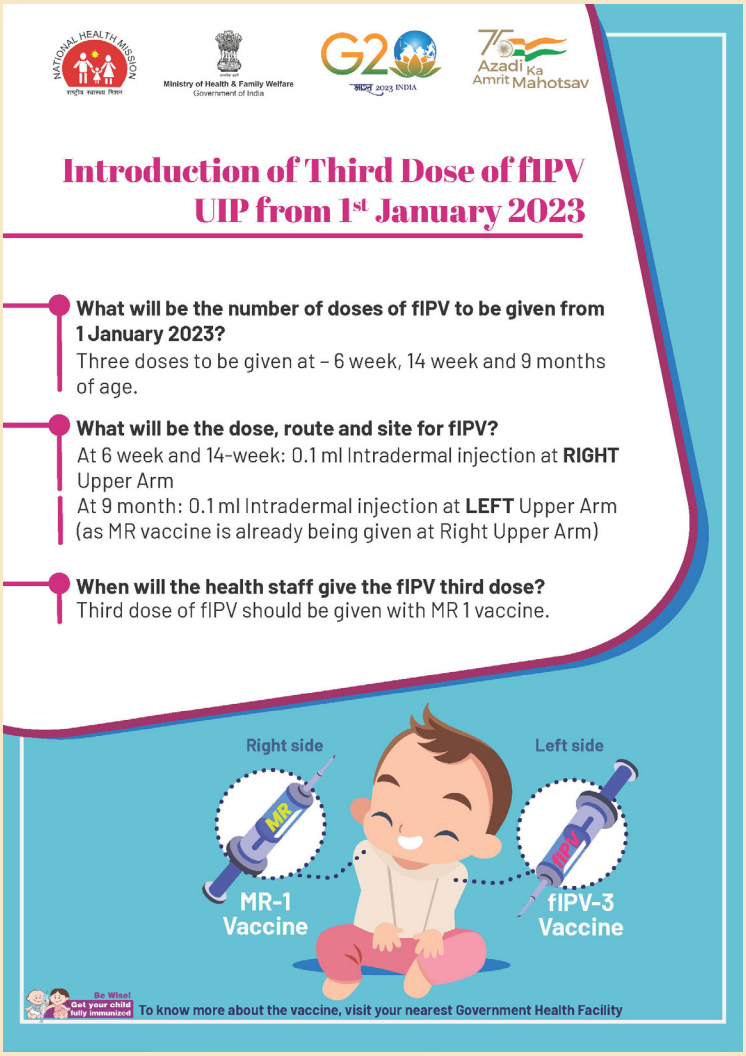
- Ensure regular engagement with regional language media including Urdu media and local TV channels. Ensure all media materials are translated into local languages before all engagements.

- Partnerships with PIB and media outlets for fact-check rumors/ fake news in a timely manner.

- Engage hyperlocal channels, social media influencers, and stringers to sensitize them on the criticality of giving space to immunization issues and to spread awareness on U-WIN.

Capacity Building of Media:

- Organizing media workshops/ roundtables with editors, health reporters, and city



reporters along with subject matter experts (State/ District Programme officials, development partners, PIB officials, IEC/ BCC Officers and State Information Officers) are critical before the launch of the programme.

- Capacity-building/ Critical Appraisal workshops of media, including Community Radio and Radio, for balanced reporting on childhood immunization issues.

- Besides reporters, involve Editors for media buy-in and specifically Sub-Editors as they define the narrative, restructure stories, give headlines for attracting readers and SEO/click baits and give captions.

- Crisis communication and AEFI Spokespersons workshops to train spokespersons for addressing media queries during crises such as AEFI

Crisis and Adverse Events Following Immunization (AEFI)

Communicating with the media during a crisis including AEFI requires specialized skills and preparation. Reporters are highly trained professionals and their broad perspective must be properly understood. The media are interested in stories that will attract attention. While the success of a vaccination programme can attract attention, so can a programme that has not gone as planned.

An important fact to be understood is that the media wants early responses to their questions and therefore waiting for the conclusion of an investigation to speak to them is rarely possible. Early and frequent dissemination of information is crucial for media coverage, as it conveys known and unknown information, avoiding unresponsiveness and misrepresentation. The role of the spokespersons is critical here.

Table 8.1: Media plan for crisis and AEFI Communication

Media releases are to be used only if required [One-to-one briefings may be considered]	Must specifically answer the 5 Ws & 1H for journalists: • Who is affected/is responsible? • What has happened? What is being done? • Where has it happened? • When did it happen? • Why did it happen? • How (how is it being handled, amplifying on the action being taken)
Spokesperson	• Identify in advance an appropriate spokesperson* with experience and training for responding to media queries (or several spokespersons in the different agencies) with an established information flow protocol from district to state to national level. • Share contact details of spokesperson(s) with all relevant focal points at different levels of programme implementation. • Ensure that the AEFI committees are aware of the need to respond to media and spokesperson is accordingly briefed. • Keep a set of key messages and holding lines ready as per anticipated situations

Media plan for crisis and AEFI Communication: The media plan for crisis and AEFI Communication should emphasize the following:

Media releases are to be used only if required [One-to-one briefings may be considered] Must specifically answer the 5 Ws & 1H for journalists (Table 8.1).

3.c.ii Digital Media

To maximize the reach of IMI communications and ensure visibility and amplification, consistent, simple and precise messaging with consistent branding, using multiple social media channels, including WhatsApp.

Digital Media: Key Actions at State Level

- Prepare a State social media plan
- Train/brief social media channel managers on the campaign
- Identify existing official social media handles for the campaign.
- Adapting content from the campaign toolkit to the state-specific context and language (shared with states in all relevant formats JPEGs / pdf / open files).
- Ensure regular sharing of e-stories, photos, videos and testimonials from the campaign or on ground activities

3.d Social Media Influencer Engagement

- Identify social media influencers in the state, and districts based on their interests (health, nutrition, child care, sports, music, public service), follower base etc.
- Ensure that the influencers are briefed about the IMI 5.0 programme and Universal Immunization Programme before they start the engagement on their social media channels.
- Ensure that they convey the simple messages on their channels through short videos, GIFs, educational videos, shorts, reels, etc.
- Engage public representatives like MP, MLA, MLC, Panchayat leaders etc. for spreading the message on IMI 5.0 campaign.
- Government officers including IAS, IPS, and Police officers too are active on social media with a sizable following. They may also be approached to spread the message about the IMI 5.0 campaign.
- Basic Social Media kit with the theme of the campaign along with few sample creatives and key messages could be shared with the social media influencers for consistency and accuracy in messages about IMI 5.0.

Table 8.2: Checklist for review at different levels

Level	Review Parameters
State Level	• Inter-department convergence • Judicious allocation of communication resources in most needy locations/ issues • Production and dissemination of materials up to district and block level • Crisis communication preparedness • Regular media monitoring for any negative media that may impact the programme and briefings (Press Conferences, Media Roundtable, Media Workshops, interviews etc.) • Active online and offline social listening to timely address any myths and disinformation • Specific communication plans for hard to reach/difficult/ hesitant/ resistant communities • Development and implementation of district specific communication plans, addressing local context • Orientation of District Managers and stakeholders • Number of case studies developed (crisis communication, vaccine hesitancy to vaccine confidence, role of FLWs in ensuring FIC in the state/district/ block)
District Level	• Development and implementation of block specific communication plans, addressing local context • Inter-department convergence • Crisis communication preparedness • Regular media (including social media) monitoring and briefing media • Dissemination of materials up to block level • Orientation of Block Managers and stakeholders • Faith leaders' meetings, local influencers meetings etc.
Block Level	• Implementation of the communication plan- with focus on Sub Health Centers/ villages with low immunization coverage • Dissemination of materials up to village level • Orientation of FLWs, local influencers
Session Site Level	• BCC/IEC material visibility • Communications plan implementation

4. Monitoring of Communication Activities

Monitoring of the Programme is key to the success of this initiative. Planning and review meetings from the state to the block and sub-block level must include a dedicated review of the development and implementation of communication plans. State – MD NHM and SIO along with Development partners should comprehensively review at the end of each round to better plan the next round. Development partners may support in monitoring and supportive supervision. The matrix below serves as a checklist for review at various levels.

5. Documentation

Concurrent documentation of communication activities held for each round is critical. The following documentation framework may be used. This must be accompanied by high-resolution action photographs, video recordings and testimonials of beneficiaries and FLWs with due consent forms. A repository of media stories must also be maintained.

Table 8.3: Documentation Framework of communication activities held

Key Communication Activity	Objective	No. Planned	No. Implemented	Total Population Reached	Results

CHAPTER-9:
VACCINE AND LOGISTICS - SUPPLY CHAIN MANAGEMENT

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

District level:

- 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 the ensure repair or replacement of non-functional CCE.
- The district vaccine store manager should ensure that adequate vaccine supplies are available in stock, based on the target beneficiaries and the permissible wastage rates of individual vaccines. The indent of vaccines should be placed well in advance keeping in mind the lead time for supply of vaccines. If the eVIN system is used for indenting the vaccines then the supplying store should take into account the increased number of sessions while generating indent for lower stores.
- Regular monitoring of stock position across all CCPs in eVIN, with the supply of vaccines to ensure adequate stock across all CCPs.
- Ensure availability of all immunization logistics including syringes, hub cutters, waste disposal equipment, tally sheets, etc. in all CCPs

CCP level:

- Timely fulfilment of indents of vaccines on eVIN to ensure real time visibility of actual stock position at the CCP level.
- Ensure that adequate vaccine stocks are available in time for each round based on HCS and the session plan.
- Monitor the vaccine storage temperature and ensure immediate information to the district in case of malfunctioning CCE.
- Monitor and ensure the daily entry of issue and return of vaccines (open & closed vials both) in eVIN and on the stock register and distribution register as per the SOP.
- Ensure availability of adequate numbers of AVD volunteers for vaccine transport and timely distribution to cater for additional session sites.

Session site level:

- Timely indent of vaccines for the session by ANM to the Cold Chain Point.
- Ensure the return of all vaccines (open & closed vials) to the CCP through AVDS after the session along with the details of vaccine consumption.
- The open vials should not be transferred from one session site to another.

- The MO PHC and Block MO and DIO should ensure availability of enough AEFI management kits (at least one for each AEFI management centre), and anaphylaxis kits with all vaccinators (including additional vaccinators).
- A minimum of one anaphylaxis kit per session is an absolute requirement.
- At the time of Inspection, MO PHCs should certify that adrenaline ampoules will not expire within the next three months.

CHAPTER-10:
MONITORING & EVALUATION

Readiness Assessment

A team of officials from MoHFW and technical officers from immunization partners will visit high priority areas to objectively assess the readiness for IMI. The assessment will cover thematic areas on planning and coordination, capacity building (training), Head Count Survey, the progress of U-WIN cascade trainings and use of the platform by Vaccinators and mobilizers for at home registration of beneficiaries, microplanning of sessions, human resource availability, vaccine/logistic availability and distribution, communication plan implementation, AEFI management preparations and supportive supervision/monitoring plan. The observations of the preparedness assessment will be reviewed and feedback shared with the state. Similar teams should be constituted by States to visit the districts.

Further, progress on key preparatory activities like the conduction of State Steering Committee, Task Forces, review meetings, training workshops, the status of head count survey, microplan preparation, supervisory plan, the status of vaccines and logistics and conduction of communication activities is to be tracked and monitored regularly at all levels.

Monitoring of operations

Medical Officer in charge should develop a monitoring & mentoring plan involving medical officers/supervisory staff and partners. The identified high risk areas should be prioritized for monitoring. Medical Officers from the Government Public Health system, Medical Colleges, and Immunization partners should be involved in the monitoring activities.

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 coverage. The monitoring will be done through revised IMI Monitoring formats on paper format/ ODK based application. If monitoring is done on paper-based format, data entry in the ODK application should be ensured on the same day. The session and house to house monitoring formats are placed in Annexures 8a and 8b

Key session indicators: In addition to the usual monitoring indicators, special focus should be given to the indicators being captured to assess:

- **Operationalization of U-WIN:** The key indicators to include:
  - » % Session sites registered on U-WIN
  - » % Session sites active vs. registered on U-WIN
  - » % Vaccinators registered on U-WIN
  - » % Sessions planned and published on U-WIN
  - » % Sessions held on U-WIN
  - » % Sessions where e-Vaccination certificate is generated after administering vaccine

- **IMI specific activities:** The key indicators to include:
  - » % Session site planned specifically for IMI
  - » % Sessions planned specifically in HRAs
  - » % Sessions located at the same site where RI session is usually held

The sessions of urban areas need to be monitored and reviewed specifically. Quantum of monitoring in urban areas should also be increased and rationalized as in rural areas

Key house to house monitoring indicators: In addition to the usual monitoring indicators, special focus should be given to:

- **IMI Specific Indicators**
  - » % Children due for at least one vaccine during IMI
  - » % Children received all / some /none of due vaccine dose during IMI
  - » % Children received the vaccine for first time in life (0-1, 1-2 and 2-5 years)
  - » % Children completed age specific vaccination as per UIP schedule (0-1, 1-2 and 2-5 years)

- **Indicators for IMI Target age group**
  - » % Children 4-11 months not vaccinated with Pentavalent-1dose
  - » % Children 9-11 months achieved full immunization (1st year vaccines for FI)
  - » % Children 12-23 months achieved full immunization (1st year vaccines for FI)
  - » % Children 12-59 months not vaccinated with Pentavalent-1/DPT dose (zero dose children)
  - » % Children 12-59 months vaccinated with DPT-1 dose during this IMI

- % Children above 2 years vaccinated with MRCV1, DPT1 during this IMI (missed children)
- % Children given MRCV-1
- % Children given MRCV-2

- **Indicators for Targeted Mid-Course corrective action**
  - % Areas with 2 or more children missed one/all of the due vaccine doses
  - % Reasons for a child missing due IMI vaccine dose – below 1 year, 12-23 months and above 2 years of age

Monitoring and Review of Coverage Reports
The suggested indicators that should be reviewed at all review platforms are:

- % Sessions held against planned
- % Coverage of co-administered antigens/ vaccines
- % Children vaccinated against a target number of children for all age groups (Upto 1, 1-<2 and 2-5 years)
- No. of children vaccinated with DPT-1
- % Pregnant women vaccinated with Td against target

U-WIN Dashboard

Indicators to be reviewed for assessing Operationalization of U-WIN are as follows:

- No. of districts where entries completed on U-WIN portal
- % of infants registered on U-WIN against target
- % of pregnant women registered against target
- % of vaccination sessions held digitally against total sessions held
- % of vaccination sessions held digitally against total sessions planned digitally

Mismatch between coverage reports and U-WIN reports should be closely monitored and rectified continuously.

The number of hospitalizations due to AEFI reported daily and the hospitalizations reported in UWIN-SAFEVAC should also be matched

CHAPTER-11:
AREAS OF SUPPORT FROM OTHER MINISTRIES / DEPARTMENTS AND ROLE OF PARTNERS

As in the past, partnership with various departments of the Health Ministry as well as other Ministries (Table 10.1) is to be established with defined roles and responsibilities. In the earlier phases of MI & IMI, fruitful partnerships have been established with 12 Ministries viz. Ministry of Women and Child Development; Panchayati Raj; Minority Affairs; Education; Information and Broadcasting; Housing and Urban Affairs, Ministries of Defence, Home Affairs, Sports and Youth Affairs, Rural Development, Railways, and Labour and Employment. They supported specific activities, such as expanding service delivery points, transportation of supplies to the last mile, community awareness, and social mobilization.

The partner agencies and other stakeholders also play a significant role in implementation of MI/IMI. The actions of all partner agencies should be aligned to ensuring operationalization of U-WIN and conducting IMI activity in an effective manner. Under the Ministry's City Embrace Model, high priority urban areas have been mapped to partner agencies. The allotted partners will be responsible for the effective implementation of IMI in their allotted areas.

Key state and local bodies such as IMA, IAP and CSOs should be actively involved with critical role in awareness generation and advocacy, particularly at the local level. IMA/IAP will support in creating awareness about full immunization and complete immunization. Details of specific activities to be supported by various Departments/ Ministries is placed at Annexure 10.

Table 11.1: Role of other ministries in U-WIN rollout

S. No.	Name of Ministry/Department	Role
1.	M/o Health and Family Welfare	Ensure smooth implementation of U-WIN and adequate capacity building of stakeholders
2.	M/o Information and broadcasting	Generate widespread awareness regarding the benefits of U-WIN and the key messages for beneficiaries regarding the same. Request the Pregnant women and Parents/Guardians of children for keeping a track of the age-appropriate vaccine doses through the e-vaccination certificate available on U-WIN
3.	M/o Sports and Youth	Promote self-registration by beneficiaries on U-WIN

CHAPTER-12:
STATE LEVEL ACTIVITIES AND RESPONSIBILITIES

Table 12.1: Governance mechanism at State Level

Governance Mechanism at State Level
State Steering Committee (SSC)
Chairperson: Chief Secretary **Convener:** Principal Secretary (Health) **Members** • **Government Departments:** Health, Women and Child Development, (WCD), Panchayati Raj, Minority Affairs, Education, Information and Broadcasting, Housing & Urban Affairs, Defence, 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, BMGF, IPE Global and other partners supporting RI in the state
State Task Force for Immunization (STFI)
Chairperson: Principal Secretary (Health) **Co-chair:** Mission Director- NHM **Member secretary:** State Immunization Officer (SIO) **Members** • Key departments, partner agencies, CSOs, religious leaders.
State AEFI committee
Member secretary: State Immunization Officer (SIO) **Members** • Specialists, DIOs, representatives of the District AEFI Committees.

Activities to be undertaken at State Level

State Steering Committee (SSC) meeting:

At least one meeting of SSC should be held during the preparatory stage. The SSC should review state's preparatory activities in terms of operational and communication planning, set accountability throughout state, district, and block level by reviewing and ensuring that regular meetings of State Task Force (STF) and District Task Force (DTF) are held and ensure active involvement of other non-health departments for their defined support.

Under IMI 5.0, it is critical that the status of operationalization of U-WIN is reviewed at all the platforms. The status of trainings, registration of health professionals and service delivery points including health facilities and session sites on U-WIN, head count survey and registration of beneficiaries, etc. need to be reviewed in the preparatory phase.

It is of utmost importance that the performance of IMI is reviewed using the U-WIN platform.

The committee should also ensure that there are sufficient and skilled human resources available at each level to plan and timely execute activities.

Sensitization of District Magistrates

The Principal Secretary (Health) and Mission Director (NHM) may sensitize and provide necessary directions related to IMI 5.0, to all concerned district magistrates about IMI through video conferencing. The guidelines and necessary directions are to be communicated to all the district administrations.

A review of preparedness before the mission starts and performance review following each round are critical for effective conduction of the campaign activities. The key focus areas during the preparatory phase are timely conduction of trainings, good quality head count survey, efficient microplanning and registration of beneficiaries on U-WIN. The state should communicate the feedback from monitoring observations and indicators to the districts through letter, and also share the communique from MoHFW, GoI.

State Task Force for Immunization (STFI) meeting:

At least one STFI to be conducted during each month during the preparatory phase and one in between each round. The STFI should review preparedness activities for the upcoming round of IMI, ensure trainings, Head Count Survey, updation of micro planning, stock and supply of vaccines and logistics, human resource deployment etc. The communication strategy should be reviewed and activities like IEC in local language and media dissemination should be planned and implemented in a timely manner.

The STFI should ensure conduction of DTFI meeting, Interdepartmental and inter-sectoral coordination at state and district level. The STFI should also ensure deployment of state level health officials in each of the districts to ensure accountability, assess preparedness, and oversee the activities. The supervision activities may be prioritized for high focus areas. STFI should oversee visit of state observers to districts during preparatory and implementation phase, and redress issues identified by them.

Reviewing the financial progress of the activities is also the responsibility of STFI. 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 should also be reviewed.

STFI can plan for a meeting, physically/ virtually, with concerned Chief medical officers (CMO), District Immunization Officers (DIO) and Block Medical Officer In charge (MOiC) to review the preparedness status, identify bottlenecks and resolve issues. The status of the state and district AEFI committee meetings and documentation of AEFI cases should also be reviewed regularly.

State AEFI committee meetings

The state AEFI committee should meet at least a month before the IMI round to review preparations for strengthening AEFI surveillance in the districts:

1. Establishment of AEFI reporting processes by DIO within medical colleges and other large hospitals in public and private sector.
2. Monitoring of AEFI registers at all planning units and health facilities in public and private sector.
3. Capacity building of vaccinators for managing anaphylaxis at session site, and of doctors in PHCs/ AEFI management centres for managing AEFIs

A week before the commencement of the first round, the state AEFI committee will review the status of above-mentioned activities in each district and status of district AEFI committee meetings. It will be ready to support districts in conducting special investigations when required.

Between the IMI rounds, the committee will meet to monitor timeliness and completeness of reporting and documentation of AEFI cases, reporting of minor AEFIs through U-WIN and will conduct expedited causality assessments.

The SEPIO, who is the Member-Secretary of the State AEFI Committee will report the salient points of state AEFI committee meetings to the State Task Force on Immunization.

State Level IMI Reviews:

SIO should review the IMI preparedness and progress of the districts through meetings/ video conferencing with DIOs (Half-day workshops) before and in between the rounds. The review activity is to be supported by Immunization partners.

- **Daily review meetings during IMI**

During IMI, the SIO should review the performance of districts daily. The state level officers and partners analyze the coverage and monitoring data, and feedback from state observers and other stakeholders. It is of utmost importance that the performance of IMI is reviewed using the U-WIN platform. The SIO should also review the status of reporting of minor, serious and severe AEFIs through U-WIN and give feedback to the DIO on unverified AEFIs on U-WIN, and delayed reporting and investigations. The SEPIO should send necessary communication to DIOs to take corrective measures.

State level Trainings/Workshop:

State health authorities and partners should intensively monitor training for quality and attendance and share findings with STFI. Details of trainings to be conducted at the state level are given in Chapter 4.

Communication activities

Ensure that a comprehensive SBCC action plan is in place at state level well in advance. The plan should have clear cut demarcation of specific IEC /BCC activities to be conducted before and during IMI at state, district, block, and village level. Special IEC /BCC activities should be undertaken for use of U-WIN as a portal for registration of beneficiaries and promoting self-registration. 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. The program manager at state level also needs to ensure that all the stakeholders like NGO functionaries, development partners and key officials of different ministries are well oriented on specific activities and their respective roles and have access to IEC material to facilitate these activities.

List of Influencers/Motivators/Volunteers: A comprehensive list of all influencers should be in place with special focus on hard-to-reach areas and hesitant/ resistant populations. All the influencers in the list must be oriented and sensitized on the fact that children who have missed their routine immunization are prone to many diseases, therefore, it is very important that every child must be immunized as per his/her schedule. They must also be well oriented about the immunization schedule, vaccine specific benefits and common side effects, management of common side effects and whom to reach in case of serious side effects.

Media Engagement: To build an overall positive and supportive environment for IMI, a well-designed media engagement plan must be put in place with effective utilization of print and electronic media. Famous TV and Film industry personalities, political personalities, famous people from medical fraternity should be involved for positive messaging around RI. Social media plans should also be carefully designed and executed at national and state level with positive messaging and for 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 to intensify each other's coverage and frequency of engagement.

CHAPTER-13:
DISTRICT LEVEL ACTIVITIES AND RESPONSIBILITIES

Table 13.1: Governance mechanism at District Level

Governance Mechanism at District Level
District Task Force for Immunization (DTFI)
Chairperson: District magistrate / collector **Member secretary:** District Immunization Officer (DIO) **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 Minority welfare officer, District Entertainment officer, minority community leader, IMA/IAP, representative from CSOs, representation from WHO, UNICEF, UNDP, JSI and other partners
District Task Force for Urban Immunization -DTFU (I) / CTFUI
Chairperson: District magistrate / collector / mayor **Member secretary:** District Medical and Health Officer/CMO/Municipal Health Officer **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, Chief Medical and Health Officer, Project Director DRDA, Representatives from WHO India (NPSP) and UNICEF or other immunization partners.
District Review Committee (DRC)
Chairperson: CMO/CS **Convener:** District Immunization Officer. **Members:** Nodal officers, district officials of key departments, representatives of district level partners, and CSOs.
District AEFI committee
Member secretary: District Immunization Officer (DIO) **Members:** Specialists and Representatives from the Blocks (MoIC).

Activities to be undertaken at District Level

The district level activities are key for successful implementation of IMI. The district Immunization officer is the nodal person for IMI at district level, wherein following activities are to be carried out.

Meeting of District Task force for Immunization (DTFI)

The District Task Force for Immunization should meet at least twice before IMI and once between rounds to sensitize the stake holders, plan, review the progress, strengthen interdepartmental coordination, identify the bottle necks, and resolve any issues. Feedback from State observers and partner agencies would be crucial and should be deliberated during the meeting. DTFI should also plan deployment of district observers to high risk blocks.

The DTFI should review the preparedness activities for the upcoming round of IMI and monitor performance during the IMI rounds. It needs to discuss and review the Quality of headcount survey, beneficiary registration and data uploading in U-WIN, due list generation, IMI session planning, social mobilization activities, vaccine and logistic

Under IMI 5.0, it is critical that the status of operationalization of U-WIN is reviewed at all the platforms. The status of trainings, registration of health professionals and service delivery points including health facilities and session sites on U-WIN, head count survey and registration of beneficiaries, etc. need to be reviewed in the preparatory phase.

It is of utmost importance that the performance of IMI is reviewed using the U-WIN platform.

supply chain. Support required for additional manpower for headcount survey, use of U-WIN, social mobilization, supervision from other departments, operational constraints and communication challenges in conducting IMI, should be deliberated in detail with specific actionable points. AEFI reporting and investigations should be reviewed and AEFI Management system should be ensured. At the end of round, DTFI should review achievements and issues raised during round and take measures to resolve them in preparation for next month's IMI round.

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

The DTFUI should also meet at least twice before IMI 5.0 and once between rounds. The District Task Force for Urban Immunization constituted in each district/city should critically review the immunization progress, identify gaps, and decide strategic actions to improve RI coverage specific to the urban areas. The key focus areas for review are in alignment with the DTFI focus areas.

City Task Force on Urban Immunization Meeting

The CTFUI should be a platform for coordination with all stakeholders and develop innovative solutions to identified obstacles. CTFUI should undertake risk prioritization to identify high priority wards, assign senior district level officials to high priority wards/areas, review HR allocation, fund utilization, training status, vaccine, and logistics supply chain management, AEFI surveillance system, and planning and implementation of communication activities. In addition, implementation of a robust supervision and monitoring mechanism should be ensured.

Meeting of District Review Committee:

The committee is responsible for reviewing overall implementation of IMI 5.0 in the district and for implementing decisions taken in DTFI meeting. The DRC needs to ensure conduction of good quality headcount survey, beneficiary data uploading in U-WIN, generation and updation of due list, IMI session planning, rationalized involvement of health workers in blocks and urban areas, ensuring timely availability of reporting formats, timely reporting of data, monitoring of vaccine and logistics supply chain and cold chain management and ensuring that eVIN is timely updated. The status of district's AEFI committee meetings and documentation of AEFI cases also needs to be reviewed by DRC. The development of communication plan and its implementation should also be ensured by the DRC. Availability and distribution of funds should be looked into.

Daily Review Meetings are to be conducted during the IMI rounds to take stock of the progress, identify bottlenecks and address the issues, if any. The review of IMI achievement should be based on the target beneficiaries for IMI in U-WIN. The nodal officers/supervisors and monitors should also share their daily feedback for mid-course corrective action.

District AEFI committee meeting

In the district, AEFI committee meeting should be held at least a month before the IMI round, the members should monitor the following preparatory activities related to AEFI surveillance, especially the expansion of reporting network and training activities:

- Review list of medical colleges and large hospitals in the district along with details of AEFI Nodal Officer, medical college and hospital staff sensitization meeting,
- Status of functional AEFI registers in planning units and health facilities (including medical colleges and large hospitals with AEFI Nodal Officer);
- Training status of vaccinators and MOs to manage anaphylaxis and AEFIs,
- Reporting and verification status of minor, serious and severe AEFIs on U-WIN.
- Completeness and timeliness of investigations of reported AEFI

District level Trainings/ workshop

The DIO should prepare a training calendar for IMI 5.0 in discussion with nodal officers. The schedule should include training of medical officers, data entry operators, cold chain handlers, program and accounts managers, and media persons. Training of all MOs from block / urban planning unit, District Program Manager (NHM), City Programme Manager (CPM), district IEC consultant, district ASHA coordinator, district cold chain handler, district data

manager, district M&E coordinator (NHM), City M& E Officer, district accounts manager (NHM), City Accounts manager or any other programme management unit staff under NUHM should be ensured. Details of the various trainings that are to be held at district level are available in Chapter 4.

Monitoring and Mentoring

The state level monitor assigned to the district will monitor the preparedness and implementation of IMI 5.0 activities. The district will assign nodal officer for each block and urban unit. The block/urban nodal officer will monitor the quality of headcount survey, data entry in U-WIN, 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 along with Immunization Partners will undertake session and house to house monitoring and mentoring daily.

Communication activities

DTFUI/CTFUI platforms should be utilized for advocacy with stakeholders and officials from supportive departments. Orientation of CSO partners, religious leaders, community influencers and media persons for seeking support and capacity building of block/ urban staffs on communication should be undertaken.

Implementation of the Social mobilization plan should be ensured through all platforms like social media: WhatsApp, Facebook, Twitter for sharing IMI related messages/ posters/videos; planning & distribution of IEC materials and using electronic media, local radio/FM channels, and television.

Monitoring of data entry of beneficiaries of IMI in U-WIN Portal

Data Monitoring Committee headed by DIO supported by DPM (District Programme Manager), VCCM (Vaccine Cold Chain Managers), HMIS Data Entry Operator should look into the status and quality of data entry in the U-WIN Portal and feedback to be shared with Blocks/Planning Units and State and UNDP.

CHAPTER-14:
BLOCK LEVEL ACTIVITIES AND RESPONSIBILITIES

Table 14.1: Governance mechanism at Block Level

Governance Mechanism at Block Level
Block Task Force (BTF) and Tehsil Task Force (TTF)
Chairperson: BDO **Member secretary:** Block Medical Officer In-charge **Members:** ACMO/Dy CMO, Block educational officer, CDPO from ICDS dept, Representative of Partner agencies.

Activities to be undertaken at Block Level

The Block Medical Officer (BMO) should take the lead in planning and implementation of the mission. The BMO should be trained at the district level and receive necessary communication from DIO and the block nodal officer. The major activities at the block are: Block and Tehsil Task force meetings, Planning meeting for IMI 5.0, Training of front-line health workers on IMI and U-WIN functioning, Headcount survey, Due list preparation, Micro plan preparing, Block level compilation and review of micro plan, Communication activities, Vaccine and logistics supply chain management, conduction of IMI session, documentation and reporting, and review of data.

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

The BTFI/ TTFI needs to sensitize/orient all the stakeholders, get administrative support to resolve issues and get support from other departments and strengthen coordination. Small urban areas can also conduct meetings through Block task Forces. It is the group's responsibility to ensure quality of headcount survey and beneficiary data uploading in U-WIN during the preparatory phase. Any technical issues faced in the registration of beneficiaries in U-WIN, due list generation, or IMI session planning should be flagged up to DIO. The status of U-WIN registration of beneficiaries, health facilities and health professionals in their area should be regularly reviewed. The achievement of IMI should also be reviewed based on vaccinations conducted through U-WIN. The group should also discuss communication challenges and plan accordingly for relevant activities.

Planning meeting for IMI 5.0

The MoIC should conduct a meeting within 2 days of district level training in their respective PHCs. The nodal officer of concerned block/urban should provide overall guidance and support the meeting.

Objective: To plan for activities and timeline, define roles and responsibilities, understand bottle necks, and plan for solutions.

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

Points to discuss:

- Timeline for trainings, BTF meetings, headcount survey, micro plan preparation etc.
- Trainings on IMI activities & operationalizing U-WIN for IMI (Details of trainings have been discussed in Chapter 4).
- Ensuring quality Head count Survey of 0-5 years Children and Pregnant Women.
- Operationalization of U-WIN:
  - » Registration of target beneficiaries on U-WIN Portal.
  - » Identify challenges in U-WIN use and flag it to higher authorities at district level for timely solutions
  - » Monitor entries in U-WIN by the Health Care Workers for correctness and completeness.
- Identification of High-risk areas that need more focus and planning for intensification of activities
- HR availability to conduct headcount survey and micro plan preparation.
- Gaps identified in the last IMI round and plans to address them

- Assigning roles and responsibilities to each staff member
- Communication challenges and plan for demand generation
- AEFI Management: Availability of anaphylaxis kits and AEFI management kits, training on use of adrenaline, functional AEFI registers in every health facility, expansion of AEFI reporting network in medical colleges and large hospitals in public and private sector
- Other issues specific to the block/urban units

Under IMI 5.0, it is critical that the status of operationalization of U-WIN is reviewed at all the platforms. The status of trainings, registration of health professionals and service delivery points including health facilities and session sites on U-WIN, head count survey and registration of beneficiaries, etc. need to be reviewed in the preparatory phase.

It is of utmost importance that the performance of IMI is reviewed using the U-WIN platform.

Monitoring & Mentoring

Monitoring & Mentoring is an important activity for successful implementation of IMI. It is a process of guiding the field staff to improve their work performance, identify the gaps and plan for solutions. 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 staff related to RI, Immunization field volunteers, etc. The supervisors should be trained and oriented on IMI and the supervisory plan is to be shared on time. Special attention is needed in the high priority areas. The sessions of urban areas need to be monitored and reviewed specifically. Quantum of monitoring in urban areas should also be increased and rationalized as in rural areas

Headcount survey and beneficiaries' data entry in U-WIN should be closely monitored. Due list preparation and micro plan preparation at the sub-center also needs supervision.

Daily review meeting

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

Communication activities

The micro plan should include a plan for communication activities at all levels. Key activities include advocacy & sensitization of stakeholders (Block level administration, ICDS, Education, and others), Capacity building of ANM, ASHA, AWW and Link workers on communication, sharing of IEC materials (Poster, leaflets, messages, videos) through social media, community mobilization through meetings with mothers, community/Influencers, VHSNC, Rallies, Mosque/temple announcement, IPC session, miking, and others.

Monitoring of data entry of beneficiaries of IMI in U-WIN Portal

- Data Monitoring Committee headed by Block Medical Officer supported by BPM (Block Programme Manager), BCPM (Block Community Process Manager), VCCM (Vaccine Cold Chain Managers) and HMIS Data Entry Operator to look into the status and quality of data entry in the U-WIN Portal and feedback to be shared with Health Care Workers and Supervisors.
- Data Monitoring Committee will also look into the challenges faced by Health Care Workers and flag them up to DIO for further remedial measures.

ANNEXURES

Annexure 1: National Immunization Schedule

Age	Vaccines given
Birth	• Bacillus Calmette Guerin (BCG), Oral Polio Vaccine (OPV)-0 dose, Hepatitis B birth dose
6 Weeks	• OPV-1, Pentavalent-1, Rotavirus Vaccine (RVV)-1, Fractional dose of Inactivated Polio Vaccine (fIPV)-1, Pneumococcal Conjugate Vaccine (PCV) -1
10 weeks	• OPV-2, Pentavalent-2, RVV-2
14 weeks	• OPV-3, Pentavalent-3, fIPV-2, RVV-3, PCV-2
9-12 months	• Measles & Rubella (MR)-1, fIPV-3 , PCV-Booster, JE-1*
16-24 months	• MR-2, JE-2*, Diphtheria, Pertussis & Tetanus (DPT)-Booster-1, OPV – Booster
5-6 years	• DPT-Booster-2
10 years	• Tetanus & adult Diphtheria (Td)
16 years	• Td
Pregnant Mother	• Td1, 2 or Td Booster**

* JE in endemic districts
** One dose if previously vaccinated within 3 years

National Immunization Schedule (NIS) for Infants, Children and Pregnant Women (Vaccine-wise)

Vaccine	When to give	Dose	Route	Site
For Pregnant Women				
Tetanus & adult Diphtheria (Td)-1	Early in pregnancy	0.5 ml	Intra-muscular	Upper Arm
Td-2	4 weeks after Td-1	0.5 ml	Intra-muscular	Upper Arm
Td- Booster	If received 2 Td doses in a pregnancy within the last 3 yrs*	0.5 ml	Intra-muscular	Upper Arm
For Infants				
Bacillus Calmette Guerin (BCG)	At birth or as early as possible till one year of age	0.1ml (0.05ml until 1 month age)	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 aspect of mid-thigh
Oral Polio Vaccine (OPV)-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral (Mouth)
OPV 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks (OPV can be given till 5 years of age)	2 drops	Oral	Oral (Mouth)
Pentavalent 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks (Penta-1 can be given till one year of age)	0.5 ml	Intra-muscular	Antero-lateral aspect of left mid-thigh
Pneumococcal Conjugate Vaccine (PCV)	Two primary doses at 6 and 14 weeks followed by Booster dose at 9-12 months.	0.5 ml	Intra-muscular	Antero-lateral aspect of right mid-thigh In places where JE vaccine is administered, PCV Booster is to be given on antero-lateral aspect of left mid-thigh
Rotavirus (RVV)	At 6 weeks, 10 weeks & 14 weeks (RVV-1 can be given till one year of age)	Rotavac: 5 drops (liquid vaccine) - open vial policy Rotasil Liquid- 2ml - single dose tubes	Oral	Oral (Mouth)

Vaccine	When to give	Dose	Route	Site
For Infants				
Inactivated Polio Vaccine (IPV)	Three fractional doses at 6, 14 weeks of age & 9-12 months of age	0.1 ml	Intradermal three fractional dose	fIPV-1 & fIPV 2- Intradermal: Right upper arm fIPV-3 Intradermal: Left upper arm
Measles Rubella (MR) 1st dose	9 completed months-12 months. (Can be given till 5 years of age)	0.5 ml	Sub-cutaneous	Right Upper Arm
Japanese Encephalitis (JE) - 1(Killed vaccine)**	9 completed months-12 months.	0.5 ml	Intra-muscular	Anterolateral aspect of right mid thigh
Vitamin A (1st dose)	At 9 completed months with Measles-Rubella	1 ml (1 lakh IU)	Oral	Oral
For Children				
Diphtheria, Pertussis & Tetanus (DPT) booster-1	16-24 months	0.5 ml	Intra-muscular	Antero-lateral aspect of left mid-thigh
MR 2nd dose	16-24 months	0.5 ml	Sub-cutaneous	Right upper Arm
OPV Booster	16-24 months	2 drops	Oral	Oral (Mouth)
JE-2 (Killed vaccine)	16-24 months	0.5 ml	Intra-muscular	Antero-lateral aspect of right mid thigh
Vitamin A* (2nd to 9th dose)**	16-18 months. Then one dose every 6 months up to the age of 5 years.	2 ml (2 lakh IU)	Oral	Oral (Mouth)
DPT Booster-2	5-6 years	0.5 ml.	Intra-muscular	Left Upper Arm
Td	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

*One dose if previously vaccinated within 3 years
**JE Vaccine is introduced in select endemic districts after the campaign

Annexure 2: SoPs for Organizing Vaccination Session on Demand

Demand driven vaccination sessions:

Step-1: Identification of influencers:
Identify the key 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 on the days when 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.

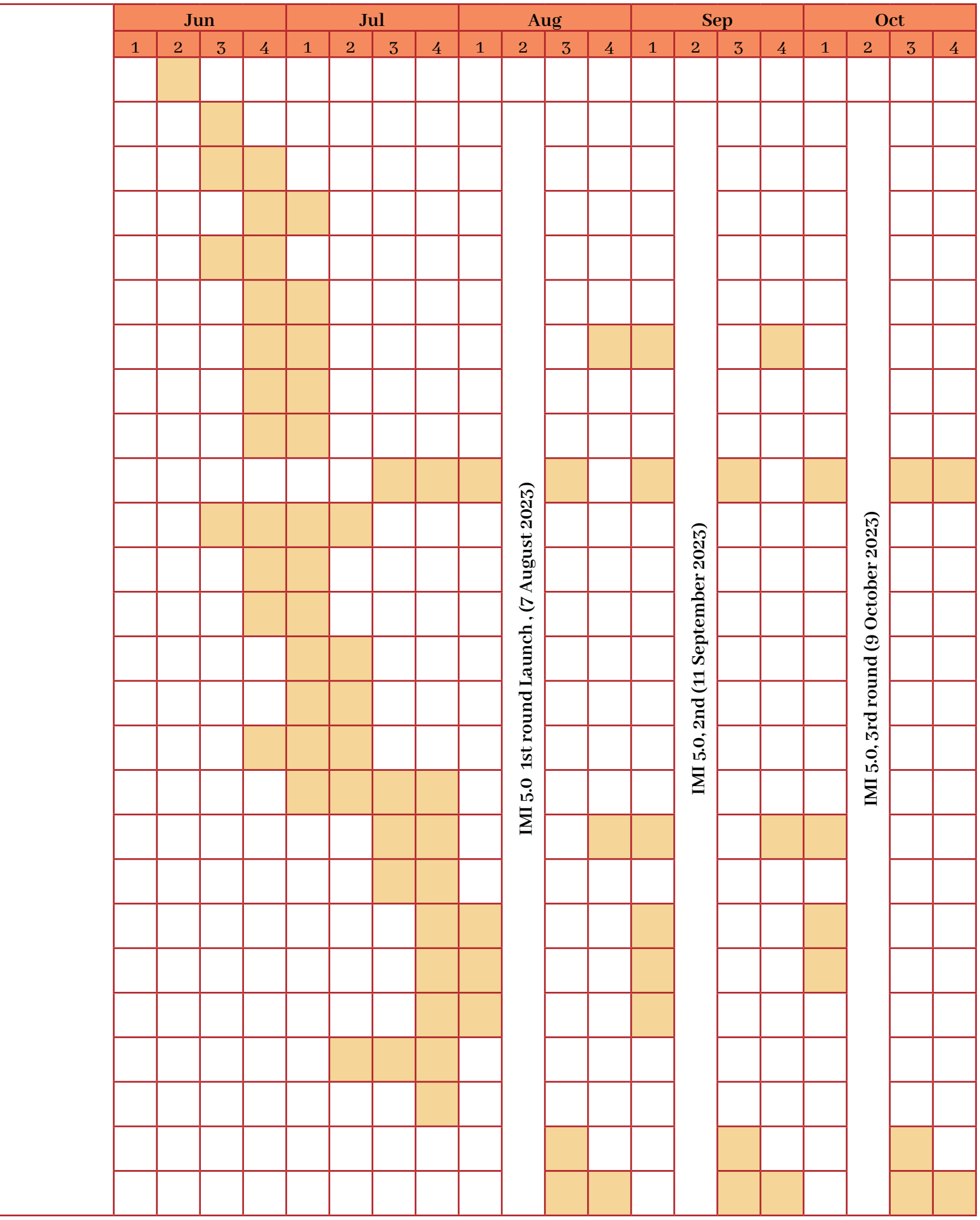
Step-4: Update micro plans to conduct sessions as per community needs:
Once immunization-session schedules are decided and agreed to with the communities, it is imperative that they be adhered to. Micro plans should be modified to reflect newly/ revised session sites and plans, and further coverage data 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', program managers may consider package of health services that can be provided during outreach for effective allocation of resources.

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.

Annexure 3: Gantt Chart of Key Activities for IMI 5.0

Level	Activities / Timeline	Responsibility
National	National workshop on U-WIN Operationalization	MoHFW/ UNDP
National	National workshop on Operational Guidelines for IMI 5.0	MoHFW / Partners
National	Dissemination of Operational, Financial guidelines and IEC materials	MoHFW
State	State Steering Committee meeting	CS / PHS
State	State ToT /workshop on U-WIN Operationalization	SEPIO /UNDP
State	State ToT /workshop on IMI Operational guideline & U-WIN	SEPIO / Partners
State	State Task Force meeting on IMI	PHS / SEPIO
State	Communication to districts / Blocks on IMI 5.0	STFI
State	State AEFI Committee Meeting	SEPIO
State / District	Establishing Coordination centers including District Control Room	CMO
District/ Block	District/ Block workshops on U-WIN Operationalization	CMO / DIO
District	District workshops on IMI 5.0 & U-WIN	CMO / DIO
District	District / Urban Task Force meeting	DM/ MC/CMO
District	Sensitization workshops / meeting with IMA, IAP, Civil societies etc.	CMO / DIO
District	District AEFI Committee meeting	DIO
District / Block	Block orientation on IMI - HCS, microplanning & U-WIN	DIO/ BMO
District / Block	Head Count Survey & Pre registration on U-WIN	BMO/ANM
District / Block	Due list & IMI 5.0 microplan preparation	BMO/ANM
District / Block	Enlisting sessions & beneficiaries into U-WIN	DIO/ BMO
District / Block	Pre activity monitoring and redressal of issues	DTFI
District / Block	District/ Urban / Block Task Force meeting for review of preparedness	DM/CMO
District	Media Sensitization	DM
All levels	Preparedness Assessment for IMI 5.0	MoHFW / SEPIO
All levels	Launch & IMI 5.0 activity	PHS / DM / CMO
All levels	Activity monitoring and sharing daily feedback to next higher level	CMO / DIO / Partners
All levels	Post activity review and initiate preparation for IMI 5.0 round on next month	CMO / DIO / Partners


Jun
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1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
IMI 5.0 1st round Launch , (7 August 2023)
IMI 5.0, 2nd (11 September 2023)
IMI 5.0, 3rd round (9 October 2023)

Annexure 4: Agenda for IMI 5.0 workshops

Agenda for District level IMI 5.0 workshop for medical officers

Training materials: Copy of operational guidelines & U-WIN modules including annexures for each participant
Duration: 1 day

Session No.	Time	Session	Facilitator
1.	45 minutes	Registration Welcome, introduction of participants	
		Introduction and objective of IMI 5.0 workshop	DIO
		Opening remarks	District Magistrate CMO/ DHO
2.	30 minutes	Overview of Universal immunization programme at national and state level	WHO India
Tea			
3.	90 minutes	Microplanning for IMI 5.0 • Conducting head count survey • Preparation of due list • Preparation of IMI 5.0 Microplan	DIO & WHO India
Lunch			
4.	90 minutes	Microplanning for IMI 5.0 • Conducting head count survey • Preparation of due list • Preparation of IMI 5.0 Microplan	UNDP
Tea			
5.	15 minutes	Organizing cascaded trainings	DIO
6.	30 minutes	Overview of Communication for IMI 5.0	UNICEF
7.	15 minutes	Monitoring and Supervision	WHO India
8.	15 minutes	Adverse Event Following Immunization	WHO India
9.	15 minutes	Financial Guidelines	District Accounts Manager/ DIO
10.	15 minutes	Way forward – Timeline of activities for IMI 5.0	DIO
11.	15 minutes	Open discussion, feedback and wrap-up	

Agenda for district orientation of district and block level program/ accounts managers on financial guidelines for IMI 5.0

Participants: District Programme Manager, District Accounts Manager, Block Programme Manager, Block Accounts Manager and other related officials handling NHM funds
Training materials: Copy of operational guidelines including financial guidelines for each participant
Time: 1 hour

Session No.	Time	Session	Facilitator
1.	15 minutes	Introduction to IMI 5.0	DIO/ Partners
2.	30 minutes	Financial guidelines for IMI 5.0	District Programme Manager (NHM)/District Accounts Officer (NHM)
3.	15 minutes	Way forward for IMI 5.0– Timeline of activities and support available	DIO

Agenda for district workshop on IMI 5.0 for data handlers

Participants: District data handlers and one data handler from block and urban area responsible for routine immunization data entry at these levels
Training materials: Head count survey and microplanning formats and Reporting formats for Intensified Mission Indradhanush 5.0 U-WIN module
Time: Half day

Session No.	Time	Session	Facilitator
1.	15 minutes	Introduction to IMI 5.0	DIO
2.	60 minutes	Microplanning for IMI 5.0 • Conducting head count survey • Preparation of due list • Preparation of IMI 5.0 Microplan	DIO, ToT, WHO India Other partners
Tea			
3.	60 minutes	U-WIN modules • Session planning • Vaccinator module • Mobilizer module • Recording and reporting of IMI 5.0 coverage	UNDP
7.	15 minutes	Data flow from ANM to district for IMI 5.0: Key indicators from the data	DIO/ Partners
8.	15 minutes	Role of Data handlers in IMI 5.0	DIO
9.	15 minutes	Way forward for IMI 5.0 and Timeline of activities	DIO

Agenda for district workshop on IMI 5.0 for vaccine and cold chain handlers

Participants: One cold chain handler from each cold chain point
Training materials: Vaccine and cold chain reporting format and open vial policy
Time: Half day

Session No.	Time	Session	Facilitator
1.	15 minutes	Introduction to IMI 5.0	DIO
2.	30 minutes	Microplanning process for IMI 5.0	DIO/ ToT/ Urban Nodal Officer/ partners
3.	30 minutes	U-WIN modules	DIO/Partners
Tea			
4.	30 minutes	Availability of vaccine and logistics. Issue and receipt of vaccine and logistics for IMI 5.0	DIO/Partners
5	30 minutes	Planning for alternate vaccine delivery	DIO/ Partners
6.	15 minutes	Open vial policy	DIO/ Partners
7.	15 minutes	Role of Cold chain handlers in IMI 5.0	DIO
8.	15 minutes	Day-wise vaccine and diluent utilization report to be submitted to DIO during IMI round	DIO/ Partners
9.	15 minutes	Way forward for IMI and Timeline of activities	DIO

Agenda for block/ urban area/ Planning unit level training of health workers for IMI 5.0

Session No.	Time	Session	Facilitator
1.	15 minutes	Registration Welcome, introduction of participants	
		Introduction to IMI 5.0	Medical Officer in charge
Tea			
2.	90 minutes	Microplanning for IMI 5.0 • Conducting head count survey • Preparation of due list • Preparation of IMI 5.0 Microplan	MO (trained for IMI 5.0)
3.	15 minutes	Use of Immunization tracking bag and counterfoil of MCP card (this topic was there in previous IMI guidelines)	MO (trained for IMI 5.0)
4.	30 minutes	Cold chain maintenance at IMI session site Open vial policy Conducting safe immunization practices at session	MO (trained for IMI 5.0) & VCCM
5.	15 minutes	Adverse Event Following Immunization	MO (trained for IMI 5.0),
Lunch			
6.	60 minutes	U-WIN modules • Session planning • Vaccinator module • Mobilizer module • Recording and reporting of IMI 5.0 coverage	Block data manager/ partners
Tea			
7.	30 minutes	IEC & IPC for mobilization of beneficiaries Role of HWs in sensitizing social mobilizers, influencers	Block Education officer/ any other trained in communication
8.	30 minutes	Group work: Preparing IMI 5.0 microplans and planning IMI 5.0 sessions	MO (trained for IMI 5.0),
9.	30 minutes	Preparing ANM roster for IMI 5.0	MO (trained for IMI 5.0),
10.	15 minutes	Frequently asked questions	MO (trained for IMI 5.0),
11.	10 minutes	Financial Guidelines	Block Accounts Manager/ DIO
12.	5 minutes	Open discussion and wrap-up	

Annexure 5: IMI 5.0 Microplanning Formats

Head count survey (HCS) planning at Sub Centre/ANM area – IMI 5.0

Head count survey (HCS) planning at Sub Centre/ANM area - IMI 5.0
(MO to ensure this format is filled for all sub-centres including vacant sub-centres)

Format HC-0

District/ Corporation:______________________________ Block/urban area:______________________________ PHC/ UPHC:_________________________ Sub Centre / Health Facility :_____________________

Whether Sub centre / ANM area has full time ANM (encircle) : Full Time / Vacant/ Temporarily Vacant Name of ANM with mobile number: _______________________________ No. of ASHAs working in Subcenter/ ANM area:_____

Sl. No.	Write Names of ALL Villages / Hamlets/ Urban localities / HRA Sites under the Sub centre separately, one area in each row	Estimated number of households (HH)	Is this a High Risk Area (HRA)? Yes/No	If HRA-Yes, mention code*	Name of ASHA / AWW / Link worker designated for this area	Name of person doing head count survey (Surveyor/s)	Designation of Surveyor (encircle applicable)	Contact Number of surveyor/s	Dates Planned to conduct Headcount Survey From / To	Name and mobile number of local influencer
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
						1. 2.	ASHA, AWW / Link Worker/ Others	1. 2.		
Total										

***# Type of HRA code:** **Migratory HRA:** 1 = Slums with migration; 2 = Nomads; 3 - Brick kiln; 4 - Construction site; 5 - Other migratory high-risk areas (fishermen villages, riverine areas with shifting populations, migrants in tea/coffee estates etc); **Non-Migratory (Settled) HRA:** 6A- Settled Slums (notified & non-notified); 6B- Hard to Reach Area; 6C- Areas under Vacant / temporarily vacant (More than 3 months) sub centres; 6D- Areas with Measles/Rubella outbreaks or cases of Diphtheria, Pertussis, Neonatal tetanus in last 2 years; 6E- Areas with vaccine hesitancy/ refusal; 6F-Other settled high-risk areas*

Signature of ANM with date

Signature of Medical Officer

House to House Survey form-IMI 5.0 (Format-HC 1)

House to House Survey form-IMI 5.0

Format-HC 1

District/Corpn: _____ Block/Urban area:_____ Sub Centre/ANM area: _____ Date of survey : ___ /___ /___

Village/Urban area/Ward (as per form HC-0):_____ANM name and phone no.:_____

ASHA/ AWW/Link worker/ other surveyor Name and Ph No.: _____; _____

First house visited today - House No. : _____	Last house visited today - House No. :
Name:_____ Address with landmark: _____	Name:_____ Address with landmark: _____

HH number (as per chullah)		**Family Details**			**Pregnant Woman**	**Children upto 5 years**			
						Children 0 to 2 years		**Children 2 to 5 years**	
	Name of Head of family	**Name of Mother / Father / Guardian**	**Contact number**	**How many family members are living in this house?** *(Include All adults & children including newborn)*	**No. of Pregnant Women** *(if present mention detail in HC-2)*	**No. of children aged less than 1 year** *(if present mention detail in HC-3)*	**No. of children aged between 1 to 2 Years** *(if present mention detail in HC-3)*	**No. of children aged 2-5 years**	**No. of children 2 to 5 Years with missed doses*** *(mention detail in HC-3A)*
A		**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
Total HH			**TOTAL**						

Signature of ASHA/AWW/ Link worker/ Other surveyor :

Verified by ANM (Signature):

SHEET NUMBER :_____

Pregnant Women Survey Listing – IMI 5.0

Pregnant Women Survey Listing - IMI 5.0

Format-HC 2

District/Corpn: _____ **Block/Urban area:**_____ **Sub Centre/ANM area:** _____ **Date of survey :** ___ /___ /___

Village/Urban area/Ward name (as per form HC-0):_____ **ANM name and phone no.:**_____

ASHA/ AWW/Link worker/ other surveyor Name and Ph No.: _____; _____ ; _____

HH No as in HC-1	Name of the pregnant woman	Year of birth	Age in years	Husband's name	Mobile number	UWIN ref ID / MCP card number	Tetanus Toxoid Vaccination			For ANM only
							Td-1	Td-2	Td-Booster *(If 2 doses of TT / Td have been given within 3 years of the current pregnancy)*	Td due Y/N
A	B	C		D	E	F	G			H
							Date / Y / N / Unknown	Date / Y / N / Unknown	Date / Y / N / Unknown	
Total PW									Total	

Signature of ASHA/AWW/ Link worker/ Other surveyor **Verified by ANM (Signature)** **Signature of Supervisor with date**

Head count survey of Children (0-2 years) - IMI 5.0

Head count survey of Children (0-2 years) - IMI 5.0

Format: HC 3

District/Corpn: ________________________________ **Block/Urban area:**_________________________________ **Sub Centre/ANM area:** _______________________________ **Date of survey :** ___ /___ /___

Village/Urban area/Ward name (as per form HC-0):____ **ANM name and phone no.:**____

ASHA/ AWW/Link worker/ other surveyor Name and Ph No.: ____; ____; ____

HH No as in HC-1	Name of the child	Date of Birth *dd/mm/yy*	Age in months (completed)*	Gender M / F	Name of the mother / father / guardian with mobile number	bOPV-Birth dose	BCG	Hepatitis B Birth dose	bOPV1	RVV1	f IPV1	PCV 1	Penta-1/ DPT-1$	bOPV 2	RVV 2	Penta 2 / DPT -2$	bOPV 3	RVV 3	fIPV 2	PCV 2	Penta 3 / DPT-3$	fIPV 3	MR 1	PCV Booster	JE 1 *(elligible dists)*	Vitamin A 1	bOPV Booster	DPT Booster 1	MR 2	JE 2 (elligible dists)	Vitamin A 2	For ANM only		
																																Is child due for any vaccine (Y/N)	Is child >1 yr due for MR-1 (Y/N)	Is child >=1 yr & not recieved Penta-1 (Y/N)
A	B	C	D	E	F	G			H					I			J					K					L					M	N	O
						Date / Y / N			Date / Y/ N					Date / Y/ N			Date / Y/ N					Date / Y/ N					Date / Y/ N							
		_/_/_		M / F																														
		_/_/_		M / F																														
		_/_/_		M / F																														
		_/_/_		M / F																														
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		_/_/_		M / F																														
		_/_/_		M / F																														
		_/_/_		M / F																														
		_/_/_		M / F																														
		_/_/_		M / F																														
																						TOTAL numbers of 'Y'												

** Mention Age in completed months, if date of birth is not available*

$: If the child is more than 1 year and not received Penta-1, then the child should start with DPT-1 instead of Penta. DPT 2 and DPT 3 is given at a gap of 4 weeks. DPT 1st booster is given after 6 month of DPT-3

#: Zero dose child: Child more than one year who has not received Penta1

Signature of ASHA/AWW/ Link worker/ Other surveyor **Verified by ASHA Facilitator (Signature)** **Verified by ANM (Signature)**

List of children between 2-5 years missed vaccine doses-IMI-5.0

List of children between 2-5 years missed vaccine doses-IMI-5.0
(This format should be updated before each IMI round)

Format: HC 3A

District/Corpn: ____________________________Block/Urban area:__________________________Sub Centre/ANM area: _______________________________ Date of survey : ___ /___ /___ IMI round: I/ II/ III

Village/Urban area/Ward name (as per form HC-0):____ ANM name and phone no.:______________________________________

ASHA/ AWW/Link worker/ other surveyor Name and Ph No.: ____; ____

HH No as in HC-1	**Name of the child**	**Date of Birth** dd/mm/yy	**Age in months** (completed)*	**Gender M / F**	**Name of the mother / father / guardian with mobile number**	**Missed vaccine** (Encircle Y/N)									
						MR-1	**MR-2**	**OPV**			**DPT***			**OPV booster**	**DPT-1 booster**
								1	**2**	**3**	**1**	**2**	**3**		
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**	**P**
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
		__/__/__		M / F		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Total missed children:					**Total number of missed doses (Number of 'Y')**										

*: If the child is more than 1 year and not received Penta-1, then the child should start with DPT-1 instead of Penta. DPT 2 and DPT 3 is given at a gap of 4 weeks. DPT 1st booster is given after 6 month of DPT-3

Name of ASHA/AWW/ Surveyor **Verified by ASHA Facilitator (Signature)** **Verified by ANM (Signature)**

IMI SESSION DUE LIST (for ASHAs/ Mobilizers)

IMI SESSION DUE LIST (for ASHAs/ Mobilizers)

(Prepared by ANM)

Due list

Block / Urban : _____ PHC / UPHC Planning Unit: _____ Name of Sub-Centre / ANM area: _____ Name of Session Site : _____

Name and Ph no of ASHA:_____ Name and Ph no of AWW / Mobilizer:_____ Name and Ph no of Influencer:_____

Name and Ph no of ANM :_____ Date of Session: _____ Date of next session at this site: _____

Details of Pregnant Women / Children upto 5 years due for vaccination for IMI session											After the IMI session (to be filled by ANM)					
Sl. No.	MCP Card UWIN No.	Name of Child / Pregnant Woman	Date of Birth (for Child) / Expected date of Delivery (for PW)	Age in years and months (completed)	Gender (M / F)	Name of Father / Mother/ Husband with contact number	Vaccines due in this IMI session				Did the pregnant woman / child arrive today? (Yes / No)	If yes, vaccines administered today to pregnant woman / child	Has vaccination status updated in U-Win	If not vaccinated then reason (R1/R2/R3/R4/R5)	When to come for next vaccination? (date)	What vaccines is/are due next session?
							Mention name of ALL due vaccines	Is child >=1 yr & not recieved Penta-1 (Y/N) *NA if pregnant woman*	Child >1 yr due for MR-1 (Y/N) *NA if pregnant woman*	Child >2 yrs due for MR-2 (Y/N) *NA if pregnant woman*						
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1			__/__/__								Y / N		Y / N		__/__/__	
2			__/__/__								Y / N		Y / N		__/__/__	
3			__/__/__								Y / N		Y / N		__/__/__	
4			__/__/__								Y / N		Y / N		__/__/__	
5			__/__/__								Y / N		Y / N		__/__/__	
6			__/__/__								Y / N		Y / N		__/__/__	
7			__/__/__								Y / N		Y / N		__/__/__	
8			__/__/__								Y / N		Y / N		__/__/__	
9			__/__/__								Y / N		Y / N		__/__/__	
10			__/__/__								Y / N		Y / N		__/__/__	
						TOTAL numbers of 'Y'										

Vaccination coverage of due beneficiaries

	Pregnant women	Total children upto 2 yrs	Total children b/w 2-5 yrs	Is child >=1 yr & not recieved Penta-1 (Y/N)	Child >1 yr due for MR-1	Child >2 yrs due for MR-2
Total number as per due list						
Total number vaccinated						

Tracking of missed beneficiaries of the IMI session

Reason for beneficiaries who did not attend this session		R1: Out of Village	R2: Sick	R3: Refused	R4: Already vaccinated in RI/ IMI session/ Pvt facility	R5: Fear of AEFI	R6: Others
	Reason -						
	Number -						
Have these beneficiaries been included in the due list of next session?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Signature of ANM:_____ Signature of ASHA:_____ Signature of AWW: _____

IMI session planning at Sub-centre / ANM area – IMI 5.0 (for ANM) MP-1

IMI session planning at Sub-centre / ANM area - IMI 5.0 (for ANM)

MP-1

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

District/ Corporation:_____ Block/urban area:_____ PHC/ UPHC:_____

Name of sub centre/ Health Facility :_____ Name & mobile number of ANM:_____

S. No	Name of villages, hamlet, Urban localities, slum, migrant area, etc.	Is this a High Risk Area (HRA)? Yes/No	If HRA-Yes, mention code*	Head count done (Y/N)	Due Beneficiaries			Number of immunization sessions required	Location of session site(s) including *additional session(s)	Name & mobile number of vaccinator conducting session	Name, designation & mobile no of mobilizers only for areas requiring immunization sessions	Name and mobile number of local influencer
					Children 0–2 years	Children 2-5 years	Pregnant women					
												1. 2.
												1. 2.
												1. 2.
												1. 2.
												1. 2.
												1. 2.
												1. 2.
												1. 2.
												1. 2.
												1. 2.
	Total											

**Additional sessions to be considered for: a) High Risk areas - Migratory HRA: 1 = Slums with migration; 2 = Nomads; 3 - Brick kiln; 4 - Construction site; 5 - Other migratory high-risk areas (fishermen villages, riverine areas with shifting populations, migrants in tea/coffee estates etc); Non-Migratory (Settled) HRA: 6A- Settled Slums (notified & non-notified); 6B- Hard to Reach Area; 6C- Areas under Vacant / temporarily vacant (More than 3 months) sub centres; 6D- Areas with Measles/Rubella outbreaks or cases of Diphtheria, Pertussis, Neonatal tetanus in last 2 years; 6E-Areas with vaccine hesitancy/ refusal; 6F-Other settled high-risk areas (b) Small villages, hamlets, field huts, etc., clubbed with another village for RI sessions and not having independent RI sessions (c) Any other areas for RI strengthening*

Signature of ANM *Signature of Block MO IC*

Block/Urban area planning: IMI 5.0 MP-2

Block/Urban area planning: IMI 5.0

MP-2

For Block/PHC/urban planning unit

(Compile information from Format MP-1)

District/ Corporation:_____ Block/urban area:_____ PHC/ UPHC:_____

Number of sub-centres/ANM Areas:_____ Number of ANMs:_____ Number of vacant sub-centres/ANM areas:_____

S. No	Name of sub-centre	Name of areas requiring IMI session(s)	Is this a High Risk Area (HRA)? Yes/No	If HRA, mention code 1-5 & 6A-6F	Head count survey done (Y/N)	Due Beneficiaries			No of immunization sessions required			For IMI sessions (excluding mobile), mention location of session site(s). If mobile session, write "mobile"	Name, designation & mobile no of mobilizers (ASHA, AWW/ link worker)	Which ANM will conduct immunization session in this area			
						Children 0–2 years	Children 2-5 years	Pregnant women	IMI session *(exclude mobile sessions)*	Mobile session	Total sessions			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.				
Total																	

Additional sessions to be considered for: a) High Risk areas - Migratory HRA: 1 = Slums with migration; 2 = Nomads; 3 - Brick kiln; 4 - Construction site; 5 - Other migratory high-risk areas (fishermen villages, riverine areas with shifting populations, migrants in tea/coffee estates etc); Non-Migratory (Settled) HRA: 6A- Settled Slums (notified & non-notified); 6B- Hard to Reach Area; 6C- Areas under Vacant / temporarily vacant (More than 3 months) sub centres; 6D- Areas with Measles/Rubella outbreaks or cases of Diphtheria, Pertussis, Neonatal tetanus in last 3 years; 6E-Areas with vaccine hesitancy/ refusal; 6F-Other settled high-risk areas (b) Small villages, hamlets, field huts, etc., clubbed with another village for RI sessions and not having independent RI sessions (c) Any other areas for RI strengthening

Signature of ANM

Signature of Block MO IC

ANM micro plan roster for IMI 5.0 (MP 3 – For ANM)

ANM micro plan roster for IMI 5.0 *Form-MP 3*

(One format for each ANM in the district) **Round I/II/III**

District/ Corporation:_____ **Block/urban area:**_____ **PHC/ UPHC:**_____ **Sub-centre/ ANM area:**_____

ANM (name & mobile): _____ **AEFI management centre name & Tel no:** _____

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

	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**
Date						
Village/ urban area						
Session site address & timing						
Is the session regitered in U-WIN	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Name & Tel no of mobilizer						
Designation of mobilizer						
Name of Community Influencer						
Name & Tel no of AVD person						
0–2 years due beneficiaries						
2–5 years due beneficiaries						
Due pregnant women						
Head count survey done	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Person responsible for U Win entry / updation						

Signature of ANM Signature of MOIC Signature of DIO

Mobile team planning for IMI 5.0 (MP 4 form)

Mobile team planning for IMI 5.0

MP 4 form

(Round I / II / III / IV) ***(One format for each mobile team)***

District/ Corporation:_____ Block/urban area:_____PHC/ UPHC:_____ Sub-centre/ ANM area:_____

ANM (name & mobile): _____ **AEFI management centre name & Tel no:** _____

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

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

Signature of ANM Signature of MOIC Signature of DIO

PHC / Block / District level – Manpower Planning – IMI 5.0 (Form MP 5)

PHC / Block / District level - Manpower Planning - IMI 5.0 **Form MP 5**

Round I / II / III

District/ Corporation:_____Block / PHC/ UPHC:_____Name of MO / BMO / DIO:_____Mobile no. of MO / BMO / DIO:_____

Sl No.	Name of Subcenter /ANM area/ PHC / Block	Target pregnant women for IMI 5.0	Target children upto 2 years for IMI 5.0	Target children between 2-5 yrs for IMI 5.0	Number of IMI session required *(exclude IMI mobile sessions)*	Number of IMI Mobile Teams required	Number of session planned through Mobile team	Total IMI sessions planned	No. of sessions planned in HRAs*	Number of ANMs	ANM days for Indradhanush (ANM*6)	No. of ANM days required based on Microplan	ANM days utilized			Hired ANM days required	Additional ANM days required from other PHC / Blocks	Number of vehicles required for mobile team
													Same sub-centre	Other sub-centre from same PHC/block	For supporting activity outside PHC/ block			
					a	b	c	(a+c)										
TOTAL																		

**High Risk areas - Migratory HRA: 1 = Slums with migration; 2 = Nomads; 3 - Brick kiln; 4 - Construction site; 5 - Other migratory high-risk areas (fishermen villages, riverine areas with shifting populations, migrants in tea/coffee estates etc); Non-Migratory (Settled) HRA: 6A- Settled Slums (notified & non-notified); 6B- Hard to Reach Area; 6C- Areas under Vacant / temporarily vacant (More than 3 months) sub centres; 6D- Areas with Measles/Rubella outbreaks or cases of Diphtheria, Pertussis, Neonatal tetanus in last 2 years; 6E-Areas with vaccine hesitancy/ refusal; 6F-Other settled high-risk areas*

Signture of MOIC/ BMO/ District Immunization Officer

Annexure 6: HCS Validation Format for IMI 5.0

Template for Validation of Head Count Survey (HCS) – Intensified Mission Indradhanush 5.0

Template for Validation of Head Count Survey (HCS) - Intensified Mission Indradhanush (IMI) - 5.0, 2023

Date: _ _ / _ _ / _ _ State/UT: ..... District: ..... Block/ Urban area: ..... CHC/PHC/UPHC/Others: .....

Name of Planning unit: ..... Subcenter/ ANM area:..... Village/ Ward/ Mohalla: ..... Setting: Urban / Rural, If Urban, NUHM City: Yes/ No;

Name of ANM/ Vaccinator..... Name of Monitor: .....; Organization: Govt / WHO / UNICEF / JSI / CHAI / Others (specify): .....;
Designation: .....;

Is head count survey (HCS) conducted in this area (as per survey plan): Yes / No*: if No - inform Medical Officer and proceed to another area as per validation plan.*

Monitor to visit 5 households (HH) with at least one child below 5 years eligible for one/more vaccine dose for first round of IMI. The select HH with children due for one / more vaccine, may also have pregnant woman. Select HH should be representing the survey area where validation is being done. Try interacting with caregivers and check if surveyor/team has visited for HCS for IMI. Meet surveyor and/or cross validate the findings observed with findings in HCS format. Ensure data entry in ODK tool same day/at the earliest in case you have done validation on paper format.

No.	Monitoring and validation details:		HH-1	HH-2	HH-3	HH-4	HH-5
1	a. Ask family member if surveyor/team visited HH for HCS?		Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
	b. If visited, date surveyor visited this HH (from wall/caregiver recall, else NA)		__ / __ / __ / NA	__ / __ / __; NA	__ / __ / __; NA	__ / __ / __; NA	__ / __ / __; NA
	c. House No. put by the surveyor (From wall of HH, else consider unmarked (UM)		_____ / UM	_____ / UM	_____ / UM	_____ / UM	_____ / UM
2	a. Name of the head of family						
	b. Mobile/landline contact number						
3	Pregnant woman	a. Is there a pregnant woman found in this HH?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
		b. Name of the pregnant woman (If 'Yes' in 3a) [Select one PW due for Td]					
		c. Is the selected PW identified by surveyor in HCS format [NA if 'No' in 3a]	Y / N / NA	Y / N / NA	Y / N / NA	Y / N / NA	Y / N / NA
4	Children **<1 Year (0-11 months)**	a. No. of children found in this HH by monitor					
		b. No. of children due for one/more vaccine dose during first IMI round					
		c. Name(s) of the child(ren) due for vaccine dose for cross validation with information in HCS format					
		d. No. of children due but missed in HCS format					

No.	Monitoring and validation details:		HH-1	HH-2	HH-3	HH-4	HH-5
5	Children **1-2 years (12-23 months)**	a. No. of children found in this HH by monitor					
		b. No. of children due for DPT-1 during first IMI round					
		c. No. of children due for Penta/DPT-2 or 3 dose during first IMI round					
		d. No. of children due for MR1 dose during first IMI round					
		e. No. of children (16-23 months) due for MR2 during first IMI round					
		f. Name(s) of the children with due dose(s) for cross validation with information in HCS format – DPT1					
		f. Name(s) of the children with due dose(s) for cross validation with information in HCS format – Penta/DPT 2 or 3					
		f. Name(s) of the children with due dose(s) for cross validation with information in HCS format – MR1					
		f. Name(s) of the children with due dose(s) for cross validation with information in HCS format – 16-23 M – MR2					
		g. No. of children due for DPT-1 but missed in HCS format					
		h. No. of children due for Penta/DPT2 or 3 but missed in HCS format					
		i. No. of children due for MR1 but missed in HCS format					
		j. No. of children (16-23 M) due for MR2 but missed in HCS format					
6	Children **2-5 years (24-59 M)**	a. No. of children found in this HH by monitor					
		b. No. of children found due for MR-1/MR2 dose during first IMI round	MR1: MR2:	MR1: MR2:	MR1: MR2:	MR1: MR2:	MR1: MR2:
		c. Name(s) of the children due for MR-1/MR2 for cross validation with information in HCS format – MR1					
		c. Name(s) of the children due for MR-1/MR2 for cross validation with information in HCS format – MR2					
		d. No. of children due for MR-1/MR2 but missed in HCS format	MR1: MR2:	MR2: MR2:	MR1: MR2:	MR2: MR2:	MR1: MR2:

7	*Vaccine Refusal*	Did you (monitor) feel that the child has missed due dose as per age due to vaccine hesitancy/refusal and AEFI apprehension at this HH?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Interaction with the surveyor/team: Met surveyor/team? **Yes / No (If no – skip q 8 a, b, c, d, e and f)**		
8	a.* Who has done HCS? ASHA / AWW / ANM / MAS (In NUHM city) / Link worker / Others	b. Did the surveyor receive training prior to HCS? Yes / No
	c. No. of houses planned by the team per day: i) less than 25 ii) 25-50 iii) 50 - 100 iv) ≥ 100	
	d. Has the surveyor (team) used standardized HCS format? Yes / No	e. Was UWIN used enlisting beneficiaries? Yes / No
	f. Is the survey team aware of vaccine hesitancy/refusal in this area? Yes / No	If yes, how many families (HH): _____

Assessment by the monitor:	
9	a. Has surveyor missed children due for one or more vaccines in ≥2 HH? Y / N
	b. No. of cluster of ≥3 consecutive HH not visited by surveyor/team? _____

 # Recommend repeat survey in Survey compromised area (SCA): if: 1).* ≥ 3 consecutive HH not visited for survey *AND/OR 2).* ≥ 2 HH *have missed children due for any due vaccine dose(s) in survey.

Standard operating procedure: Headcount survey validation (HCS) format

The aim of the standard operating procedure (SOP) on head count survey validation is to ensure a uniform understanding of the questions in head count survey (HCS) validation format. The general detail section is self-explanatory. The partner organization other than that mentioned on the format may specify their name under others.

The monitor has to visit 5 households (HH) with at least one child below 5 years of age and eligible for one/more vaccine dose for first round of IMI-5.0. The selected HH may have pregnant woman.

A selected HH with a due child with/without a pregnant woman should be representing the area visited. The monitor should interact with caregiver and try to meet surveyor/team and validate the findings observed with the findings in HCS format. While selecting at regular interval during validation, the monitor should check contiguous HH to rule out missed areas with a cluster of ≥3 consecutive unvisited HH. Such contiguous visits may be done more than once in an area. If an area has a cluster of 3 missed consecutive HH and/or ≥ 2 HH have missed due children for any vaccine upon cross validation with surveyor's HSC format, they will be considered "Survey compromised area" and HCS will have to be repeated.

There are no prescriptive guidelines regarding the number of HH by age group-wise beneficiaries.

It should be ensured that data is entered in ODK tool same day/at the earliest in case validation has been done on paper format.

Is head count survey (HCS) conducted in this area (as per survey plan)?
Yes / No: if No - Monitor to inform MoIC, and proceed to another area as per validation plan.

1. Monitoring and validation details:

1a: Ask family member if surveyor/team visited HH for HCS?
Monitor should interact with caregivers and check the wall of the HH for marking to assess. if surveyor/team has visited for HCS for IMI. The monitor to select Yes / No as applicable.

1b. If visited, date when the surveyor visited this HH (from wall/caregiver recall, else NA)
Monitor to check the wall of the HH for date of visit by the surveyor/team and mention, else select 'NA'.

1c. House No. put by the surveyor (From wall of HH, else consider unmarked (UM)
Monitor to check the wall of the HH for house no. marked by the surveyor/team and mention, and if unmarked, select 'UM'.

2. Contact Information
2a. Name of the head of family

2b. Mobile/landline contact number

3. Pregnant woman (PW):

Monitor to be mindful of the cultural sensitivities while interacting with the PW and/or the family.

3a. Is there a pregnant woman found in this HH? Yes / No
Some of the HH with child due for one/more vaccine may or may not have a pregnant woman. The primary aim is to select HH with due child. If there is a pregnant woman, select 'Yes'.

3b. Name of the pregnant woman (If 'Yes' in 3a) [If >1 PW; Select one PW due for Td]
Monitor to request for the name of the PW and/or the family head and mention. If there are more than one PW due for Td dose (1st, 2nd or booster dose) in this HH, select recent PW that is due for Td1. However, note details of other PW due for Td2 or Td booster on a separate sheet and ensure such PW are identified in HCS format.

3c. Is the selected PW identified by surveyor in HCS format [NA if 'No' in 3a]
On meeting with the surveyor/team (or at the planning unit), monitor to cross check for the name of the PW, whether she has been identified by the surveyor in HCS format, monitor to select 'Y' or 'N' as applicable, and select 'NA' if it is 'No' in Q-3a and this Q-3c will not appear in ODK data entry tool.

4. Children <1 year (0-11 months):

A child below 15 days of birth will be assessed for birth dose of OPV, and below 6 weeks for BCG, and at ≥ 6 weeks for first dose of OPV, RVV, IPV, PCV and Pentavalent vaccine, followed for subsequent doses at 10 and 14 weeks (at 4 weeks interval). fIPV and PCV are given in two doses at 6 and 14 weeks.

4a. No. of children found in this HH by monitor
Monitor to seek no. of children below 1 year (0-11 months) and mention

4b. No. of children due for one/more vaccine dose during first IMI round
Monitor to identify children due for one or more vaccine(s)

4c. Name(s) of the child(ren) due for vaccine dose for cross validation with information in HCS format
Monitor to mention the names of children who are due for one/more vaccine dose in the format/ODK tool

4d. No. of children due but missed in HCS format
Monitor to cross check the names of due children in the validation format with names mentioned by the surveyor in their HCS format to identify children missed in HCS format. Mention such no. of missed children identified in HCS validation format.

5. Children 1-2 years (12-23 months)

5a. No. of children found in this HH by monitor
Monitor to seek no. of children 1-2 years (12-23 months) and mention

5b. No. of children due for DPT-1 during first IMI round
A child who has not taken Pentavalent-1 within 1 year of age, will be due for DPT-1 in 2nd year of life. Monitor to identify such children and mention in the HSC validation format

5c. No. of children due for Penta/DPT-2 or 3 dose during first IMI round
A child who has taken Pentavalent-1 within 1 year (most likely late or dropped out not in first year) would be due subsequently for 2nd or 3rd, and if the child has started with DPT-1 in 2nd year of life would be due for 2nd/3rd dose during IMI first round. Monitor to identify such children and mention in the HSC validation format

5d. No. of children due for MR1 dose during first IMI round
A child who has not received MR1 dose within 9-11 months of life before IMI first round, would be due for MR1 during IMI-5.0. Monitor to identify such children and mention in the HSC validation format

5e. No. of children (16-23 months) due for MR2 during first IMI round
A child aged 16-23 month who has received MR1 dose timely or at least one month prior to IMI

round would be eligible for MR2 during IMI-5.0. Monitor to identify such children and mention in the HSC validation format

5f. Name(s) of the children with due dose(s) by DPT1/ Penta/DPT 2 or 3 / MR1 / MR2(16-23 months) for cross validation with information in HCS format
Monitor to mention names of children due for DPT1 / Penta/DPT 2 or 3 / MR1 / MR2(16-23 months)

5g. No. of children due for DPT-1 but missed in HCS format
Monitor to cross check the names of due children for DPT-1 in the validation format with names mentioned by the surveyor in their HCS format to identify children missed for DPT-1 in HCS format. Mention such no. of missed children in HCS validation format.

5h. No. of children due for Penta/DPT2 or 3 but missed in HCS format
Monitor to cross check the names of due children for Penta/DPT2 or 3 in the validation format with names mentioned by the surveyor in their HCS format to identify children missed for Penta/DPT2 or 3 in HCS format. Mention such no. of missed children in HCS validation format.

5i. No. of children due for MR1 but missed in HCS format
Monitor to cross check names of due children for MR1 in the validation format with names mentioned by the surveyor in their HCS format to identify children missed for MR1 in HCS format. Mention such no. of missed children in HCS validation format

5j. No. of children (16-23 M) due for MR2 but missed in HCS format
Monitor to cross check names of due children (16-23 months) for MR2 in the validation format with names mentioned by the surveyor in their HCS format to identify children missed for MR2 in HCS format. Mention such no. of missed children in HCS validation format

6. Children 2-5 years (24-59 M)

6a. No. of children found in this HH by monitor
Monitor to seek no. of children 2-5 years (24-59 months) and mention in the HSC validation format

6b. No. of children found due for MR-1/MR2 dose during first IMI round
A child who has not received MR1 yet would be due for MR1 during IMI, and if taken MR1 one months prior to IMI round would be due for MR2. Monitor to identify such children for MR1 and MR2 and mention in relevant columns in the HSC validation format

6c. Name(s) of the children due for MR-1/MR2 for cross validation with information in HCS format - MR1 / MR2
Monitor to mention names of children due for MR1 and MR2 at relevant place in the HSC validation format

6d. No. of children due for MR-1/MR2 but missed in HCS format - MR1 / MR2
Monitor to cross check names of due children for MR1 and MR2 in the validation format with names mentioned by the surveyor in their HCS format to identify children missed for MR1 and MR2 in HCS format. Monitor to mention such no. of missed children in HCS validation format.

7. Vaccine Refusal

7. Did you (monitor) feel that the child has missed due dose as per age due to vaccine hesitancy/ refusal and AEFI apprehension at this HH? Yes / No
If the monitor when finds any child in any age group (below 5 years) in HHs visited/checked has missed a dose and it is suspected to be due to vaccine hesitancy and/or AEFI apprehension, select Yes, else No.

8. Interaction with the surveyor/team: Met surveyor/team? (If no – skip q 8 a, b, c, d and e)
If the monitor couldn't meet the surveyor, SKIP Question 8 a, b, c, d and e).

8a. Who has done HCS? ASHA / AWW / ANM / Link worker / Others
Monitor to ascertain who did the HCS in this area. This will be useful for sharing the feedback with MOIC at the planning unit as well as to the administrative head of different cadre such ICDS for course correction.

8b. Did the surveyor receive training prior to HCS? Yes / No
Monitor to ascertain from the surveyor if training regarding beneficiary age and orientation on concept of identifying beneficiaries for the first round of IMI is done.

8c. No. of houses planned by the team per day:
i) less than 25 ii) 25-50 iii) 50 - 100 iv) ≥ 100

Monitor to understand from the surveyor regarding the HH load that is expected to be visited per day for HCS. More than 50 HH per day is too high a task which may be responsible for incomplete and compromised HCS quality. If there is high workload in significant proportion of teams, planning unit Medical Officer and district health officials may be apprised for appropriate intervention.

8d. Has the surveyor (team) used standardized HCS format? Yes / No
Monitor to look for all the components in the standard HCS format as per National Guidelines for IMI-5.0, 2023. Some states may have customized to meet sate specific requirements. If all components are retained in the HCS format, monitor to respond as 'Yes' else 'No'

8e. Was UWIN used enlisting beneficiaries? Yes / No
The surveyor/team is expected to use UWIN mobilizer App for enlisting beneficiaries. It may be used for direct entry or first on format followed by UWIN App for pre-registering the beneficiaries.

8f. Is the survey team aware of vaccine hesitancy/refusal in this area? Yes / No
If yes, how many families (HH):
Monitor should interact with surveyor/team and assess if they are aware and/or come across families who are resistant to vaccination historically and have not shared the vaccination details as they are not willing for vaccination; or families who have been vaccinating but have now denied vaccination and hence not shared the details in HCS; or families are reluctant due to fever/pain/abscess or experience some illness; or there is fear/apprehension/rumor of AEFI.

9. Assessment by the monitor:

9a. Has surveyor missed children due for one or more vaccines in ≥2 HH? Y / N

9b. No. of cluster of ≥3 consecutive HH not visited by surveyor/team?

Recommend repeat survey in Survey Compromised Area if: 1). ≥ 3 consecutive HH not visited for survey AND/OR 2). ≥ 2 HH have missed children due for any due vaccine dose(s) in survey.

Annexure 7: Communication planning templates IMI 5.0

State Level Communication Plan for IMI 5.0

State Level Communication Plan for IMI 2023				
Name of the state:		Number of Districts:		Name of Nodal Officer:
Advocacy	State level meeting for planning communication for demand generation	Date…… Responsible person……	Date…… Responsible person……	Date…… Responsible person……
	Orientation of stakeholders- concerned departments; developments partners; academia 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 Religious leaders or key influencers	Date…… Responsible person……	Date…… Responsible person……	Date…… Responsible person……
	Media Sensitization workshop	Date…… Responsible person……		
	Identification and development of plan for engaging influencers	Local celebrity……Activities …… Date……..Responsible person……		
	Any Other	Date…… Responsible person……	Date…… Responsible person……	Date…… Responsible person……
Capacity Building	State ToT including communication training for district officials	Date…… Responsible person……		
	Training of concerned departments, academia and influencers	Date…… Responsible person……		
	Directives and financial guidance for BRIDGE training	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……		

COMPILATION OF DISTRICT COMMUNICATION PLANS AT STATE LEVEL											
		District 1	District 2	District 3	District 4	District 5	District 6	District 7	District 8	District 9	Total
Advocacy	Meetings of District and City Task Force										
	Orientation of stakeholders- concerned departments; developments partners; academia professional bodies (IMA, IAP, FOGSI)etc.										
	Formation of Core Group for media management including crisis communication										
	Orientation of Religious leaders or key influencers										
	Media Sensitization workshop										
	Identification and development of plan for engaging influencers										
	Any Other										
Capacity Building	Training of block level health functionaries from health and other concerned departments										
	Plan for training of FLWs at Block Level on IMI and communication planning										
Media Management	district/City level media sensitization workshop										
	Regular media monitoring at district level										
Social Media	Constitution of district.City task force for social monitoring and management										
	WhatsApp messaging through groups										
IEC and Community Engagement	Production and dissemination of materials for session sites										
	Wall paintings/ Bus panels/ hoardings etc.										
	Group meetings for parents/ male engagement/ nigrani samiti etc.										
	Others - please describe										
	Micking and PA system announcement using support of ULB and Municipalities.										
Note: I- State Immunization Officer to collect information from district and compile the state sheet. II - He/ she needs to submit this template to Mission Director- NHM.											

District level communication plan for IMI 5.0

District level communication plan for IMI 2023 (form no. 7C)				
Name of the state:		**Name of District:**		**District IEC/ Media Nodal officer:**
Advocacy	DTFI meeting	Date…… Responsible person…….	Date…… Responsible person…….	Date…… Responsible person…….
	Orientation of IMA/IAP/FOGSI members	Date…… Responsible person…….	Date…… Responsible person…….	Date…… Responsible person…….
	Orientation of Govt. School principal/ Nodal persons from urban area	Date…… Responsible person…….	Date…… Responsible person…….	Date…… Responsible person…….
	Orientation of Pvt. School nodal person and principals from urban area	Date…… Responsible person…….	Date…… Responsible person…….	Date…… Responsible person…….
	Orientation of Religious leaders or key influencers	Date…… Responsible person…….	Date…… Responsible person…….	Date…… Responsible person…….
	Media Advocacy workshop and nomination for Media spoke person.	Date…… Responsible person…….		
	Identified local celebrity/brand ambassador for the campaign	Local celebrity……Activities …… Date……Responsible person……		
	Any Other	Date…… Responsible person…….	Date…… Responsible person…….	Date…… Responsible person…….
Capacity Building	Training of block level health functionaries	Date…… Responsible person…….		
	Training of Education department officials	Date…… Responsible person…….		
	Training of block level ICDS of CDPOs and ABSAs	Date…… Responsible person…….		
	Plan for training of frontline workers on BRIDGE	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……		

COMPILATION OF BLOCK LEVEL PLANS		District	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Total
Advocacy	BTF meeting for IMI 5.0 rounds communication interventions.										
	Meeting with School principals & Nodal officer (Govt.)										
	Meeting with School principals & Nodal officer (Pvt.)										
	Joint Education & Health core group meeting										
	Microplanning meeting (For communication) IMI 5.0 rounds communication interventions.										
	Meeting with key religious leaders/ influencers at block level										
	Sensitization meeting with govt. line departments i.e. WCD, Schools										
	Any other										
Capacity Building	Orientation of ANMs (For IMI 5.0 round communication interventions)										
	Orientation of ASHAs/AWWs (For IMI 5.0 rounds campaign communication)										
Social Mobilization	Mother's meeting										
	Community/ Influencer's meeting										
	VHSNC meeting for IMI 5.0 rounds communication interventions. campaign										
	Govt. school teachers orientation/coordination meeting										
	Private school meeting										
	Parent Teachers Meeting										
	Rallies										
	Public Announcement from- Mosque/Temple/ door to door garbage collection vehicle PA system etc.										
	IPC sessions										
Mid media	Posters in community										
	Posters in Schools										
	Hoardings										
	Leaflets for community										
	Leaflets for Schools										
	Leaflets for ANM, ASHA and AWW										
	Leaflets for ASHAs/AWWs										
	Leaflets for MOs										
	Miking/Local announcements										
	Any other activity										

Note;- I-This template will be completed by district MEIO/ IEC officer/ consultant (if no one for dedicated for IEC activity) then district immunization officer will be responsible to compile with consultations of block MOIC/BEE/IEC consultant. II- one copy need to be with concern person who are looking IEC/communication and one copy need to be submitted to chief district medical officer/ CMO/CDMO before the district training start on IMI 5.0 rounds communication interventions..

IMI microplanning meeting (for communication and planning)

Block / UPHC Level Communication Plan for IMI 2023									
Name of the District:		**Name of PHC/ Planning unit:**				**Name of MO I/C:**			
Advocacy Meetings	BTF meeting for IMI campaign	Date:				Date:			
	IMI microplanning meeting (for communication and planning)	Date: Responsible person:							
	Coordination meeting with CSO/ NGOs, key religious leaders/ influencers at block level	Date: Responsible person:		Date: Responsible person:		Date: Responsible person:			
	Sensitization meeting with block-level officers from government line departments	Date: Responsible person:				Date: Responsible person:			
	Any other activity Tribal/Urban/migrant etc. population	Date: Responsible person:		Date: Responsible person:		Date: Responsible person:			
	Any other (Specify)	Date:							
Capacity Building	Orientation of ANMs on BRIDGE (for IMI communication/ planning)	Date: Responsible person:				Date: Responsible person:			
	Orientation of ASHAs/AWWs on BRIDGE (and IMI campaign communication)	Date: Responsible person:				Date: Responsible person:			
Social Media	WhatsApp messaging (in coordination with District Social Media committee)	Members: Frequency:				Members: Frequency:			
	Other (Specify)								
COMPILATION OF SUB BLOCKL LEVEL PLANS									
		PHC	SC-1	SC-2	SC-3	SC-4	SC-6	SC-7	SC-8	Total
Social Mobilization activities	Mother's meeting									
	Community/ Influencer's meeting									
	VHSNC meeting for IMI									
	Mosque/ Temple announcement									
	IPC sessions									
	Miking									
	MAS meeting for mobilization of missed children									
	Others (Specify)									
Mid media activities	Posters in community									
	Leaflets for community									
	Leaflets for ANMs									
	Leaflets for ASHAs/ AWWs									
	Leaflets for MOs									
	Any other activity (Specify)									
Note: This template needs to be filled by BEE/ IEC consultant (person responsible for IEC) in their absence MOI/C needs to fill this format with consultation with his/her ANM/ANM supervisor/ ASHA facilitators. This needs to be submitted to person in-charge for IEC at										

Sub-center level communication plan for IMI 5.0

Sub-center level communication plan forIMI 2023 (form no. 7E)																
Name of the district		Name of the facility-CHC/ PHC			Name of sub-center /health center			Name of ANM:					Name of ASHAs and AWW:			
S. No	Name of Village/ Urban Area/ School	Social mobilization activities											Med-media activities			
		Mother's meeting	Community/Influencer's meeting	VHSNC meeting	Inter Department Coordination Meetings	Teekakaran Mitr Toli	Rallies	Mosque/ Temple announcement	MAS meeting for mobilization of missed children	IPC sessions	Others (specify	Posters in community	Posters in Schools	Leaflets for community	Leaflets for Schools	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.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	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.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	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.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	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.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	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.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	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.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	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.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....
Total No.																

Note : 1-This template need to be fill-up by ANM with the help of her ASHA/AWW and MOIC.II- ANM should compile all her ASHA template and keep one copy with her and submit one copy to the MOIC before the block training for MR.

Annexure 8a: House to House Monitoring Format IMI 5.0

State/UT: ..... District: ..... Date: _ _/ _ _/ _ _ Type of monitoring: RI / SIW / Others (specify) ..... Monitoring time: _ _ : _ _ to _ _ : _ _

Block/ Urban area: ..... CHC/PHC/UPHC/Others:..... Planning unit: ..... Sub-centre/ ANM area:..... Session site/s for this area:.....

Village/ Ward/ Mohalla:..... Setting: Urban / Rural; HRA: Yes/ No; $If Yes, mention code: $ 1/ 2/ 3 / 4/ 5 / 6A / 6B / 6C / 6D / 6E / 6F;

Is there an ongoing measles outbreak in this area? Yes / No

Name of Monitor(s): ....; ..... Organization: Govt/ WHO / UNICEF/ JSI / CHAI / Others (specify): ..... Designation(s): .....;

 # Codes for HRA: 1: Slum with migration 2: Nomads 3: Brick kiln 4: Construction site 5: Other migratory sites 6A: Settled Slum 6B: Hard to Reach areas 6C:Vacant Sub-centre 6D: VPD outbreak areas 6E: Vaccine hesitancy 6F: Others

Monitor to visit 10 households (HH)			7 HH for 7 children 0-23 months (up to 2 years)							3 HH for 3 children 24-59 months (2 to 5 years)		
Details of child and vaccination status in monitored Households			HH-1	HH- 2	HH-3	HH-4	HH-5	HH-6	HH-7	HH-1	HH-2	HH-3
Details of sleeted child	1a	Name of the selected child										
	1b	Name of the Father/Mother of the child										
	1c	Person providing information [Mother = M; Father = F, Grandparents = G , Others = O]	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O
	1d	Religion (H=Hindu, M=Muslim, C= Christian, O=Others)	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O
	1e	Gender of the child: M=Male, F=Female, O= Other	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O
	1f	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
	1g	Date of birth (dd/mm/yy). [if not known, write NA]										
	1h	Age in completed months										
	$1i	Source of information on vaccination status MCP/RI Card = C, Recall = R ; e-Vaccination certificate = eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC

Write dates (dd/mm/yy) for each vaccine received if MCP /RI / eVC is available. In case of recall write Yes / No. Mention "NA" for vaccine if child is not due for vaccine in view of age or the vaccine has not been/was not introduced in the district or the child was not eligible

At Birth	2a	Hep-B birth dose Administered within 24 hours of birth											
	2b	bOPV-0 dose as early as possible, within 15 days of birth											
	2c	BCG at birth, within 1 year of age											
At 6 weeks	3a	bOPV-1 at 6 weeks, can be given up to 5 years of age											
	3b	RVV-1 at 6 weeks, not to start after 1 year of age											
	3c	fIPV-1 at 6 weeks, not to start after 1 year of age											
	3d	PCV 1 at 6 weeks, not to start after 1 year of age											
	3e	Pentavalent-1 at 6 weeks, if > 1 year of age, DPT can be given											
	3f	DPT-1 (can be given if Penta-1 not started within 1 year of age)											
At 10 weeks	4a	bOPV-2 at 10 weeks											
	4b	RVV-2 at 10 weeks											
	4c	Pentavalent-2 at 10 weeks											
	4d	DPT-2 (If DPT is initiated, else NA)											
At 14 weeks	5a	bOPV-3 at 14 weeks											
	5b	RVV-3 at 14 weeks											
	5c	fIPV-2 at 14 weeks											
	5d	PCV2 at 14 weeks											
	5e	Pentavalent-3 at 14 weeks											
	5f	DPT-3 (If DPT is initiated, else NA)											

Monitor to visit 10 HH			7 HH for 7 children 0-23 months (up to 2 years)							3 HH for 3 children 24-59 months (2 to 5 years)		
Details of child and vaccination status in monitored Households			HH-1	HH- 2	HH-3	HH-4	HH-5	HH-6	HH-7	HH-1	HH-2	HH-3
At 9 -11 months	6a	Vitamin A syrup at 9-11 months, then 6 monthly up to 5 years										
	6b	fIPV-3 at 9-11 months										
	6c	MR-1 at 9-11 months can be given up to 5 years of age										
	6d	PCV Booster at 9-11 months										
	6e	JE-1 (where applicable) at 9-11 months up to 2 years of age										
At 16-23 and 24-59 months	7a	bOPV Booster at 16-23 months. Can be given up to 5 years										
	7b	Vitamin A syrup: Total doses received for the age										
	7c	MR-2 at 16-23 months, if MR1 delayed, MR2 after 1month of MR1 & not before 16 months										
	7d	JE-2; at 16-23 months. If JE1 delayed, JE2 after 1 month of JE1 & not before 16 months. In delayed vaccination, can be completed in 2 yrs										
	7e	DPT Booster-1 at 16-23 months, can be given up to 7 years										

IMI specific vaccination status	8a	Was this child due for any dose in IMI?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
	8b	If due for ≥ 1 DUE dose during IMI, what is the status of receipt of due vaccine doses? [Encircle as applicable, NA if Q11=No] (Don't consider Hepatitis-B birth dose & bOPV-0)	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA	All doses / Some doses / None / NA
	8c	Child received vaccine for the first time in life. [Ignore Hep-B & OPV0] [Yes, only if child had not received any dose prior to this IMI]	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
	8d	If received all due IMI doses, did the child complete age appropriate vaccination as per UIP schedule? (Ignore Hep-B birth & bOPV-0]	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
	8e	If child has missed some / all due dose(s), ascertain reason(s) as told by caregiver [max. of 2 reasons by codes from table below)										

Reasons for not getting due dose/s: 1) Not aware of need for immunization 2) No one contacted 3) Concern for loss of work or wages 4) Session inconvenient 5) Unfriendly behaviour of HW 6) Session found closed 7) Vaccine not available 8) Child was travelling or away from home 9) Child was/is sick 10) Fear of multiple injections 11) Fear of AEFI 12) Adverse media reports; 13) Family is resistant 99) Others: .....

MR1/MR2 status in 24-59 months children	9a	Is there any child 2 to 5 yrs in this household? If yes, fill the details for the youngest child of 2-5 yrs, in 9b, 9c and 9d, else skip.	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	If any child is found to have missed any vaccine including MR1 / MR2 – inform MOIC and key staff to ensure such children are vaccinated.
	9b	Whether the child has received MR 1	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
	9c	Whether the child has received MR 2	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
	9d	If not received MR 1/ MR 2, name of the child								

Annexure 8b: IMI 5.0 Session Site Monitoring Format

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

State/UT: ..... District: ..... Date: _ _/ _ _/ _ _ Monitoring time: _ _: _ _ to _ _: _ _

Block/ Urban area:..... CHC/PHC/UPHC/Others: ..... Planning unit: ..... Sub-centre/ ANM area:.....Village/ Ward/ Mohalla:.....

Setting: Urban/ Rural, If Urban, NUHM City: Yes/ No ; Name of ANM/ Vaccinator..... Name of Session site: .....

Session type: a. Fixed / Outreach / Mobile/ Vaccination on demand; b.. Govt./ Pvt; c. *HRA#: Yes/ No, If Yes, mention code :..... , ..., ...

Is there an ongoing measles outbreak in this area? Yes / No

Name of Monitor(s): .....; Organization: Govt / WHO / UNICEF / JSI / CHAI / Others (specify): .....; Designation: .....;

Name of Monitor(s): .....; Organization: Govt / WHO / UNICEF / JSI / CHAI / Others (specify): .....; Designation: .....;

 # Codes for HRA*: 1: Slum with migration 2: Nomads 3: Brick kiln 4: Construction site 5: Other migratory sites 6A: Settled Slum 6B: Hard to Reach areas 6C: Vacant Sub-centre 6D: VPD outbreak areas 6E: Vaccine hesitancy 6F: Others (Specify): .....

1	Is planned session found held at the time of visit?	Yes / No	* If no-reason(s)	a. Session closed early b. ANM didn't report at the session c. Vaccine / logistics not available d. ANM and Vaccine/ logistics not available e. Others.....
			If session found 'not held' skip to Q 35-37 as applicable, and plan to conduct house-to-house monitoring in this area after the stipulated session closure time same day /at the earliest	
			If yes	a. Is the session being held at same location as per micro-plan? Yes / No b. Is the vaccinator same as per micro-plan? Yes / No

U-WIN portal use: Yes / No / NA – Not yet started in the state/district (if No encircle NA and skip Q 2 in ODK tool)		
2	a. Is this session site registered on U-WIN? Yes / No / NA	b. Is vaccinator registered on U-WIN? Yes / No / NA
	c. Is the current session registered and conducted on U-WIN Yes / No / NA	d. Whether e-Vaccination certificate is generated after administering vaccine? Yes / No / NA

Monitor observed ANM vaccinating at least 1 child? Yes / No [If no, skip to Q 8]		
3	Is ANM administering vaccines in correct sequence as per operational guidelines?	Yes / No (6-14 weeks: bOPV, RVV, BCG, fIPV, PCV, Penta); (≥9 months: Vit-A, fIPV, MR, PCV, JE); (≥16 months: Vit-A, OPV, MR, DPT, JE)
4	Are safe injection practices being followed?	Yes / No; If No, select: a. not cutting syringe hub immediately after use b. recapping c. touching the needle during preparation /administration d. pre-filling syringe
5	Is ANM providing 4 key messages [Vaccine given against disease; their side effects & how to manage, safe keep of the card, & when and where is next visit]	All 4 messages / Some messages / None
6	6A: ANM asking caregivers to wait with child for 30 min after vaccination? Y/ N	6B: Is paracetamol syr/drops provided, to be used if child develops fever following vaccination? Y / N / Paracetamol not available
7	Is ANM updating MCP/ RI card /U-WIN after vaccinating each child?	a. MCP/ RI card: Yes / No b. U-WIN portal: Yes / No / NA – Not yet started in the state/district

8	Who delivered vaccine/logistics at the session site? a. Alternate Vaccine Delivery (AVD) b. ANM / Vaccinator c. ASHA d. AWW e. Supervisor f. others g. Not applicable as session site is a CCP			
9	a. Name of cold chain point (CCP) supplying vaccines/ logistics to this session site: .....; b. Is the travel time from CCP to this session site more than 1 hour: Yes / No			
10	10a. Is Mahila Arogya Samiti (MAS) for NUHM City constituted? (Check with ANM / ASHA / mobilizer)	Yes / No / NA	10b. Mobilizer/s found working at the session a. ASHA: Yes / No / NA b. AWW: Yes / No / NA c. Link worker: Yes / No / NA d. MAS: Yes / No / NA e. Others (specify): _____	10c. Any local Influencer identified and supporting RI in ongoing MR outbreak area? Yes / No / NA; If Yes, Influencer is/are: a. Religious influencer b. PRI member c. Local doctor d. Others.....

Is the session being held at District hospital, Medical College, Block HQ PHC, CHC etc. [Which has no well-defined catchment area] Yes / No; If yes, SKIP Q11 and 12, If "No" – continue with Q11 onwards					
11	Is Head Count Survey (HCS) done specifically for this IMI5.0 session area? Y / N	11A. If yes, HCS record available: Yes / No;		11B. If No, available HCS was done a. 1-2 M of IMI b. >3-6 months c. No HCS done	
12	Status of due list availability? Yes / No	a. Paper based b. On U-WIN c. On both paper and U-WIN d. No due list			
		If yes, due list has beneficiaries from	0 to <2 Years: Y / N	2 – 5 years children missed MR1/MR2: Y / N	Pregnant woman: Y / N

13	Status of ice packs in the vaccine carrier (regular or freeze free vaccine carrier)	a. Hard frozen b. Ice-packs have Ice and water c. Ice-packs have only water
14*	Encircle vaccine/ diluent available at session :	BCG / BCG Diluent / bOPV / IPV / RVV - VVM on Cap / RVV - VVM on Label / Pentavalent / DPT / PCV / MR / MR Diluent / JE /Td
15*	Does ALL opened vials have date and time mentioned on them?	Yes / No / NA; If no, mention vaccine(s): .....; .....; .....; .....
16*	Whether ALL reconstituted vaccines (BCG / MR) are within 4 hours of reconstitution?	Yes / No / NA: If no, mention vaccine(s).....; .....;

17*	Any issue with condition of vaccine/ diluent identified?	Yes / No ; If yes, select option and *mention vaccine(s)	a. Frozen .....; b. VVM in unusable stage .....; c. Damaged label: .. ..; d. Damaged glass/septum.....; e. Beyond expiry date .....; f. Beyond 28 days of opening (for vaccines under open vial policy) .....; g. Other conditions (specify) .....;

18*	Which logistics are NOT available?	AD syringes : a. 0.1 ml, b. 0.5 ml, c. Sufficient 5 ml reconstitution; d. Vit-A solution; e. Spoon for Vit-A; f. ORS; g. Zinc tab/syr; h. Blank MCP cards; i. All logistics are available

Bio-medical waste and AEFI management [NA = Red / Black bag not available for Q 19C and Not applicable for Q 19D]

19	19A. Is working hub-cutter with white/blue puncture & tamper proof container available? Yes / No;		19B: Hub cutter with cut hubs + needle and broken vial/ampoule being sent for disposal? Yes / No
	19C. ANM segregating i). plastic portion of syringe /used empty vial into red bag – Y / N / NA; ii). Wrapper/ needle cap into black bag: Y / N / NA		19D. Red/ Black bags with contents sent for disposal? Y / N / NA
20	Is Anaphylaxis kit available?	Yes / No	If yes, a. Adrenaline within expiry date: Y / N b. Adrenaline dose chart: Y / N c. Tuberculin/Insulin syringe with detachable needle: Y / N
21	Any AEFI management centre tagged with this session: Yes / No / Not aware; If yes, mention details:		

Interaction with ANM / mobilizers		
22	Did any supervisor visit the session today?	Yes / No, If yes; select option(s): a. Medical Officer b. Health Supervisor c. Community Health Officer (CHO) d. District level Officials e. Others: .....
23	23A. ANM/vaccinator received training on concepts of IMI5.0 including HCS: Yes / No	23B. Assess whether ANM/vaccinator has prepared session due list from HCS records: Yes / No
24	24A. ASHA/mobilizer received training on new headcount survey format for IMI5.0? Yes / No	24B. Is ASHA/ mobilizer aware of how HCS is done for IMI5.0? Yes / No

IMI specific questionnaire

25	25A. Is this session site planned specifically for IMI? Yes / No (From RI micro-plan / interview ANM): Yes / No / Don't know	25B. ls the session located at the same site where RI session is usually held?
26	No. of days ANM is assigned to work in IMI as per micro-plan / ANM duty roster? (Find out from ANMs session wise micro-plan)	a. 1-2; b. 3-5; c. 6-7; d. > 7 days e. ANM roster not available/ANM unaware
27	Place of posting of this ANM?	a) same sub-centre / urban health post b) different sub-centre / urban health post in the same block / planning unit c) different block / urban planning unit

ASHA/LINK worker interviewed: ASHA interviewed: Yes / No / NA [If No or NA, skip Q28]		
28*	ASHA aware of which of the following incentives in RI programme?	a. Line listing (HCS) of HH & beneficiaries b. Due list preparation and monthly updation c. Mobilization of children d. Full Immunization with 1st year vaccines
29	Is the LINK worker aware of incentive for mobilization of children	Yes / No / Not applicable / Not met

Number of caregivers interviewed: 1 / 2 / None [If "None" SKIP Q 30- 33]		Caregiver 1	Caregiver 2
30	30A. Did the HW help you in registering your beneficiary detail on U-WIN before vaccination	Yes / No / NA	Yes / No / NA
	30B. Did you receive any message following vaccination on the registered mobile no. Yes / No / NA	Yes / No / NA	Yes / No / NA
31*	Who asked to bring child to this session? a. ASHA b. AWW c. ANM d. MAS e. Link worker f. ULB/PRI g. Religious leader h. Influencer i. Self j. Others.....	a / b / c / d / e / f / g / h / I / j	a / b / c / d / e / f / g / h / I / j
32*	What would you do if the vaccinated child develops fever / pain? a. Give Paracetamol b. Contact Health worker c. Other (specify)..... d. Not aware	a / b / c..... / d	a / b / c..... / d
33	When should you bring the child for next vaccination? (Monitor to assess and select whether the caregiver's response is Correct / Incorrect)	Correct / Incorrect	Correct / Incorrect

34*	Any IMI specific IEC material etc. displayed at session site?	Yes / No	If yes; select a. Poster b. Banner c. Wall painting d. National Immunization schedule in local language e. Others (Specify): .....

Meet Medical Officer to ascertain reason(s) for session not held [SKIP 35-37 if session was held]

35	Why ANM was not available at session site?	a. On leave b. Vacant post c. Assigned other work d. Others (specify) .....
36	Are you aware of hired vaccinator and their incentives? Yes / No	37. Reason for non-availability of vaccines/logistics? a. Not issued b. Not picked up c. Not delivered d. Others (specify) .....

Annexure 9: IMI 5.0 Recording and Reporting Forms-Master Sheet

RF1: Tally sheet for Intensified Mission Indradhanush 5.0 session

RF1: Tally sheet for Intensified Mission Indradhanush 5.0 session

Round: I / II / III **Date of Activity** _____ **Setting:** Urban/ Rural **ANM**

Block/ planning unit: _____ Sub center: _____ Village: _____ Session site address: _____ HRA (Y/N)_____

Name of ANM: _____ Name of mobilizer(s): _____

S. No	Name of beneficiary	Father/ husband name	Age	Sex	Whether child vaccinated for the first time in life (Y/N)	Pregnant Women			TICK (√) THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY																		Full immunization achieved (Y/N)	TICK (√) THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY									Complete immunization achieved (Y/N)	DPT-2nd Booster (5-6 years)
						Td-1	Td-2	Td- Booster	BCG	OPV-1	Penta 1	RVV-1	fIPV-1	PCV-1	OPV -2	Penta 2	RVV-2	OPV-3	Penta-3	RVV-3	fIPV-2	PCV-2	MR-1 (9-11 months)	MR-1 (>12 months)	JE-1#	PCV-Booster	Vit A-1	fIPV-3		•DPT-1	•DPT-2	•DPT-3	OPV-Booster	DPT- 1st Booster	MR-2 (16-24 months)	MR-2 (>24 months)	JE-2#	Vit A-2		
Total																																						

Summary		
Full immunization Achieved		
	Male	Female
Up to 1 Year		
1 to <2 Years		
Children vaccinated for the first time in life		
Up to 1 Year		
1 to 2 Years		
2 to 5 Years		
AEFI Reporting		
No. of Adrenaline doses used (if any)		
No. of hospitalized AEFI cases (if any)		

Age of child	Up to 1 Year	1- Up to 2 Years	2 to 5 Years
No. of target children for the session (as per due list after head count)			
Total Children vaccinated			
Target for MR-1			
Total Children vaccinated with MR-1*	9-11 Months	> 12 Months	
Target for MR-2			
Total Children vaccinated with MR-2**	16-24 Months	> 24 Months	
No. of Children vaccinated with DPT-1 (>1 Yrs)			
No. of target Pregnant Women for the session (as per due list after head count)			
Total Pregnant Women vaccinated			
AD Syringes 0.1ml used			
AD Syringes 0.5ml used			
5ml Reconstitution Syringes used			

Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated											
		R1 - House locked/Out of village		R2 - Sick		R3 - Refused		R4 - Already Vaccinated after the head count survey in IMI/RI till the day of vaccination		R5 - Fear of AEFI		R6-Others	
Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women

Prepare two copies of this form (1 for ANM and other to be submitted at the Block/Planning unit in the evening)

Signature of ANM

- Children less than 1 year should not be given DPT, start schedule with pentavalent vaccine only.
- As per guidelines, subsequent doses of the Pentavalent vaccine can be given to a child with more than one year of age only if the child has started with the 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 the session site for the first time (without any vaccination) should be given DPT and not the pentavalent vaccine. Other missed vaccination should be given as per guidelines.

Record vaccination wherever is applicable (as JE vaccine is applicable in JE endemic districts only)

* Data Source HC3 & HC3A

** Data Source HC3A

RF2: Block daily reporting format for Intensified Mission Indradhanush 5.0

RF2: Block daily reporting format for Intensified Mission Indradhanush 5.0

Date of Activity ______________

Block/ planning unit: ____

Round: I / II / III

Block/Planning Unit

S. No	Name of ANM	Urban/Rural	No of sessions Planned for the day	No of sessions Planned for the day (In HRA)	No of sessions held during the day	No of sessions held during the day (In HRA)	Session site address	No. of target children for the day (as per the due lists based on head count)			Target for MR Vaccine		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-2nd Booster (5-6 years)	No. of Adrenaline doses used (if any)	No. of hospitalized AEFI cases (if any)	Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated											
								up to 1 Year	1 to upto 2 Years	2 to 5 years	MR-1	MR-2	up to 1 Year	1 to upto 2 Years	2 to 5 years	up to 1 Year	1 to upto 2 Years	2 to 5 years		Td-1	Td-2	Td- Booster		BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	MR-1 (9-11 months)	MR-1 (>12 months)	JE-1#	PCV-Booster	Vit A-1	fIPV-3	9 - 11 months		12 - 23 months		DPT-1●	DPT-2●	DPT-3●	OPV-Booster	DPT- 1st Booster	MR-2 (16-24 months)	MR-2 (>24 months)	JE-2#	Vit A-2					Children	Pregnant Women	R1 -House locked/Out of village		R2-Sick		R3-Refused		R4-Already Vaccinated after the head count survey in IMI/RI till the day of vaccination		R5-Fear of AEFI		R6-Others	
																																												Male	Female	Male	Female																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, start schedule with pentavalent vaccine only.
- As per guidelines, subsequent doses of the Pentavalent vaccine can be given to a child with more than one year of age only if the child has started with the 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 the session site for the first time (without any vaccination) should be given DPT and not the pentavalent vaccine. Other missed vaccination should be given as per guidelines.

\# Record vaccination wherever is applicable (as JE vaccine is applicable in JE endemic districts only)

RF3: District daily reporting format for Intensified Mission Indradhanush 5.0

RF4: District daily reporting format for Intensified Mission Indradhanush 5.0

Date of Activity ______________

District Name: ____ Round: I / II / III

District

S. No	Block/ Urban City name	Urban/Rural	No of sessions Planned for the day	No of sessions Planned for the day (In HRA)	No of sessions held during the day	No of sessions held during the day (In HRA)	No. of target children for the day (as per the due lists based on head count)			Target for MR Vaccine		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-2nd Booster (5-6 years)	No. of Adrenaline doses used (if any)	No. of hospitalized AEFI cases (if any)	Is any death reported today due to AEFI (irrespective of date of vaccination) if Yes, give number	Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated											
							up to 1 Year	1 to upto 2 Years	2 to 5 years	MR-1	MR-2	up to 1 Year	1 to upto 2 Years	2 to 5 years	up to 1 Year	1 to upto 2 Years	2 to 5 years		Td-1	Td-2	Td- Booster		BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	MR-1 (9-11 months)	MR-1 (>12 months)	JE-1#	PCV-Booster	Vit A-1	fIPV-3	9 - 11 months		12 - 23 months		DPT-1*	DPT-2*	DPT-3*	OPV-Booster	DPT- 1st Booster	MR-2 (16-24 months)	MR-2 (>24 months)	JE-2#	Vit A-2						Children	Pregnant Women	R1 -House locked/Out of village		R2-Sick		R3-Refused		R4-Already Vaccinated after the head count survey in IMI/RI till the day of		R5-Fear of AEFI		R6-Others	
																																											Male	Female	Male	Female																	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women
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* 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.

JE vaccine wherever applicable

State reporting format for Intensified Mission Indradhanush 5.0

State reporting format for Intensified Mission Indradhanush 5.0

State Name: Round: I

S. No	District Name	Urban/Rural	No of sessions Planned for the Round: I (Including HRA)	No of sessions Planned for the Round: I (In HRA)	No of sessions held during the Round: I (Including HRA)	No of sessions held during the Round: I (In HRA)	No. of target children for the Round: I (as per the due lists based on head count)			Target for MR Vaccine		No. of children vaccinated			No. of children vaccinated for the first time in life			No. of target Pregnant women for the Round: I (as per the due lists based on head count)	Pregnant Women			No. of PW vaccinated	Record number of vaccinations for each antigen																	
							up to 1 Year	1 to <2 years	2 to 5 yrs	MR-1	MR-2	up to 1 Year	1 to <2 years	2 to 5 years	up to 1 Year	1 to <2 years	2 to 5 years		Td -1	Td -2	Td -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	MR-1 (9-11 months)	MR-1 (>=12 months)	JE-1	PCV-B	Vit A-1	fIPV-3
1		U																																				
		R																																				
2		U																																				
		R																																				
3		U																																				
		R																																				
State Total		U	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		R	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
State Grand Total			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

State reporting format fo

State Name:

For State/UTs

S. No	District Name	Urban/Rural	Full immunization achieved				Record number of vaccinations for each Antigen								Complete immunization achieved	DPT-B (5-6 years)	No. of Adrenaline doses used (if any)	No. of hospitalized AEFI cases (if any)	Is any death reported today due to AEFI (irrespective of date of vaccination) if Yes, give number	Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated											
			Male	Female	Male	Female	DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	MR-2 (16-24 months)	MR-2 (>24 months)	JE-2	Vit A-2							R1 - House locked/Out of village		R2 - Sick		R3 - Refused		R4 - Already Vaccinated after the head count survey in IMI/RI till the day of vaccination		R5 - Fear of AEFI		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
1		U																																
		R																																
2		U																																
		R																																
3		U																																
		R																																
State Total		U	0	0	0	0	0	0	0	0	0	0		0	0	0	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		R	0	0	0	0	0	0	0	0	0	0		0	0	0	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
State Grand Total			0	0	0	0	0	0	0	0	0	0		0	0	0	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

IMI Recording and Reporting Formats (Google Sheets)

Daily vaccine and diluents utilization reporting format

RF6. 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	MR	MR Diluent	DPT	Td	JE	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

State key indicators

State name	State Steering committee meeting held (Yes / No)	State Task Force meeting Held (Yes / No)	State AEFI committee meeting held (Yes / No)

District Key indicators

District Key indicators																	
S.No.	State name	District Name	DTFI held (Yes / No)	Participation of Education department officials in DTFI meeting (Yes / No)	Participation of Urban Development department officials in DTFI meeting (Yes / No)	Participation of Tribal Affairs department officials in DTFI meeting (Yes / No)	Participation of Minority Affairs department officials in DTFI meeting (Yes / No)	Participation of Women and Child Development department officials in DTFI meeting (Yes / No)	Participation of PRI department officials in DTFI meeting (Yes / No)	Participation of Youth Affairs and Sports department officials in DTFI meeting (Yes / No)	Microplan prepared		District AEFI committee meeting held (DACM) (Yes / No)	District Communication plan prepared (Yes / No)	No of planning units prepared Communication plans	Improve the visibility of IMI 2023 by ensuring display of IEC materials in session sites	
											No of block/ PUs where IMI 2023 is planned	No of block/ PUs submitted updated IMI 2023 microplan at district				Number of IMI 2023 session sites with IEC visibility (posters, banners, wall writings etc.)	Number of IMI 2023 session sites visited by district officials

Target Entry Format IMI 5.0

Target Entry Format IMI 5.0

Name of State: ____________________

S. No.	Name of State	Name of District	Urban/Rura	No of sessions Planned for the day (Including HRA)	No of sessions Planned for the day (In HRA)	No. of target children for the day (as per the due lists based on head count)			Target for MR Vaccine		Target Pregnant Women
						up to 1 Year	1 to upto 2 Years	2 to 5 years	MR-1	MR-2	
			U								
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			U								
			R								
		Total	U	0	0	0	0	0	0	0	0
			R	0	0	0	0	0	0	0	0

Annexure 10: 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 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 • Support in planning/conduction of IMI sessions in ESI dispensaries/ hospitals/Medical Colleges
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

Role & Support of Ministries / Department and Partners		
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	Ministry of Railways	• Generating awareness through A-V system at Railway Platforms • Support in IMI session Planning/conducting in the residential colonies of Railways • Support in beneficiaries data updation in U-WIN
11	Ministry of Road Transport & Highways	• Generating awareness though A-V system at Bus stands
12	Ministry of Defence	• Support in Planning /conducting IMI Sessions in hospitals in Cantonments
13	Medical colleges and Nursing schools:	• The medical colleges will be engaged to conduct assessments, reviews, monitoring, and training. The staff 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. • AEFI surveillance nodal officers in medical colleges and hospitals will be identified. They will sensitize doctors and staff to identify AEFIs and record them in AEFI registers, fill the CRFs for severe/serious AEFIs and share it with the DIO for further reporting and investigation on SAFE-VAC.
14	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. • IMA/IAP members will also be sensitized to report all AEFIs and immediate reporting of serious and severe AEFIs to the DIO.

Role & Support of Ministries / Department and Partners		
15	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. • Support in strengthening reporting network of AEFIs in medical colleges, public / autonomous and private hospitals / professional bodies, etc.
16	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
17	ITSU	• ITSU provides technical support for strategizing, developing operational guidelines and training material for IMI 5.0 • ITSU will coordinate for IMI Preparedness Assessment Activities and Monitoring by National Monitors • ITSU will coordinate with state to facilitate data flow for IMI 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. • AEFI Secretariat in ITSU will track information on AEFIs (deaths, clusters, etc.) during the campaign, collate case records, follow up with states/districts for document completion on U-WIN/SAFE-VAC portal and causality assessments at state and national level.
18	UNDP	• Pan India Roll out of U-WIN. • Trainings of all development partners/stakeholders at national level on implementation of U-WIN • Trainings on U-WIN's for States and then to districts in cascading manner. • Support state, districts, and blocks for microplanning, including cold chain and vaccine logistics planning • Digitalization of IMI sessions as per micro plan • 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

Role & Support of Ministries / Department and Partners		
19	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
20	Jhpiego & CHAI	• 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
21	BMGF	• Coordinate with implementation partners to support operational planning, implementation, monitoring, and demand generation activities.
22	USAID	• Coordinate with implementation partners to ensure their engagement in demand generation and communication activities specially in urban areas.
23	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.
24	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) 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

Annexure 11: List of High Risk Districts

S.No.	State	No. of Districts	Districts
1.	ANDHRA PRADESH	9	Alluri Sitharama Raju, Annamayya, Chittoor, Guntur, Kurnool, Parvathipuram Manyam, Prakasam, Sps Nellore, Visakhapatnam
2.	ARUNACHAL PR.	10	East Kameng, Kamle, Kra Daadi, Kurung Kumey, Longding, Lower Subansiri, Pakke Kessang, Upper Siang, Upper Subansiri, West Kameng
3.	ASSAM	14	Charaideo, Darrang, Dhubri, Goalpara, Golaghat, Hailakandi, Hojai, Kamrup (M), Karimganj, Kokrajhar, Lakhimpur, Nagaon, South Salmara Mankachar, Udalguri
4.	BIHAR	12	Araria, Bhojpur, Champaran East, Champaran West, Darbhanga, Gaya, Jamui, Khagaria, Madhepura, Patna, Purnia, Saran
5.	CHHATTISGARH	11	Balodabazaar Bhatapara, Bijaapur, Dantewada, Kanker, Kawardha, Koriya, Manendragarh Chirmiri Bharatpur, Raigarh, Raipur, Rajnandgaon, Sarangarh Bilaigarh
6.	DELHI	8	East, North, North-East, North-West, Shahdara, South-East, South-West, West
7.	GUJARAT	10	Ahmedabad Corpn., Banaskantha, Bhavnagar Corpn., Devbhumi Dwarka, Gir Somnath, Kutch, Morbi, Panchmahals, Surat Corpn., Vadodara Corpn.
8.	HARYANA	6	Faridabad, Gurgaon, Hisar, Mewat, Panchkula, Panipat
9.	HIMACHAL PRADESH	2	Kangra, Shimla
10.	JAMMU & KASHMIR	4	Baramula, Jammu, Ramban, Srinagar
11.	JHARKHAND	10	Chatra, Deoghar, Dhanbad, Dumka, Giridih, Godda, Jamtara, Pakur, Sahibganj, West Singhbhum
12.	KARNATAKA	13	Bagalkot, Ballari, BBMP, Belagavi, Bengaluru Urban, Dakshina Kannada, Dharwad, Kalaburgi, Kolar, Mysuru, Raichur, Vijayapura, Yadgiri
13.	KERALA	6	Ernakulam, Kannur, Kozhikode, Malappuram, Palakkad, Thiruvananthapuram
14.	MADHYA PRADESH	18	Alirajpur, Ashoknagar, Barwani, Bhind, Chhindwara, Damoh, Gwalior, Hosangabad, Jabalpur, Katni, Mandsaur, Panna, Sagar, Sehore, Sheopur, Singrauli, Ujjain, Vidisha
15.	MAHARASHTRA	19	Akola Corporation, Amravati Corporation, Aurangabad Corporation, Bhandara, Bhiwandi Nizampur Corporation, Dhule, Dhule Corporation, Gr. Mumbai, Latur Corporation, Malegaon Corporation, Nagpur Corporation, Nanded Corporation, Parbhani Corporation, Pimpri Chinchwad Corporation, Pune Corporation, Sangli Miraj Kupwad Corporation, Sindhudurga, Thane Corporation, Vasai Virar City Corporation
16.	MANIPUR	5	Jiribam, Noney, Pherzawl, Tengnoupal, Ukhrul

17.	MEGHALAYA	8	East Garo Hills, East Khasi Hill, Eastern West Khasi Hill, North Garo Hills, South Garo Hills, South West Garo Hills, South West Khasi Hills, West Khasi Hill
18.	MIZORAM	4	Lawngtlai, Lunglei, Mamit, Saiha
19.	NAGALAND	6	Mon, Noklak, Peren, Tuensang, Wokha, Zunheboto
20.	ODISHA	10	Bhadrak, Bolangir, Cuttack, Ganjam, Kalahandi, Khurda, Koraput, Mayurbhanj, Sambalpur, Sundergarh
21.	PUNJAB	6	Amritsar, Bhatinda, Jalandhar, Ludhiana, Malerkotla, Mohali
22.	RAJASTHAN	13	Ajmer, Alwar, Bharatpur, Churu, Jaipur, Jaisalmer, Jodhpur, Karauli, Kota, Nagaur, Sawai Madhopur, Sikar, Tonk
23.	TAMIL NADU	10	Chengalpattu, Chennai, Coimbatore, Kancheepuram, Krishnagiri, Madurai, Nagapattinam, Tiruchirappalli, Tirunelveli, Tiruppur
24.	TELANGANA	11	Hanumakonda, Hyderabad, Karimnagar, Khammam, Mahabubnagar, Medchal Malkajgiri, Nalgonda, Nizamabad, Rangareddy, Sangareddy, Vikarabad
25.	TRIPURA	3	Dhalai, Tripura North, Unakoti
26.	UTTAR PRADESH	26	Agra, Aligarh, Ambedkar Nagar, Azamgarh, Badaun, Badohi, Balrampur, Banda, Etawah, Farrukhabad, Ferozabad, Gautam Budh Nagar, Ghaziabad, Gonda, Hardoi, Jalaun, Kanpur(Nagar), Kasganj, Kheri, Mau, Meerut, Pratapgarh, Prayagraj, Siddharthnagar, Sitapur, Unnao
27.	UTTARAKHAND	4	Dehradun, Haridwar, Nainital, Udhamsingh Nagar
28.	WEST BENGAL	12	24-Parganas North, 24-Parganas South, Basirhat, Darjeeling, Diamond Harbour, Howrah, Hoogli, Kolkata, Maldah, Murshidabad, Paschim Bardhaman, Uttar Dinajpur
Total		270	

List of Districts with Vaccine Hesitant Areas

S.No.	State	No. of Districts	Districts
1.	ANDHRA PRADESH	4	Annamayya, Guntur, Kurnool, Visakhapatnam
2.	ARUNACHAL PR.	8	East Kameng, Kamle, Kra Daadi, Kurung Kumey, Longding, Pakke Kessang, Upper Siang, West Kameng
3.	BIHAR	7	Araria, Bhojpur, Champaran West, Darbhanga, Madhepura, Patna, Purnia
4.	CHHATTISGARH	1	Kawardha
5.	DELHI	4	East, North, Shahdara, South-East

6.	GUJARAT	8	Banaskantha, Bhavnagar Corpn., Devbhumi Dwarka, Gir Somnath, Kutch, Panchmahals, Surat Corpn.
7.	HARYANA	1	Mewat
8.	JHARKHAND	4	Chatra, Dhanbad, Giridih, Jamtara
9.	KARNATAKA	10	Bagalkot, BBMP, Belagavi, Bengaluru Urban, Dakshina Kannada, Kalaburgi, Kolar, Raichur, Vijayapura, Yadgiri
10.	KERALA	3	Kannur, Kozhikode, Malappuram
11.	MADHYA PRADESH	5	Bhopal, Indore, Jabalpur, Sehore, Ujjain
12	MAHARASHTRA	11	Akola Corporation, Amravati Corporation, Aurangabad Corporation, Bhiwandi Nizampur Corporation, Gr. Mumbai, Malegaon Corporation, Nagpur Corporation, Nanded Corporation, Parbhani Corporation, Thane Corporation, Vasai Virar City Corporation
13.	MANIPUR	3	Jiribam, Pherzawl, Ukhrul
14.	MEGHALAYA	6	East Garo Hills, East Khasi Hill, Eastern West Khasi Hill, South Garo Hills, South West Khasi Hills, West Khasi Hill
15.	MIZORAM	3	Lawngtlai, Lunglei, Mamit
16.	PUNJAB	1	Malerkotla
17.	RAJASTHAN	2	Alwar, Bharatpur
18.	TELANGANA	3	Hyderabad, Medchal Malkajgiri, Rangareddy
19.	UTTAR PRADESH	24	Agra, Aligarh, Ambedkar Nagar, Azamgarh, Badaun, Balrampur, Banda, Etawah, Farrukhabad, Ferozabad, Gautam Budh Nagar, Ghaziabad, Gonda, Hardoi, Jalaun, Kanpur(Nagar), Kasganj, Kheri, Meerut, Pratapgarh, Prayagraj, Siddharthnagar, Sitapur, Unnao
20.	UTTARAKHAND	4	Dehradun, Haridwar, Nainital, Udhamsingh Nagar
21.	WEST BENGAL	8	24-Parganas South, Diamond Harbour, Howrah, Kolkata, Maldah, Murshidabad, Paschim Bardhaman, Uttar Dinajpur
Total		120	

IMMUNIZATION
TECHNICAL SUPPORT UNIT
Ministry of Health & Family Welfare