NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

Be Wise!
Get your child fully immunized

Guidance Document on Strategic Approach for Reaching Zero Dose Children in India

India's Zero Dose Implementation Plan

U-WIN

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अपूर्व चन्द्रा, भा.प्र.से.
सचिव
APURVA CHANDRA, IAS
Secretary

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

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

MESSAGE

It is with great pride and optimism that I introduce this pivotal guidance document on the "Zero Dose Implementation Plan," prepared in alignment with the Immunization Agenda 2030. This is, undoubtedly, a visionary initiative, which represents a giant leap forward in our commitment to achieving universal immunization coverage and leaving no child behind.

One of the most vital public health interventions is vaccination against childhood diseases. The "Zero Dose Implementation Plan" seeks to address the pressing challenge of zero-dose children across our diverse nation. This comprehensive document outlines a multifaceted approach to reach every child with life-saving vaccines, leveraging evidence-based strategies, and harnessing the power of innovation and technology. Our collective efforts to combat zero-dose children are bolstered by the strategic collaboration with the Health System Strengthening (HSS-3) project.

I acknowledge the dedication of stakeholders, including health professionals, community leaders, government agencies, and civil society organizations and appreciate their invaluable support in advancing nationwide immunization. With collective determination, we aim at overcoming challenges and ensuring a healthier future for our children.

I would like to congratulate the whole team of Universal Immunization Programme (UIP) at Central and State level for collaborating together to undertake root cause analysis on the challenges in reaching zero dose children and for developing focused strategies to reach such children in a mission mode to reduce the burden of zero dose children in the country.

As we progress, let us remain committed to Immunization Agenda 2030 and the "Zero Dose Implementation Plan." Together, we can realize this vision, ensuring no child in India is left without vaccine protection.

Dated 5th February, 2024

(Apurva Chandra)

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Government of India
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi - 110011

MESSAGE

With immense pleasure and pride, I present this pivotal document, detailing the comprehensive immunization strategy known as "India's Zero Dose Implementation Plan," as a part of the Health System Strengthening (HSS-3) project. I am happy to introduce this transformative initiative which underscores our dedication to safeguarding community health and ensuring a brighter future for generations to come.

Immunization stands as one of the most successful and cost-effective public health interventions in history. Over the years, it has played a pivotal role in reducing the burden of life-threatening diseases, saving countless lives, and contributing to the overall well-being of our society. However, we recognize that there are still areas where we must bolster our efforts to reach every child, regardless of their location or circumstances.

The Zero Dose Implementation Plan marks a strategic milestone in our endeavour to identify, reach and vaccinate zero dose children who reside in most vulnerable communities. These vulnerable populations have been deprived of the protection that vaccines provide, leaving them susceptible to potentially life-threatening diseases. Mostly, these missed communities are home to Vaccine Preventable Disease (VPD) outbreaks. The core objective of this plan is to identify and eliminate barriers that hinder access to vaccinations, including but not limited to geographic, socio-economic, and cultural factors.

The Zero Dose Implementation Plan reinforces our commitment to building robust and sustainable health systems. The intended focus on enhancing health service delivery, health information systems, and community engagement, will provide a strong foundation for us to achieve our zero-dose reduction goals.

I urge all health professionals, community leaders, policymakers, and citizens to rally behind this initiative. With the help of this guidance document, we can break down barriers, empower communities, and extend the reach of life-saving vaccines to every child, ensuring that no child is left unvaccinated.

(Ms. L. S. Changsan)

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MINISTRY OF HEALTH AND FAMILY WELFARE
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FOREWORD

"India's Zero Dose Implementation Plan" is an innovative and comprehensive strategy to address a critical concern of zero-dose children in the country. It is a proud privilege for me to introduce this significant initiative which exemplifies the government's commitment to advancing public health and ensuring equal access to life-saving vaccinations for every child across our diverse country.

One of the keys to our success in public health has been immunisation, which has significantly reduced the burden of vaccine-preventable diseases, thereby, safeguarding the health of the country's population. However, the presence of zero-dose children is a persistent challenge that demands urgent attention and collective action. These vulnerable children, for various reasons, have been deprived of their essential first dose of vaccinations, leaving them susceptible to vaccine preventable diseases and putting their lives at risk.

The Zero Dose Implementation Plan is a strategy grounded in evidence. The complete portfolio planning process followed for the development of this plan, involved a meticulous root cause analysis to identify priority populations, barriers, and challenges. Subsequent consultations with multiple stakeholders were conducted to deliberate on the most crucial interventions. This comprehensive approach ensured that our strategy, informed by evidence, would provide a well-considered framework to reach and effectively address the needs of Zero Dose children.

The plan aims to strengthen service delivery by extending immunization services to reach missed communities through improving and inclusive microplanning, incentivizing mobilizers, and capacitating immunization workers by imparting reinforced and institutionalized trainings. The in-built mechanisms of monitoring and mentoring will further enhance the capacities of the program functionaries. Service delivery strengthening interventions will be complemented by demand generation activities like establishing a 'Community of Practice on Demand' as a knowledge hub for demand generation, informing demand generation strategy through regular assessments of Social & Behavioural determinants for Immunization etc. The initiative to strengthen local partnerships through organized groups to improve demand for immunization, is the cornerstone for enhancing community engagement.

The plan also emphasizes the importance of digitizing service delivery processes through the expansion of an electronic Immunization registry- U-WIN. Regular utilization of data-driven review mechanisms will be ensured by strengthening data quality and using data analytics for evidence-based decision-making. These interventions will be regularly monitored through programmatic monitoring for action. The progress of the entire plan will be reviewed by the Immunization Action Group for any mid-course corrective actions.

As we embark on this transformative journey, I call upon all stakeholders to embrace the spirit of unity and collective action. Let us redouble our efforts to ensure that no child remains unvaccinated and every community is empowered to protect its children against vaccine-preventable diseases.

K.K. Tripathy

(Dr. K.K. Tripathy)

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MBBS, MD, DNB, MBA
Additional Commissioner, Incharge (FP&MH)

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PREFACE

I am delighted to present this pioneering guidance document on reducing zero-dose children in India - "India's Zero Dose Implementation Plan,". This document represents a milestone achievement in our commitment to ensure that every child in our nation receives the protection of life-saving vaccinations, leaving no one behind.

Immunization is a cornerstone of public health, and we recognize the urgency of addressing the challenge of zero-dose children to further strengthen our healthcare systems. The integration of India's Zero Dose Implementation Plan with the Health System Strengthening would mark a significant stride towards achieving this goal.

This comprehensive plan outlines a multifaceted approach to combat zero-dose children, encompassing various interventions that build on the collective efforts of stakeholders across the country. One of the key initiatives highlighted in this document is the application of the U-WIN platform which leverages technology to streamline data management, supply chain logistics, and monitoring of vaccination coverage, thereby enhancing our ability to reach the most vulnerable populations effectively.

Capacity building remains a cornerstone of our efforts to strengthen immunization services, we empower our healthcare professionals with the necessary knowledge and skills, ensuring a more robust and resilient health system capable of addressing the challenges posed by zero-dose children. We also firmly believe in the power of collaboration, and the plan emphasizes engaging Civil Society Organizations (CSOs) to forge partnerships at the grassroots level. These collaborations will foster community engagement, advocacy, and awareness, ultimately amplifying the reach and impact of our immunization initiatives.

Furthermore, we understand the significance of delving into the behavioural and social drivers behind zero-dose children. As such, the implementation plan includes a comprehensive survey that will provide valuable insights into the factors influencing vaccination uptake. Armed with this knowledge, we can tailor our interventions to address the specific challenges faced by different communities and design more effective strategies.

I extend my heartfelt appreciation to all the stakeholders who have played a crucial role in crafting this guidance document. It is through dedication, expertise, and collaborative spirit that we have formulated a roadmap towards a future where no child in India remains unvaccinated.

As we forge ahead, I urge all stakeholders to join hands and work together towards achieving our shared vision of zero number of zero-dose children in the country. Let us translate this guidance document into impactful actions that will transform the lives of countless children and propel India towards a healthier, more resilient future.

(Dr Pawan Kumar)

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List of Abbreviations

AEFI – Adverse Events Following Immunization
AMR – Antimicrobial Resistance
ANM - Auxiliary Nurse and Midwife
ASHA – Accredited Social Health Activist
AWW – Anganwadi Workers
BeSD – Behavioural and Social Drivers
BMGF – Bill and Melinda Gates Foundation
BTFI – Block Task Force for Immunization
CBO – Community-based Organisations
CCP – Cold Chain Point
CEM – City Embrace Model
CHAI – Clinton Health Access Initiative
CHC – Community Health Centre
CHO – Community Health Officer
CoE – Centre of Excellence
CoP – Communities of Practice
CoPD – Community of Practice on Demand
CRS – Civil Registration System
CSO – Civil Society Organisations
DIO – District Immunization Officer
DPT – Diphtheria Pertussis Tetanus
DSS – Decision Support System
DTFI – District Task Force for Immunization
DVC – Data Validation Committee
EPI – Expanded Programme on Immunization
eVIN – Electronic Vaccine Intelligence Network
EVM – Effective Vaccine Management
FIC – Full Immunization Coverage

FLW – Frontline workers
F/EM – Field/External Monitor
GIS – Geographic Information System
GMSD – Government Medical Store Depot
HBNC – Home-based New-born Care
HCD – Human-centred Design
HMIS – Health Management Information System
HPV – Human Papilloma Virus
HRA – High Risk Area
HRG – High Risk Group
HSS – Health System Strengthening
HWC – Health and Wellness Centre
IA2030 – Immunization Agenda 2030
IAG – Immunization Action Group
IAPSM – Indian Academy of Preventive and Social Medicine
ICDS – Integrated Child Development Scheme
IEC – Information, Education and Communication
IFV – Immunization Field Volunteers
IMI – Intensified Mission Indradhanush
IPC – Interpersonal Communication
IPV – Inactivated Polio Vaccine
IRMMA – Identify-Reach-Monitor-Measure-Advocate
IT – Information Technology
ITB – Invitation to Bid
iTMIS – Integrated Training Management Information System
ITSU – Immunization Technical Support Unit

LHV – Lady Health Volunteer
M&E – Monitoring and Evaluation
M&M – Monitoring and Mentorship
MAS – Mahila Arogya Samiti
MC – Medical Colleges
MCV – Measles Containing Vaccine
MI – Mission Indradhanush
MIS – Management Information System
MNCH – Maternal, New-born and Child Health
MO I/C – Medical Officer In-charge
MoHFW – Ministry of Health and Family Welfare
MoWCD – Ministry of Women and Child Development
MPR – Monthly Progress Report
MR – Measles Rubella
NCCMIS – National Cold Chain Management Information System
NCCVMRC – National Cold Chain and Vaccine Management Resource Centre
NFHS – National Family Health Survey
NHM – National Health Mission
NPO – National Professional Officer
NUHM – National Urban Health Mission
OPV – Oral Polio Vaccine
PCV – Pneumococcal Conjugate Vaccine
PHC – Primary Health Centre
PIP – Program Implementation Plan
PMA – Program Monitoring and Action
PMU – Project Management Unit
PO – Program Officer
PRI – Panchayati Raj Institution
QPR – Quarterly Progress Report
RCH – Reproductive and Child Health
RFP – Request for Proposals

RI – Routine Immunization
RISE – Rapid Immunization Skill Enhancement
RRT – Rapid Response Team
RVV – Rotavirus Vaccine
SAC – Scientific Advisory Committee
SBCC – Social and Behaviour Change Communication
SDG – Sustainable Development Goals
SHG – Self Help Groups
SIHFW – State Institutes of Health and Family Welfare
SMNet – Social Mobilization Network
SMO – Surveillance Medical Officer
SOP – Standard Operating Procedure
SPO – Senior Program Officer
SRS – Sample Registration System
STFI – State Task Force for Immunization
TBD – To Be Determined
Td – Tetanus and Adult Diphtheria Vaccine
TA – Technical Assistance
ToT – Training of Trainers
UFP – Urban Focal Person
UHC – Urban Health Centre
UIP – Universal Immunization Programme
ULB – Urban Local Bodies
UNDP – United Nations Development Programme
UPHC – Urban Primary Health Centre
VCCM – Vaccine and Cold Chain Manager
VHSNC – Village Health, Sanitation and Nutrition Committee
VPD – Vaccine Preventable Diseases
WUENIC – WHO and UNICEF Estimates of National Immunization Coverage
ZD – Zero Dose

Purpose of the Document

The document aims to provide an understanding of the concept of Zero Dose (ZD) children & missed communities in India's context. A brief outline is provided for the approach that can be adopted for reaching the zero dose children and missed communities with full course of vaccines available under UIP. This guidance aligns with the Identify – Reach – Monitor – Measure – Advocate (IRMMA) framework & Immunization Agenda 2030.

The document captures the processes and outcomes of the multiple stakeholder consultations that were held in identified high priority areas and priority populations to understand the challenges encountered in reaching the unreached communities and to develop context specific interventions.

The intended audience of this document are the program managers of the Universal Immunization Program i.e., Block Officers, District Officers, State & National level Program Managers and all the implementing partners for the identified activities.

Note: *The document intends to give a brief background of the various initiatives that are envisaged to be implemented under the Health Systems Strengthening-3 support.*

Acknowledgements

India's Strategy to Reach Zero Dose Children & Missed Communities is a targeted Zero Dose Implementation Plan to reach the unreached in a sustainable manner. The health systems' strengthening approach of the plan assures of an effective and long standing impact.

The process adopted to develop this plan is praise worthy. Decentralized stakeholder consultations were held to identify the priority populations and understand the challenges faced by them followed by analysis of the root causes of the challenges that ensured development of context specific solutions.

The development of this Plan has contributions from country's key policy makers, guided by the leadership of Shri Apurva Chandra (Secretary, H&FW), Mr. Rajesh Bhushan, (Ex-Secretary, H&FW), Mr. Sudhansh Pant (Ex-Secretary, H&FW), Ms. L.S. Changsan (ASMD, NHM), Ms. Roli Singh (Ex-ASMD, NHM), Mr. Vikas Sheel (Ex-ASMD, NHM), Dr. K.K. Tripathy (EA, JS-RCH) and Dr. P Ashok Babu (Ex-JS-RCH) along with the entire team of Immunization Division, MoHFW.

Ministry of Health and Family Welfare is very thankful to the following officers for their involvement and guidance during the process of the development of this Plan. They have added credibility to the whole plan. As a next step, their directions will help in roll out this Plan as intended in this document.

Arunachal Pradesh's Special Secretary (HFW) - Shri Vivek H.P. and MD NHM - Shri Liyon Borang, Bihar's Additional Chief Secretary (H&FW) - Shri Pratyaya Amrit and Executive Director - Mr Sanjay Kumar Singh, Haryana's ACS (Health) - Dr. G. Anupama, MD-NHM - Sh. Prabhjot Singh, Jharkhand's ACS Health - Shri Arun Kumar Singh & MD NHM - Shri Ravi Shankar Shukla, Madhya Pradesh's Additional Chief Secretary (ACS) Health - Shri Mohd. Suleman and Mission Director (NHM) - Ms. Priyanka Das, Maharashtra's ACS (HFW) - Shri Pradeep Kumar Vyas, and MD (NHM) - Shri. Ramaswami N, Meghalaya's PS(Health) - Shri Sampath Kumar, MD NHM – Mr. Ram Kumar, Mizoram's Secretary (HFW) - Shri R Lalramnghaka and MD (NHM) - Dr. Eric Zomawia, Nagaland's PS(Health) - Shri Amardeep Singh Bhatia and MD (NHM) - Dr. Kevichusa Medikhru, Rajasthan's Secretary (MH&FW) - Shri Ashutosh A.T. Pednekar and MD (NHM) - Shri Naresh Kumar Thakral, Uttar Pradesh's ACS - Shri Amit Mohan Prasad, MD-NHM - Smt. Aparna U.

The deep engagement of the State Immunization Officers, under the guidance of Dr. Pawan Kumar- Addl. Comm. (UIP) and Dr. Veena Dhawan, Ex-Addl. Comm. (UIP), Arunachal Pradesh's Dr. D. Padung, Bihar's Dr. NK Sinha, Haryana's Dr. Virendra S. Ahlawat, Jharkhand's Dr. Ajit Prasad, Madhya Pradesh's Dr. Santosh Shukla, Meghalaya's Dr. P. Manners, Mizoram's Dr. (Ms.) Lalzawmi, Nagaland's Dr. Ritu Thurr, Rajasthan's Dr. Raghu Raj Singh and Uttar Pradesh's Dr. Ajai Ghai and Dr. Manoj Shukla have yielded structured workplans for the roadmap of reaching each and every child with vaccines under Universal Immunization Program. The constant support and guidance provided by Dr. Ashish B Chakraborty & Dr. Suhas Dhandore, Officers from Immunization Division MoHFW, is much appreciated.

The consolidated efforts of all the Partners - WHO, UNICEF, UNDP, BMGF, JSI, and ITSU in the entire process of project development is acknowledged and is reassuring for an effective implementation of the Zero Dose Plan.

The documentation support provided by the entire team of ITSU, especially Dr. Sonu K. Gupta, Mr. Paras Jain, Ms. Aakanksha Sharma & Dr. Pratishtha Rathore, under the able guidance of Dr. Pritu Dhalaria, Technical Director - ITSU, needs a special mention.

Lastly, the entire Gavi team at Geneva, specially Mr. Tokunbo Oshin, Mr. Homero Hernandez, Ms. Sabrina Clement, Ms. Ranjana, Ms. Laura, Dr. Binay Kumar, Dr. Sugata and the Gavi Secretariat in India- Dr. Kapil Singh, Dr. Disha Agarwal, Mr. Sharad Yadav, Dr. Sahil Parmar and Mr. Arvind Kr. Jha, who have been constantly working on the next phase of India Gavi-India Partnership, right from the inception to approvals to drafting and then rolling out of the plans is praiseworthy. The alignment of their approach with the country's Immunization agenda is commendable.

A positive outcome of the Zero Dose Implementation Plan is assured because of the intellects that have been involved and the efforts that have been put in in the planning of the Plan.

Chapter 1:
Introduction

Immunization - Best buy in public health

Immunization is a proven success story for global health and development, saving millions of lives every year. Vaccines play a pivotal role in prevention and control of many communicable diseases and have attributed to the reduction in the number of deaths from infectious diseases, dramatically. Since vaccines also prevent disability, which can impair children's growth and cognitive development, vaccination ensures that the child not only survives but also flourishes.

Immunization is critical in preventing vaccine preventable diseases, which are among the key factors responsible for childhood malnutrition. Recurrent diseases can reduce children's appetite and absorption of nutrients from the gastrointestinal system . Malnutrition results in increased susceptibility to infections. This vicious cycle can lead to growth and developmental disorders such as difficulty in gaining height, reduced cognitive abilities, and even other metabolic diseases, all of which afflict children until adulthood.

At a time when antimicrobial resistance (AMR) has been identified as one of the biggest threats to global health, the importance of vaccination in preventing AMR cannot be disregarded. Immunization not only protects people against drug-resistant infections but also reduces their spread as well as the need for and use of antibiotics, thereby contributing to the battle against antimicrobial resistance.

The benefits of immunization go beyond the improvements in health and life expectancy to an impact on social and economic indicators. In many countries, out-of-pocket expenditures for health care have a catastrophic impact on household finances, potentially plunging households into poverty. Preventing infection by vaccination can reduce families' expenditure on health care, contributing to financial protection, which is a core component of universal health coverage.

Immunization is the foundation of a healthy, productive population. **Children protected against infectious diseases have better educational attainment and contribute more to national development and prosperity.**

The COVID-19 pandemic has reminded the world of the power of vaccines to fight disease, save lives, and create a healthier, safer, and more prosperous future.

Vaccines benefit not only infants and children but also adults. They can prevent infection related cancers, protecting the health of the vulnerable and the elderly thereby increasing longevity and promoting healthier lives.

Thus, re-emphasizing and reiterating the importance of vaccines in preventing life-threatening diseases and helping people of all ages live longer, healthier lives, a new global vision and strategy, called the **Immunization Agenda 2030 (IA2030)** has been developed. IA2030 envisions a world where everyone, everywhere, at every age, fully benefits from vaccines to improve health and well-being. It aims to maintain hard-won gains in immunization, recover from the disruptions caused by COVID-19, and

Immunization plays a critical role in achieving the SDGs, specifically SDG3, "Ensure healthy lives and promote well-being for all at all ages", and also contributes directly or indirectly to other SDGs.

achieve even more – by leaving no one behind, in any situation or at any stage of life[1].

IA2030 is based on a conceptual framework of seven strategic priorities. Each strategic priority has defined goals, objectives and key areas of focus. These seven strategic priorities are anchored by four core principles that will shape the nature of actions undertaken to achieve each strategic goal and objective. Snapshot of the IA 2030 framework is captured in **Figure 1**.

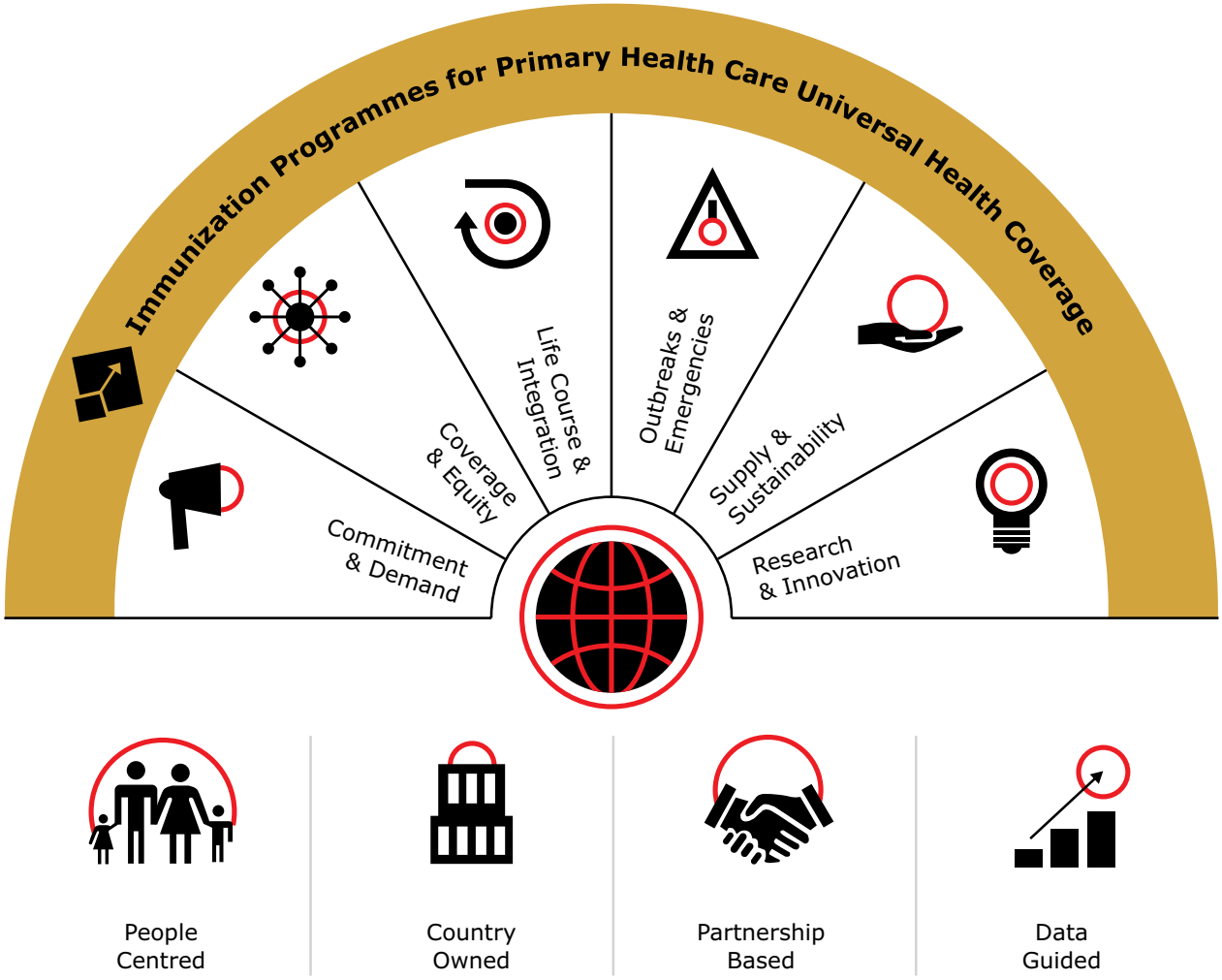
A brief outline of the IA 2030 Goals and indicators, along with targets for the year 2030 is placed at **Annexure 1.**

Thus, aligning with the Immunization Agenda 2030 & India's roadmap to 90% full immunization coverage, India's Zero Dose Implementation Plan has been developed. Under this renewed partnership, it is targeted to achieve a 30% reduction in zero-dose children by 2026 against the 2019 pre-pandemic baseline.

India's Universal Immunization Program - Journey So Far

India's National Immunization programme was launched in 1978 as Expanded Programme on Immunization (EPI), with the introduction of vaccines namely, BCG, OPV, DPT and typhoid-

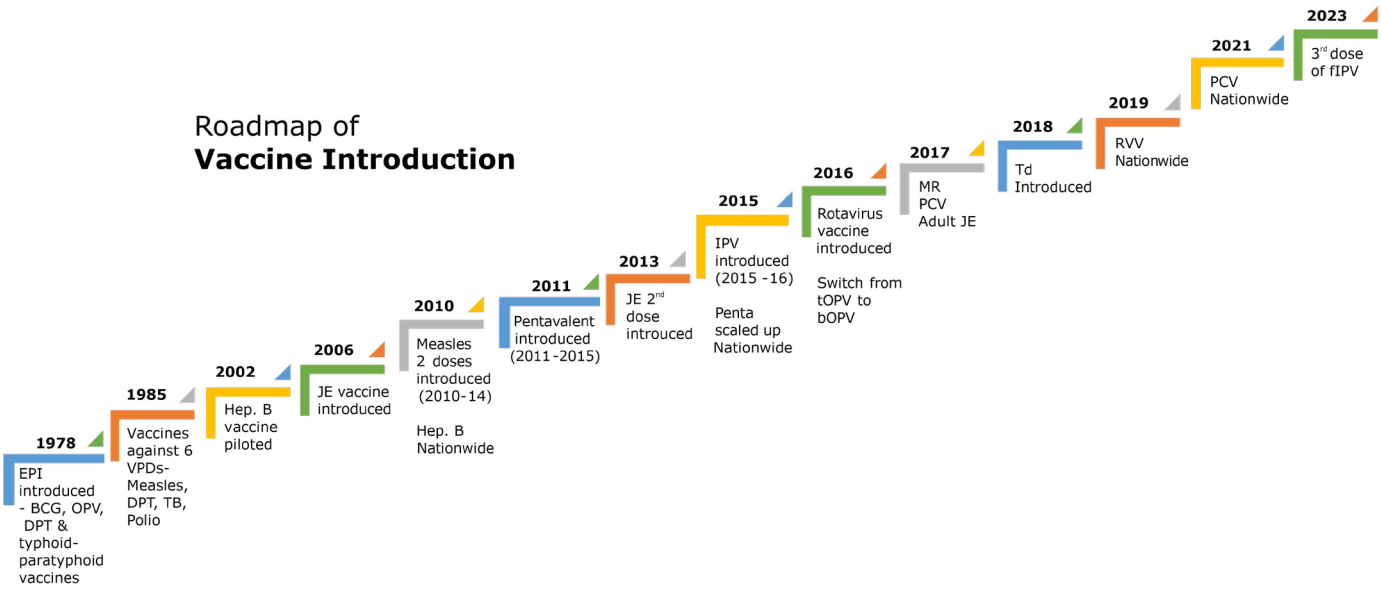
Figure 1: Immunization Agenda 2030 - Strategic Priorities and Core Principles



One of the key targets under the IA 2030 is **50% reduction in the number of zero dose children at country, regional, and global levels, by 2030.**

[1] https://www.immunizationagenda2030.org/

Figure 2: Vaccine introduction under UIP



paratyphoid. The EPI was rechristened as Universal Immunization Programme (UIP) in 1985. Initially, six vaccines (BCG, OPV, DPT and measles) were provided in the programme. Subsequently, over the years new antigens and vaccines were introduced and currently, under UIP, immunization is being provided free of cost against 12 vaccine preventable diseases:

- Nationally against 11 diseases- Diphtheria, Pertussis, Tetanus, Polio, Measles, Rubella, severe form of Childhood Tuberculosis, Rotavirus diarrhoea, Hepatitis B, Meningitis & Pneumonia caused by Hemophilus Influenza Type B and Pneumococcal Pneumonia.
- Sub-nationally against 1 disease - Japanese Encephalitis (only in endemic districts).

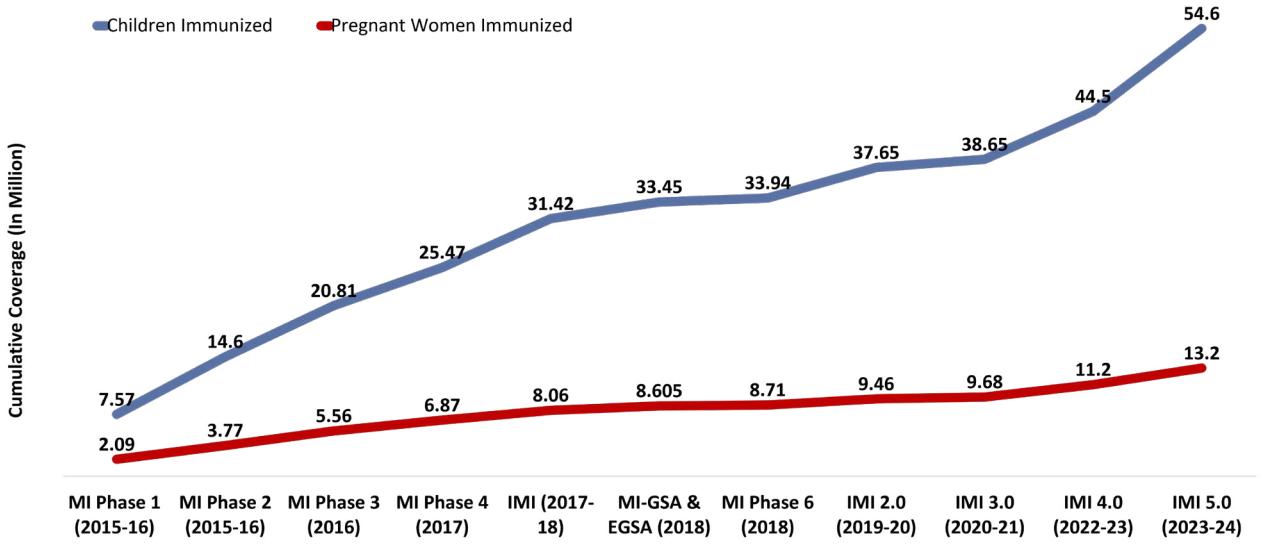
It is noteworthy that since 2015, India has introduced and scaled up following six new vaccines in a very short span of time- **Inactivated Polio Vaccine (IPV), Rotavirus vaccine (RVV), Measles Rubella (MR) vaccine, Pneumococcal Conjugate Vaccine (PCV), Tetanus & adult Diphtheria (Td) vaccine and Adult JE vaccine (Figure 2).**

Over the years, focused initiatives have been undertaken to strengthen the country's Immunization Programme and improve the immunization coverage. As a result of these targeted and sustained efforts, India was able to achieve the milestone of being declared Polio free in 2014 and achieving maternal and neonatal Tetanus elimination in 2015.

In December 2014, the Government of India launched the "Mission Indradhanush," a crucial initiative aimed at intensifying activities within the country's Immunization Program. This initiative, which stands as one of the government's flagship schemes, strives to achieve a full immunization coverage (FIC) of 90%. It is primarily focused on reaching unvaccinated and partially vaccinated children, as well as pregnant women in regions with low immunization coverage, including high-risk areas.

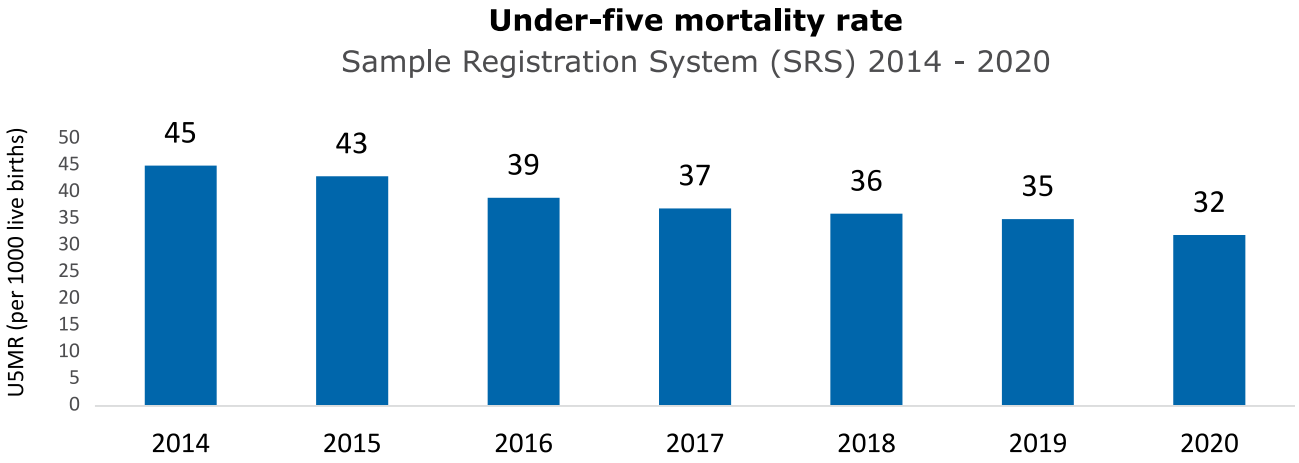
Till date, **12 phases** of Mission Indradhanush and Intensified Mission Indradhanush have been successfully completed across the country. During these phases, an impressive 54.6 million children and 13.2 million pregnant women received vaccinations. (**Figure 3**)

Figure 3: Coverage under MI/IMI



One of the most evident achievements of these intensified efforts has been the improvement in immunization coverage of the country. As per the latest National Family Health Survey (NFHS) reports, full immunization coverage of the country has shown an increase from 62% in 2015-16 to 76.4% in 2019-21. Vaccination has significantly contributed to decline in the mortality and morbidity due to the Vaccine Preventable Diseases (VPDs), which has attributed to the reduction in Under-5 mortality rate in India from **45/ 1000 live births** in 2014 to **32/ 1000 live births** in 2020 (**Figure 4**).

Figure 4: Under-Five Mortality Rate (SRS)



Chapter 2:
Concepts

Before understanding the new global concept of Zero Dose Children and Missed Communities and the related measurement yardsticks, it is important to understand the existing concepts & measurement yardsticks. This will help in establishing linkages between the new concept of Zero Dose Children with the existing concepts of unvaccinated/left-out children and partially vaccinated/drop-out children.

Concepts:

- **Fully Immunized Child:** A child is said to be fully immunized **if child receives all due vaccine as per national immunization schedule within the 1st year of a child's life. Operationally it is defined as children who have received 1 dose of BCG vaccine, 3 doses of DPT containing vaccines, 3 doses of OPV and 1 dose of Measles containing vaccines within the first year of life.**
- **Partially Vaccinated/Drop-Out Children:** Children who have received some vaccines but did not complete the full course of routine vaccines under national immunization schedule.
- **Unvaccinated/Left-Out Children:** Children who have never been vaccinated or reached (thus remaining unvaccinated). Globally, the Unvaccinated/Left-Out children have been termed as Zero Dose children and these ZD children predominantly reside in missed communities.
- **Zero Dose (ZD) Children:** 'Zero-dose children' (ZD) are those who have not received any basic vaccine. **For operational and reporting purposes,** "zero-dose children" are defined as children who have not received a first dose of **Pentavalent vaccine,** till one year of age. Number of Zero Dose Children is calculated as the difference between the estimated number of surviving infants and the reported number of infants (under 1 year of age) vaccinated with Pentavalent 1 vaccine. At the national and subnational level, administrative reporting systems (HMIS) and survey results can be used to establish estimates for zero-dose children. [Calculation of ZD%: 100-Percentage coverage of 1st dose of Pentavalent vaccine]

Focus on reaching Zero dose children does not stop at providing a first dose of Pentavalent vaccine. The goal is to ensure that these children are fully vaccinated with all age-appropriate vaccines.

- **Missed communities:** 'Missed communities' are those communities which often face multiple deprivations and vulnerabilities, including socio-economic

COMMON GENDER-RELATED BARRIERS TO VACCINATION

- Caregivers may lack information and awareness on the benefits of vaccination
- Division of labour in the household may detract from fathers' involvement with childcare duties, including vaccination
- Low socio-economic status of caregivers or lack of women's access to household funds may limit means to afford indirect costs of vaccination
- Religious practices or cultural values may prevent female caregivers from seeking immunization services from male health workers
- Travelling long distances to health clinics may deter women, particularly younger mothers, from bringing children for immunization due to safety and mobility issues
- Long wait times at clinics and immunization sites only open during working hours may conflict with caregivers working in income-generating activites
- Negative attitudes of some health service providers may discourages caregivers from return visits to complete immunization schedule

disparities and lack of access to health services, which can be further exacerbated by **gender-related barriers*.** These communities are home to clusters of zero-dose/unvaccinated children.

Importance of Reaching the ZD children & Missed Communities

Reaching out to the Zero Dose children and vaccinating this cohort is significantly important considering the generalised vulnerability and the evidence that communities with zero-dose children also have a significant number of under vaccinated children.[2] Zero-dose children are more likely to experience early childhood nutritional failures linked to high risk of morbidity and mortality in childhood, poor growth trajectories, and poor health outcomes over the life course[3].

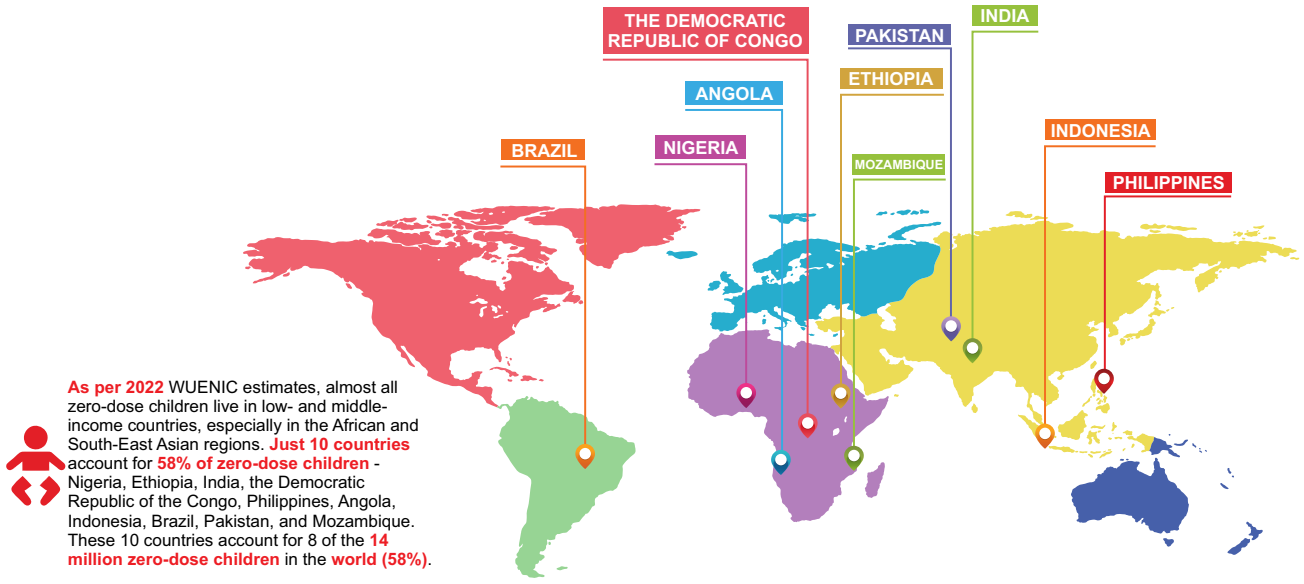
Missed communities, which are home to clusters of zero-dose and under vaccinated children, are vulnerable to recurrent vaccine-preventable disease outbreaks, such as measles, which spread rapidly, worsening health and development outcomes[4]. These missed communities often face multiple deprivations and vulnerabilities, including inadequate access to basic services like water and sanitation, socio-economic inequities, and often gender related barriers (like mothers' access to education, lack of household decision-making for healthcare, gender-based violence, child marriages and teenage pregnancies). The deprivations exist across multiple geographic settings, predominantly in urban/peri-urban, remote rural or conflict settings[2]. Thus, reaching zero-dose and under vaccinated children would mean reaching the missed communities they are part of and building the link to the healthcare system and essential services. Thus, the imperative of reaching and ensuring complete immunization for zero-dose children becomes pressing.

Defining the Problem

Global Scenario

As per WUENIC (WHO and UNICEF Estimates of National Immunization Coverage), globally, the number of zero-dose children (not receiving any DPT doses) was 12.9 million in 2019. The number of these zero-dose children, increased to 16.1 million in 2020 and 18.1 million in 2021. In 2022, global vaccination coverage with DTP containing vaccine partially recovered and the number of Zero dose children decreased from 18.1 Million in 2021 to 14.3 Million. However, this

Figure 5: Global Distribution of Zero Dose Children

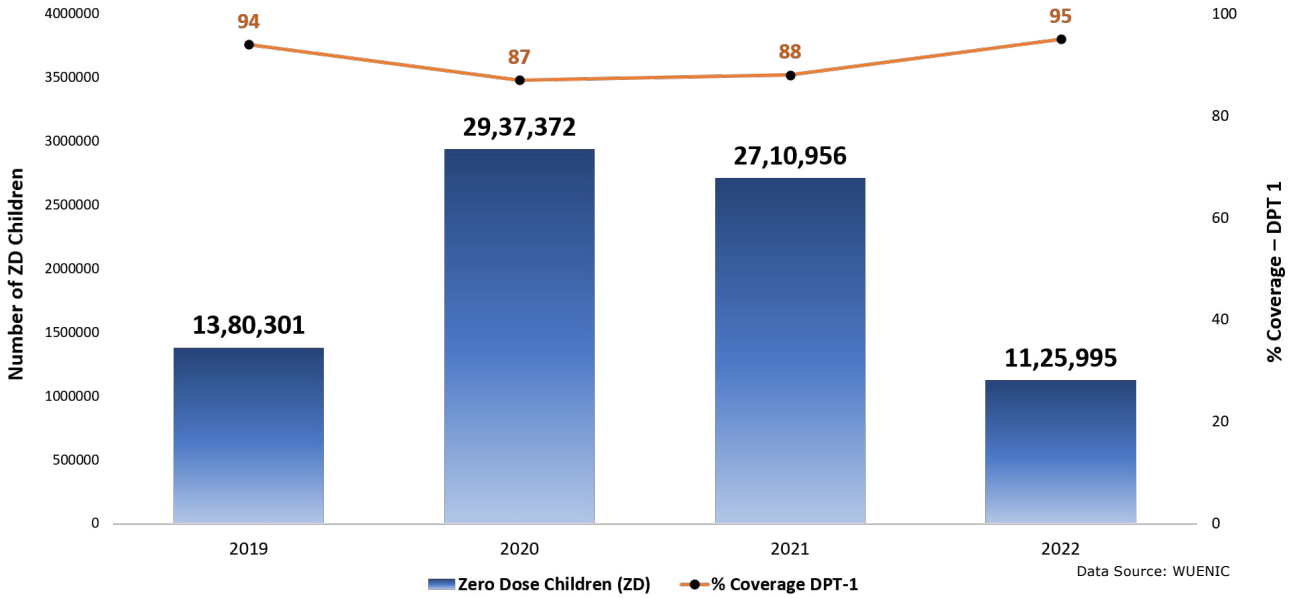


[2] Analysis of Institute for Health Metrics and Evaluation (IHME) district-level coverage estimates shows that for every 1pp increase in % zero-dose, there is a 0.6 pp increase in DTP drop-out rate on average in Gavi-supported countries

[2] Johri M, Rajpal S, Subramanian SV. Progress in reaching unvaccinated (zero-dose) children in India, 1992-2016: a multilevel, geospatial analysis of repeated cross-sectional surveys. The Lancet. Global Health. 2021 Dec;9(12):e1697-e1706. DOI: 10.1016/s2214-109x(21)00349-1. PMID: 34798029.

[3] https://www.Gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities

Figure 6: No. of Zero Dose Children in India



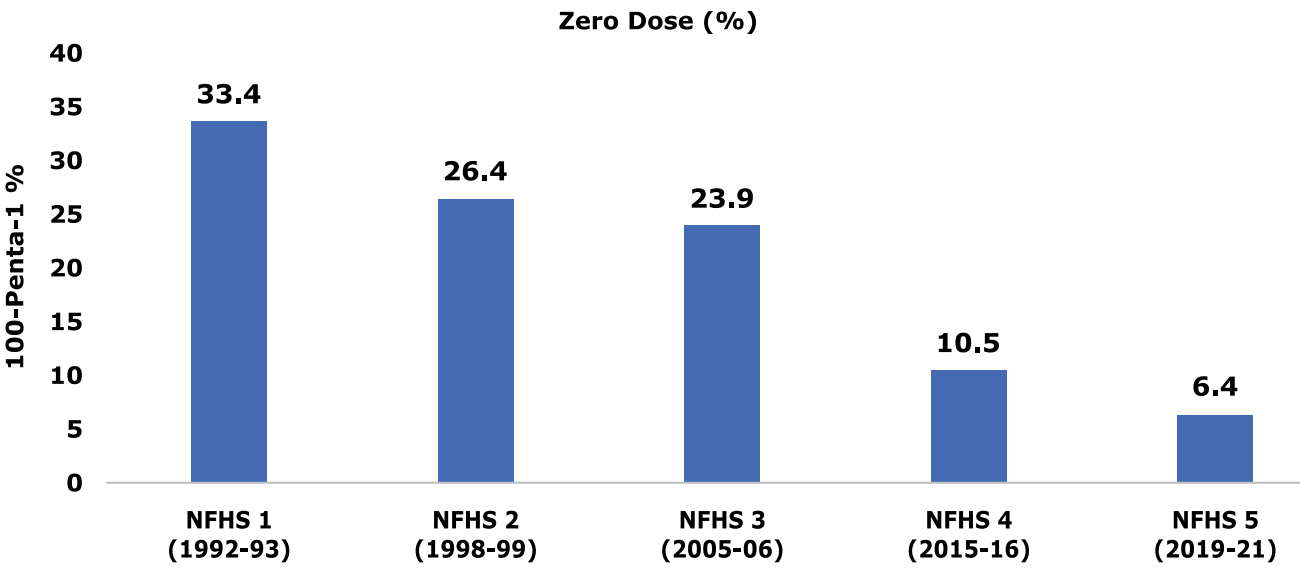
is not yet back to pre-pandemic level of 12.9 million (2019). Almost all zero dose children live in low and middle-income countries, especially in the African and South-East Asian regions. Just 10 countries account for 58% of zero-dose children - Nigeria, Ethiopia, India, the Democratic Republic of the Congo, Philippines, Angola, Indonesia, Brazil, Pakistan, and Mozambique. These 10 countries account for 8 of the 14 million zero-dose children in the world (58%) (**Figure 5**).

Indian Scenario

As per the data obtained from WUENIC (WHO and UNICEF Estimates of National Immunization Coverage), in the year 2019, the DPT-1 (Penta-1) vaccine coverage reached 94%, which equated to approximately 1.4 million children who had not received any doses. In 2020, the number of zero dose children in the country doubled, reaching 2.9 million, primarily due to the disruptions caused by the COVID-19 pandemic. Following that, there was a recovery in 2022, resulting in the reduction of zero dose children to approximately 1.1 million (**Figure 6**).

As per National Family Health Survey (NFHS) reports, there is a decline in % of Zero Dose Children (**Figure 7**) over the years from 33.4% (NFHS-1) to 6.4% (NFHS-5).

Figure 7: Percentage of Zero Dose children as per NFHS



Thus, over the period, India has made significant progress in reaching zero dose children/ unvaccinated children across the country as per the evaluated survey. However, there are some persistent pockets of zero dose children which could not be linked to the immunization services. Further, in the pandemic there was a disruption of RI services resulting in backsliding of the gains made previously. However, there is an increasing trend towards recovery of coverage to pre-pandemic levels.

Impact of COVID-19 Pandemic on Immunization

- Due to Covid-19 pandemic related restrictions across the countries, Global DTPcv3 coverage declined by 5 percentage points during 2019–2021, meaning that at least 22.9 million children in 2020 and 25.0 million children in 2021 did not access or fully utilize routine immunization services. Recovering from the Post-COVID-19 pandemic era, DTPcV3 coverage increased from 81% in 2021 to 84% in 2022, but remained below the 2019 level (86%). (Data source: WUENIC)
- In India, as per the HMIS data: Full Immunization Coverage (FIC) experienced a decline from 92.8% in 2019-20 to 87.5% in 2020-21, followed by a modest recovery to 88% in 2021-22 and a notable increase to 95% in 2022-23.
- The country's routine immunization, which experienced setbacks during the COVID-19 pandemic, has successfully recovered due to relentless efforts by the Ministry of Health and Family Welfare (MoHFW), Government of India, and efficient teams at the state and district levels along with dedicated front line workforce. Despite the challenges posed by the pandemic, continuing immunization services, coupled with frequent catch-up vaccination campaigns like Intensified Mission Indradhanush 3.0 (early 2021), IMI 4.0 (2022-23), and IMI 5.0 (2023-24), have played a pivotal role in restoring immunization coverage.

Chapter 3:
Global Framework

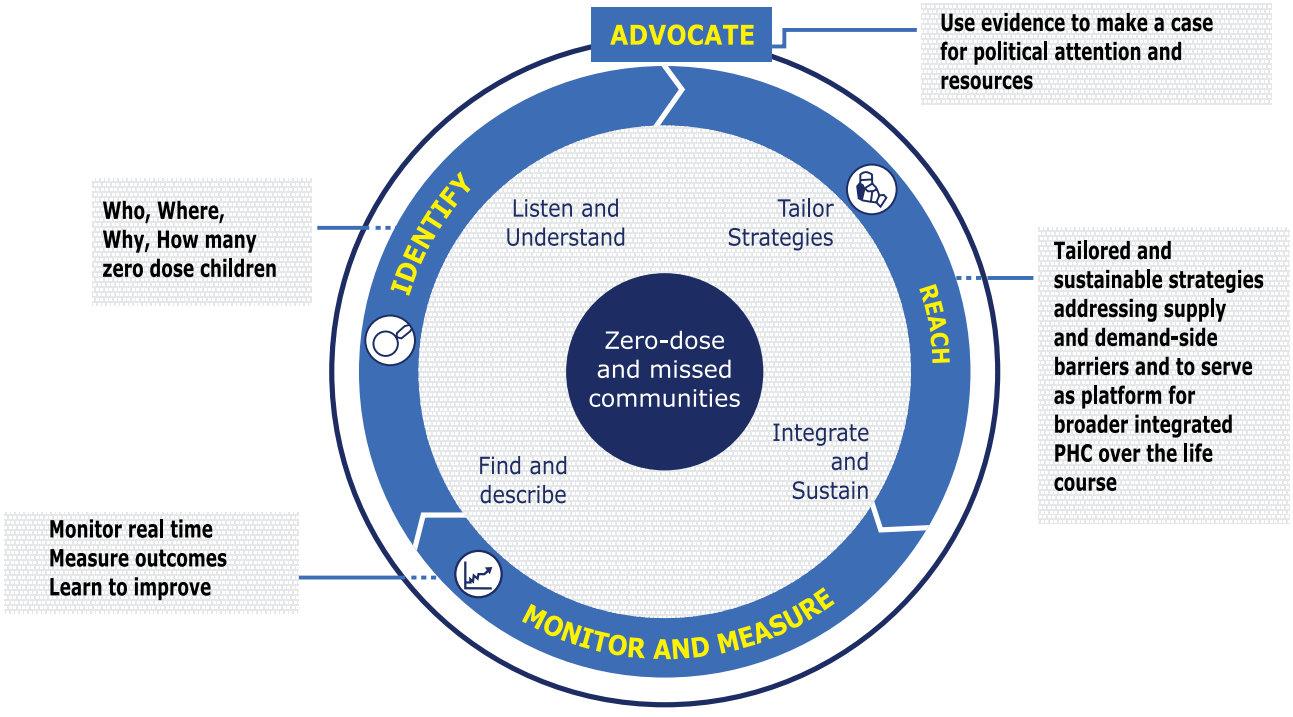
Identify – Reach – Monitor – Measure – Advocate (IRMMA) framework

Zero-dose children account for more than half of vaccine preventable deaths and are key to enhancing public health outcomes. Serving zero dose children and missed communities will also require customized approaches suited to local contexts; interventions will need to address barriers to both service provision and service utilisation. The IRMMA framework (Identify – Reach – Monitor – Measure – Advocate) has been developed to help countries adopt a structured approach to reach zero-dose children and missed communities (**Figure 8**). The framework can be used to initiate multi-stakeholder discussions on determining appropriate interventions.

Identify

This step requires a clear understanding of who, where, and how many zero-dose children and missed communities exist and why they have been missed. Given the impact of the COVID-19 pandemic, it may be needed to identify communities missed due to COVID-related disruptions and communities which were previously not being reached. This step may include triangulation of existing subnational data, both within immunization (e.g., polio and/ or measles campaign data), MNCH, preventive health programmes, and other sectors (including nutrition and education), mapping and analysing the concentration or dispersion of zero-dose children and understanding behavioural and social drivers of under-vaccination. Furthermore, equity,

Figure 8: IRMMA (Identify, Reach, Monitor, Measure and Advocate) Framework



gender, social inclusion and protection, and/ or disability-related considerations need to be accounted for by this step[5]. Quantitative and qualitative analyses can draw from existing country data systems and community-based monitoring systems for identification of zero-dose children and missed communities across regions, their social and economic profile, and reasons for missing out/ under immunization. This will help in building an understanding of barriers faced and ways to address them. The approach for identification of ZD children or missed communities can be captured in following 2 steps:

- **Find and describe (i.e. who, where, and how many)**

  As a first step in identification of zero-dose and under-immunized children (and communities), it is important to have a robust understanding of the "precise" target population, both in terms of number and geography (block, village, taluka etc.). If possible, knowledge of social determinants at the decentralised level should be used. Once the target population has been ascertained, it is important to understand the distribution of zero-dose and under-immunized communities.

- **Understand and listen (i.e. why)**

  Once areas and/or population with significant number of missed children have been identified, it is important to reflect upon demand and supply side barriers faced by communities (under immunized children) and primary health care system.

Reach (Tailor strategies, integrate and sustain)

A coherent strategy to sustainably reach zero-dose children and missed communities will require jointly addressing supply side barriers (service availability and quality) and demand side barriers (vaccine confidence, service uptake, and utilisation). Reach strategies should be tailored to the specific context of communities.

Monitor & Measure (and Learn)

Interventions need to be individually monitored to assess progress, review data, and allow for learning and course correction as necessary. In addition to Pentavalent1 coverage monitoring, it is needed to assess progress through multiple indicators and data sources to determine if zero-dose communities are being correctly identified, if zero-dose children are being reached, and if interventions are truly providing the full course of vaccination in these communities.

Advocate

Use of evidence-based policies to advocate for political commitment and access to financial resources to achieve immunization targets (zero-dose children and missed communities) at the national, subnational level is required. Securing the commitment of national and state-level community leaders, civil society, development partners is essential, and it is important to ensure that this commitment is integrated into immunization policies, planning, and the allocation of domestic resources.

Evidence suggests that approximately half of zero-dose children and missed communities live in urban settings including peri-urban settlements and urban slums, remote rural contexts, or conflict settings. The remainder live in other contexts but typically face common barriers to accessing immunization including gender, poverty, ethnicity, socio-cultural, inclusion, protection and/or disability-related barriers. To successfully reach zero-dose children and missed communities, countries must develop gender responsive and potentially transformative strategies and interventions that are differentiated according to country context, such as immunization coverage, concentration of zero-dose, and identified barriers to immunization delivery.

[5] https://irp.cdn-website.com/44236788/files/uploaded/Gavi_Zero-dose_FundingGuidelines.pdf

Chapter 4:
Approach to Identify Zero Dose Children and Missed Communities

Geographical Prioritization

Under this Zero Dose Implementation Plan, 143 districts across 11 states (Uttar Pradesh, Rajasthan, Madhya Pradesh, Bihar, Haryana, Maharashtra, Jharkhand, Meghalaya, Mizoram, Arunachal Pradesh & Nagaland (List of selected areas is placed at **Annexure 2**) are being targeted, to maximize the impact (**Figure 9**).

These districts have been identified based on the Zero Dose children data from National Family Health Survey-5, with the following criterion:

- Top 50% contributor districts in states of UP, Bihar, MP and Rajasthan +
- Districts with >10% zero-dose cohort in states of Arunachal Pradesh, Meghalaya +
- Selected Urban areas/cities of Maharashtra (Pune, Nasik, Thane and Greater Mumbai) +
- Government Priority districts

Barriers identified

The root cause analysis process

Government of India carried a comprehensive process of planning in 2021- 2022 to understand barriers in reaching out to the zero-dose, under-immunized and missed communities in the 143 identified districts and accordingly plan the interventions for the coming years.

During the initial planning phase, multiple workshops were held at national and sub-national levels, with participation of around 400 participants including respective States Health Secretaries, Mission Directors, State Immunization Officers, Districts Immunization Officers, CSOs/CBOs, key immunization partners Gavi and MoHFW representatives.

During these workshops, priority population was identified for each district. Barriers to immunization in these priority population

Figure 9: Geographies identified for ZD Implementation Plan

State	Districts covered
Uttar Pradesh	60
Bihar	25
Rajasthan	16
Madhya Pradesh	15
Arunachal Pradesh	12
Meghalaya	6
Maharashtra	4
*Additional GoI priority districts	5
Total	143

Selection from coverage perspective

Selection from equity perspective

Selection for urban program

*Nuh (Haryana), Sahebganj (Jharkhand), South West Khasi Hill (Meghalaya), Lawngtlai (Mizoram), Mokokchung (Nagaland)

were discussed, based on which, potential interventions that could address these barriers in the short, medium, and long-term were discussed and prioritized (**Figure 10**).

Throughout the deliberations, IRMMA framework (Identify, Reach, Measure & Monitor and Advocate) was used to identify priority population, categorize immunization barriers, and formulate interventions in a stepwise process. The template used for the full portfolio planning is placed at **Annexure 7**.

The stakeholders identified priority population namely, **urban slums, peri-urban, migratory, tribal, hard-to-reach, underserved, pockets of vaccine hesitancy,** during the sub-national workshops. These priority populations are home to maximum number of zero dose and under immunized children. Details of the specific challenges faced by states to reach out to these identified priority populations are tabulated below.

Based on the root cause analysis of the challenges specific to priority population, the key barriers were clubbed into three main pillars of immunization program: Demand, Supply, Cross cutting (Data & Governance) (**Table 1**).

During the course of discussions, a total of 700+ challenges were identified. To overcome these challenges, 500+ potential interventions were discussed and prioritised.

Figure 10: Barriers to Immunization identified during Stakeholder Consultations

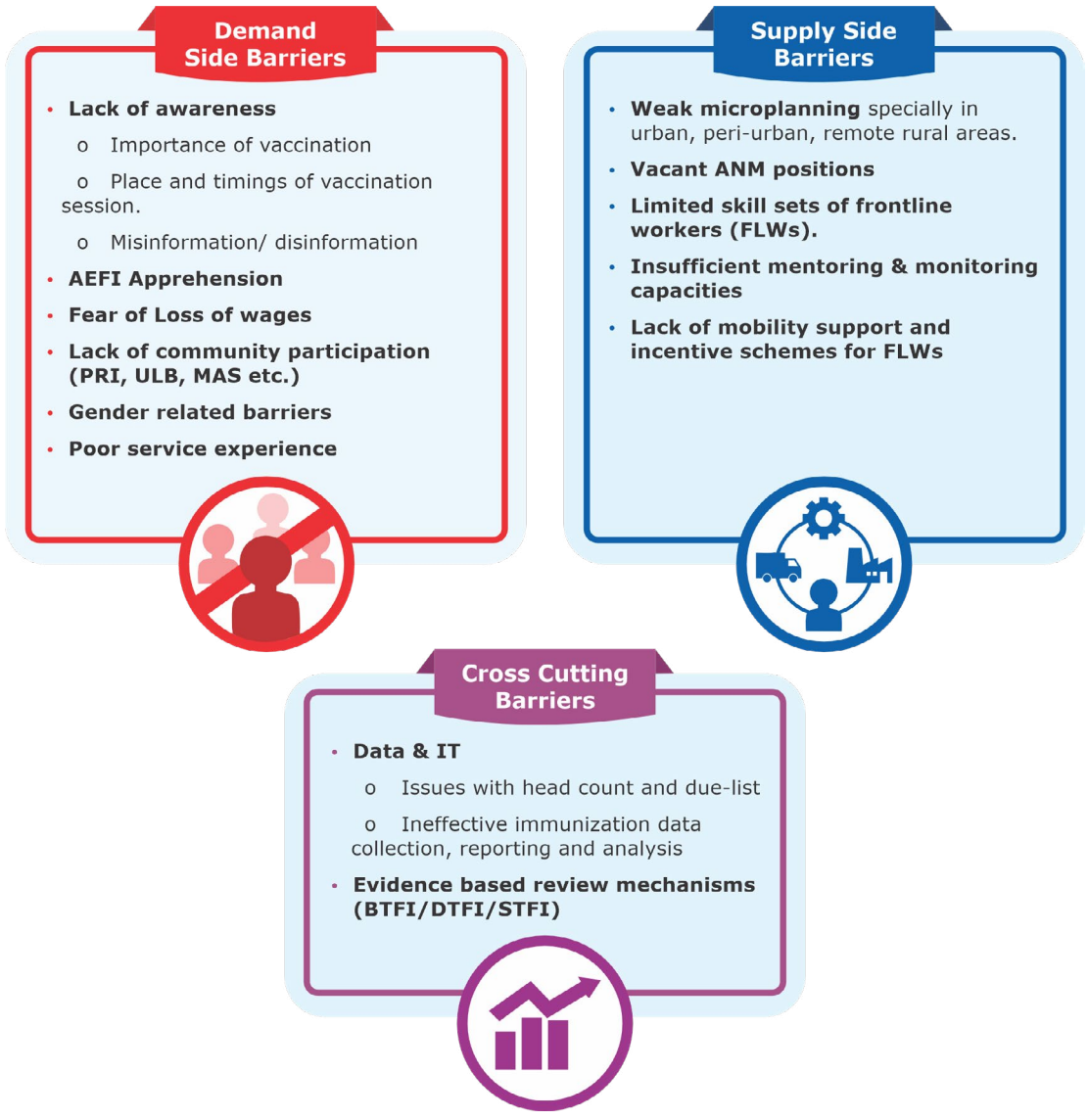
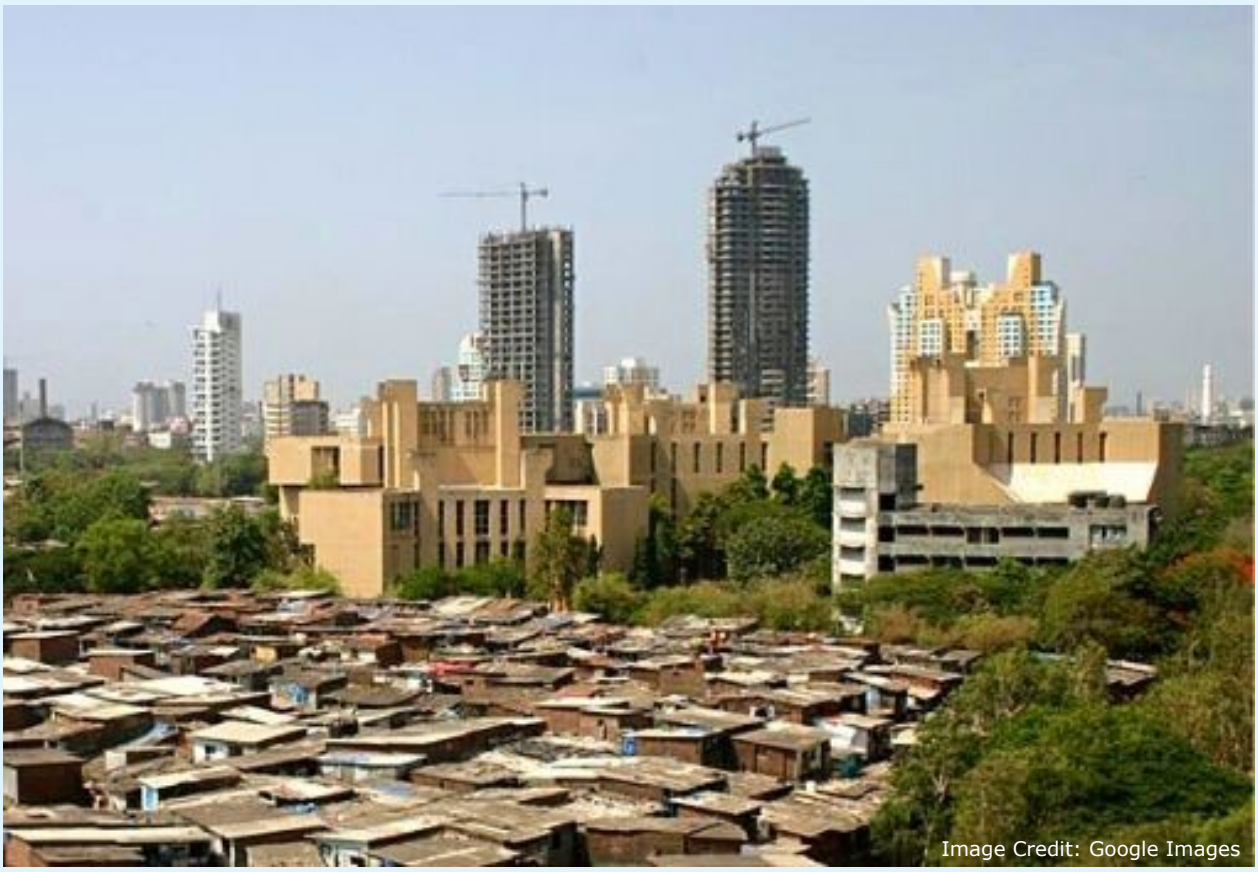


Table 1: Priority population & Challenges identified by the states

States identified priority population	Description of challenges identified
Priority Population: Urban slums and peri-urban populations  Image Credit: Google Images	
Madhya Pradesh, Uttar Pradesh, Rajasthan, Maharashtra & Meghalaya	**Mapping and area demarcation:** Mapping and demarcation of urban slums and peri-urban areas is not always well organised nor systematic, especially in informal or unrecognized slums. The microplanning is weak as wards are not mapped accurately and the head count surveys are inaccurate. There is neither standardization among administrative bodies for managing health services nor defined reporting structures. **Limited awareness:** Populations in these areas tend to have limited awareness on the availability of immunization services, with respect to time place etc. With strong digital penetration, the urban population is also often dissuaded by misinformation. **Access to immunization services:** The urban population is often forced to trade-off immunization of their child against the loss of their daily wage. Due which they are not able to access immunization services on regular basis.

Priority Population: Migratory populations

Image Credit: Google Images

Madhya Pradesh, Uttar Pradesh, Bihar, Rajasthan, Maharashtra & Arunachal Pradesh	**Inability to track:** There are several types of migratory populations in India. Workshops surfaced at least three: migrants between rural and urban areas, migrants crossing states borders, and those coming from neighbouring countries. There is no systematic process to track beneficiaries when they migrate, and they might drop out of immunization services. In addition, negative social norms which inhibit uptake of immunization services are strong and exacerbated by strong trends of seasonal migration.

Priority Population: Hard to Reach Populations

Image Credit: Google Images

Bihar, Rajasthan & Meghalaya	**Operational and geographical challenges:** Populations in Hard-to-Reach areas tend to be scattered geographically or be in zones with operational and geographical challenges. Those include, but are not limited to, areas with seasonal floods and hilly terrains, lack of road accessibility or unreliable electricity supply. In such areas, poor service delivery, weak community outreach & engagement results in a low level of knowledge on immunization service availability, the communities do not value immunization, and are strongly affected by misinformation. Population residing in such areas are not only cut off from the immunization services but also from other essential health services.

Priority Population: Tribal populations

Image Credit: Google Images

Madhya Pradesh, Rajasthan & Arunachal Pradesh	**Limited awareness:** Tribal populations often have limited awareness and information of the importance and value of immunization, leading to high vaccine hesitancy and fear of AEFI. These are compounded by the issue of poor accessibility to health centers and vaccination sessions.

Priority Population: Underserved populations

Image Credit: Google Images

Uttar Pradesh & Bihar	**Lack of context specific service delivery:** There is lack of evidence on coverage estimates for underserved populations. However, the reasons for poor vaccination are not always well understood or elaborated, workshop participants pointed out the limited human capacities and lack of awareness, misconceptions, coupled with a strong distrust in public system at the community level.

Priority Population: Pockets of vaccine hesitancy

Image Credit: Google Images

Identified across most priority populations	**Vaccine Hesitancy:** Across all states and priority populations, workshop participants pointed to pockets of high vaccine hesitancy. No awareness of the importance and benefits of vaccination leads caregivers to become indifferent. Among those who are slightly aware about immunization benefits, certain events turn them against immunization: poor prior experiences, family disapproval, doubt on efficacy of vaccines, low trust on system, negative social norms and strong gender barriers, lack of decision-making autonomy among mothers and female caregivers, and religious misbeliefs.

Chapter 5:
Plan to Reach ZD Children

As the country continues with the efforts of reaching every child and pregnant woman with all vaccines under UIP, this plan is focussed towards reaching the unreached children and communities which stay disconnected from the health system as well as from other social services such as education, shelter, drinking water, electricity etc.

Goal

The overall goal of the Zero Dose Implementation Plan is to **IDENTIFY** zero-dose children, **REACH** them with full course of vaccines, **MONITOR, MEASURE** the performance, and evaluate interventions, **ADVOCATE** for continued political commitment and financial resources, in the identified districts across select states.

The process of identifying and reaching the Zero dose children will be leveraged to improve the overall full immunization coverage.

Since these Zero Dose children and communities are consistently missed, so there is need for innovative approaches, dedicated resources and new partnerships to reach the last mile and reach those who are left farthest behind.

Table 2: Objectives of Zero dose Implementation Plan

Objective 1: To improve reach & quality of immunization service delivery
1.1 Extend immunization services to reach missed communities
1.2 Improve service quality by enhancing skills of healthcare workers.
1.3 Strengthening supervision system of Immunization services and reach
1.4 Ensuring community mobilization for increasing uptake of immunization services
Objective 2: To implement evidence-based demand generation activities
2.1 To establish a knowledge and dissemination hub for demand generation on immunization
2.2 Designing and implementing interventions based on evidence.
2.3 Regular assessment of Social & Behavioural determinants for Immunization.
2.4 Strengthen local partnerships through organized groups for improving demand for immunization
Objective 3: To digitize service delivery processes and develop data driven action plans.
3.1 To digitally link all the beneficiaries for Immunization services.
3.2 Strengthening Data Quality and use of data analytics for evidence-based decision making
3.3 To develop a system of monitoring program activities and evaluating outcome
Objective 4: To strengthen governance and review mechanisms
4.1 To establish participatory and data driven review mechanisms at all levels.

The Plan- Bringing together ZIP Activities to Achieve Immunization Outcomes

The challenges identifed to reach the priority populations under three main pillars of Immunization: Demand, Supply and Data which is cross-cutting the other pillars. These challenges define four key objectives (**Table 2**) for developing any solution/intervention. **Table 3** also identifies the exisitng interventions which are being implemented under National Health Mission and the planned interventions to be implemented under HSS-3 support.

Table 3: The Plan - Bringing Together ZIP Activities

Health System Challenges for Immunization	Objectives	India's Interventions to address the Immunization challenges	
		Existing interventions	Newer Interventions (ZIP)*
Supply side barriers			
• Weak microplanning specially in urban, peri-urban, remote rural areas. • Vacant ANM positions • Limited skill sets of frontline workers (FLWs). • Insufficient mentoring & monitoring capacities • Lack of mobility support and incentive schemes for FLWs	**Objective 1: To improve reach & quality of immunization service delivery** 1.1 Extend immunization services to reach missed communities 1.2 Improve service quality by enhancing skills of healthcare workers. 1.3 Strengthening supervision system of Immunization services and reach 1.4 Ensuring community mobilization for increasing uptake of immunization services	Training on microplanning, Preparation & regular updation of Microplans based on head count survey is an integral part of UIP. The activity is budgeted through PIP. Provision of hiring alternate vaccinator in urban slums is also available under PIP. Regular trainings on various aspects of program implementation are undertaken under UIP- routinely as well as during Mission Indradhanush, IMI rounds and any other supplementary immunization activity.	• Inclusive & Improved Microplanning • RISE • Capacity Building of Training Institutes for Strengthening Routine Immunization in India • Training of healthcare workers on revised MO Handbook • Monitoring & Mentorship • Mobilizer Incentivization

Health System Challenges for Immunization	Objectives	India's Interventions to address the Immunization challenges	
		Existing interventions	Newer Interventions (ZIP)*
Demand Side Barriers			
• Lack of awareness o Importance of vaccination o Place and timings of vaccination session. o Misinformation/ disinformation, • AEFI Apprehension • Fear of Loss of wages • Lack of community participation (PRI, ULB, MAS etc.) • Gender related barriers • Poor service experience	**Objective 2: To implement evidence-based demand generation activities** 2.1 To establish a knowledge and dissemination hub for demand generation on immunization 2.2 Designing and implementing interventions based on evidence. 2.3 Regular assessment of Social & Behavioural determinants for Immunization. Improve capacity in designing, implementing, monitoring and/or evaluating demand generation activities at all levels 2.4 Strengthen local partnerships through organized groups for improving demand for immunization	• BRIDGE training for enhancing IPC skills of front-line workers. Communication planning as part of microplan to undertake demand generation activities • Communication planning is an integral part of microplanning under UIP. Awareness generating and community mobilization activities are regularly undertaken for routine immunization as well as Mission Indradhanush, New Vaccine introductions and supplementary Immunization activities. The existing structure of ASHA under NHM and Anganwadi worker of MoWCD is recognized and incentivized for community mobilization to the session site. • The structure of SMNet in UP & Bihar which was supported through HSS2 has also been embedded in the domestic budget and is supporting community mobilization activities.	• Community of Practice on Demand • BeSD Surveys • CSO Engagement

Health System Challenges for Immunization	Objectives	India's Interventions to address the Immunization challenges	
		Existing interventions	Newer Interventions (ZIP)*
Cross Cutting Barriers			
• Data & IT o Issues with head count and due-list o Ineffective immunization data collection, reporting and analysis • Evidence based review mechanisms (BTFI/DTFI/ STFI)	**Objective 3: To digitize service delivery processes and develop data driven action plans.** 3.1 To digitally link all the beneficiaries for Immunization services. 3.2 Strengthening Data Quality and use of data analytics for evidence-based decision making 3.3 To develop a system of monitoring program activities and evaluating outcome **Objective 4: To strengthen governance and review mechanisms** 4.1 To establish participatory and data driven review mechanisms at all levels.	• Monthly dashboards using data from various sources like HMIS, concurrent monitoring, RCH portal etc. disseminated to states and partners • eVIN and NCCMIS systems established to manage vaccine logistics and cold chain domains respectively Accountability framework in form of IAG, STFI, DTFI, UTFI/CTFI etc. and regular feedback at various levels	• U-WIN • Data Analytics for RI review • Program Monitoring for Action

*Details in subsequent sections

Chapter 6:
Interventions

During national and subnational stakeholder consultations, structural and functional challenges were discussed and tailored interventions for these challenges were proposed and prioritized. Based on this prioritization, the above 11 key interventions have been developed (**Figure 11**).

The description of each intervention is detailed below.

1. U-WIN

Background: Building on the successful roll-out and implementation of eVIN as a tool for vaccine supply chain strengthening and Co-WIN for beneficiary management, recording and reporting of COVID-19 vaccination, a 3rd pillar has been built based on the existing 1st (eVIN) & 2nd (Co-WIN) pillar for registering beneficiaries, recording and reporting of Universal Immunization Program. This digitalization effort through U-WIN would target the beneficiary cohort of pregnant women and children (**Figure 12**).

Description of activities: U-WIN has been developed as the Electronic Immunization Registry for the Universal Immunization Program. Purpose of this IT platform is to register every pregnant woman, capture the delivery outcome, newborn birth registration and vaccination event. GIS based digital microplanning, creation of Due List and GIS-tagging will be an essential part of U-WIN.

Figure 11: Snapshot of Interventions under ZD Implementation Plan

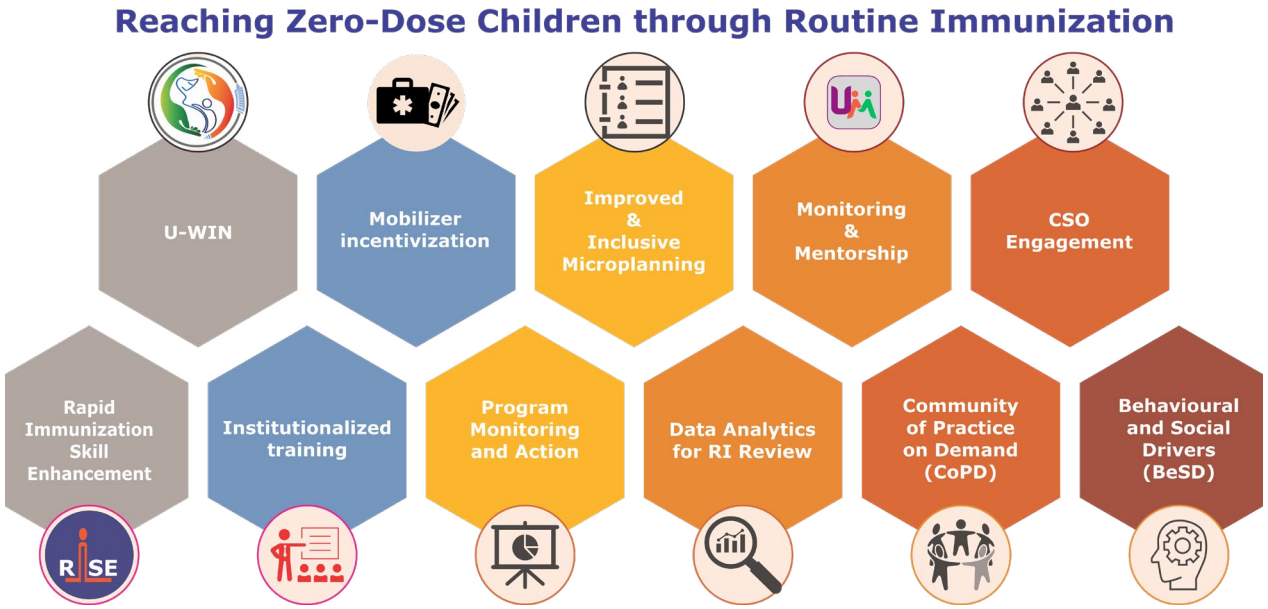
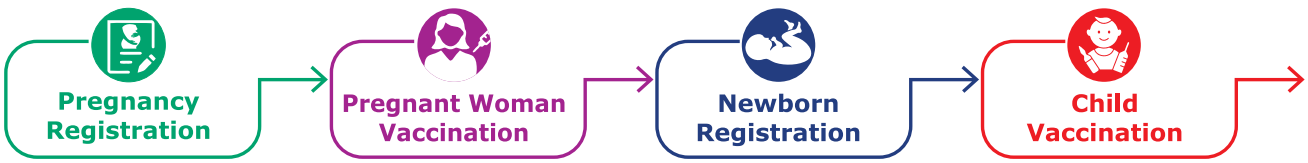


Figure 12: Scope and Process Flow of U-WIN

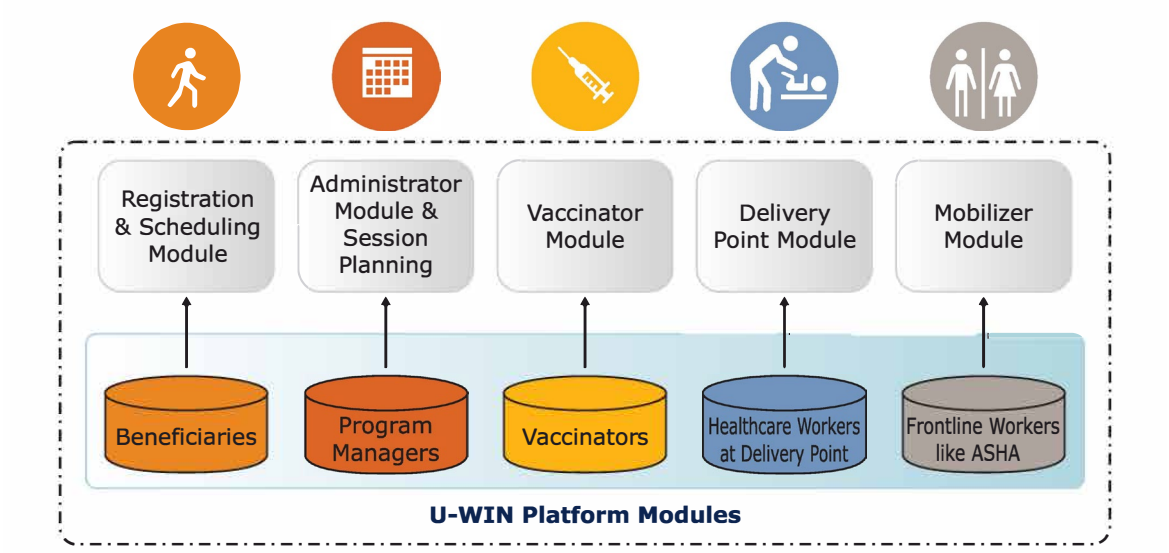


The basic structure of U-WIN platform has 5 modules, as briefed below (**Figure 13**):

- **Registration & Scheduling Module -** Registration can be done online and onsite for pregnant women, infants and children. Existing Co-WIN database can be utilized to tag reproductive age group beneficiaries as pregnant. New registrations may also be done for children linked to the mother/ father/guardian. Also download of the vaccination record/acknowledgement and raising grievance redressal requests will be done through this module.
- **Administrator Module & Session Planning -** This module will be used for adding the health facilities (Cold chain points, planning units, subcentres), session sites (fixed, outreach, mobile, delivery point) and users (State/district/sub-district administrators, Planning Unit Managers, Delivery Point Managers, Vaccinators, Mobilizers including ASHAs). Rights for session planning and tracking status of planned sessions will be given at the health facility level.
- **Delivery Point Module -** The delivery point module would need to be filled in by the facility where the delivery takes place. Recording of the pregnancy outcome, registration of the newborn and recording of the Immunization services at birth would be digitally recorded at delivery point by Health care Worker.
- **Vaccinator Module -** This module will be used to track and record the services which are being delivered on the day of the session for Children and Pregnant Women. Once the health care worker starts the session, s/he will be able to see the list of the beneficiaries who have booked slots online and will also be able to add beneficiaries who report to the session site directly as walk-ins.
- **Mobilizer Module -** Through this module the mobilizers will get details of planned sessions in the catchment area and the due list of beneficiaries for mobilization. The mobilizer will be able to tag refusals in his/ her catchment area and this information can be shared with the supervisor for further action including counselling.

The information gathered through U-WIN platform will be utilized for auto generating due lists, list of beneficiaries with details of vaccination status and list of drop-outs for follow-up. It will have features for GIS mapping of session sites, GIS based area demarcation, tagging resistant households etc. These details will help in tagging the beneficiaries to the vaccination sessions, following up and tracking the beneficiaries. The platform will be critical in tracking the migrant/ moving population and tagging the eligible beneficiaries of this population to the nearest vaccination session sites for availing timely services.

Figure 13: U-WIN Modules



Program managers can access real time dashboards for planning the vaccination sessions as per the requirement. Mapping of all health facilities of urban areas like Corporations, Councils Wards, Zones will help improvise session planning activities. A report section will be available to Program Managers at all levels for monitoring and facilitating data driven actions.

A citizen portal is being developed under U-WIN, wherein citizens can learn about benefits of vaccination, track vaccination status, check digital vaccination card and search nearby vaccination sessions. The platform will also have an inbuilt system to send SMS notifications/ reminder messages to the beneficiaries. It is noteworthy that U-WIN has already been linked to eVIN, SAFEVAC, Ayushmaan Bharat Digital Mission, and all important modules used by Ministry of Health and Family Welfare.

Implementation Plan:

The existing structure at the national and the state/ regional/ district/ sub district level involved with the functioning of Electronic Vaccine Intelligence Network (eVIN) & CoWIN will be utilized for activities planned under U-WIN. Government authorities/CSOs/partner agencies engaged under the immunization program will ensure that every eligible beneficiary is registered in the system through extensive monitoring, improved and inclusive microplanning, regular data review and analytics. The process of connecting missed communities to health systems is shown in **Figure 14**.

The geographical details and the beneficiary information gathered by the U-WIN platform is to be utilised to track the migratory beneficiaries which is one of the major contributors to under-vaccinated/drop-out children. U-WIN will strengthen the micro plans by ensuring that every new beneficiary moving into an area is linked to the health system anywhere in the country not only for immunization services but for comprehensive health care services.

Structure for activity implementation

Existing support: The team at state level for eVIN, will coordinate with State RI Cell to ensure smooth roll out and implementation of U-WIN. This team will ensure sensitization of the state, timely communication to districts, proper state trainings, district and sub-district level trainings as well as efficient management of U-WIN Coordinators (new proposed HR for effective roll out of U-WIN at ground level) (**Flowchart 1**).

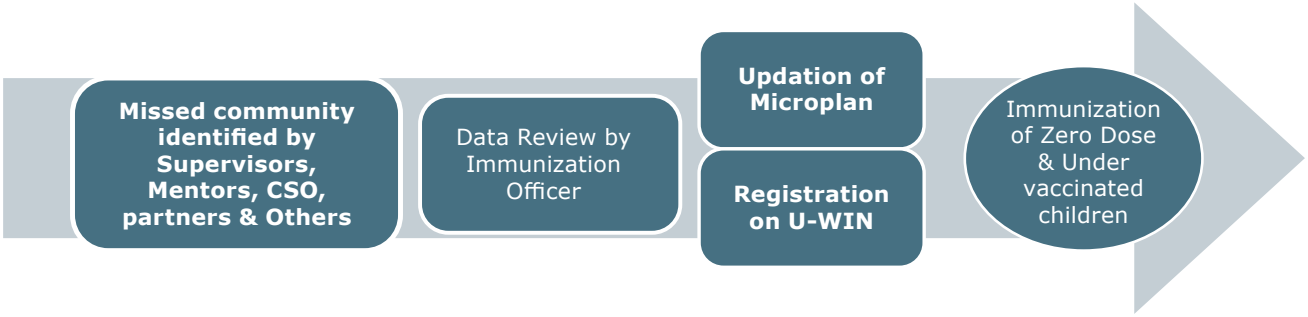
New Support being provided:

Supporting Partner- UNDP

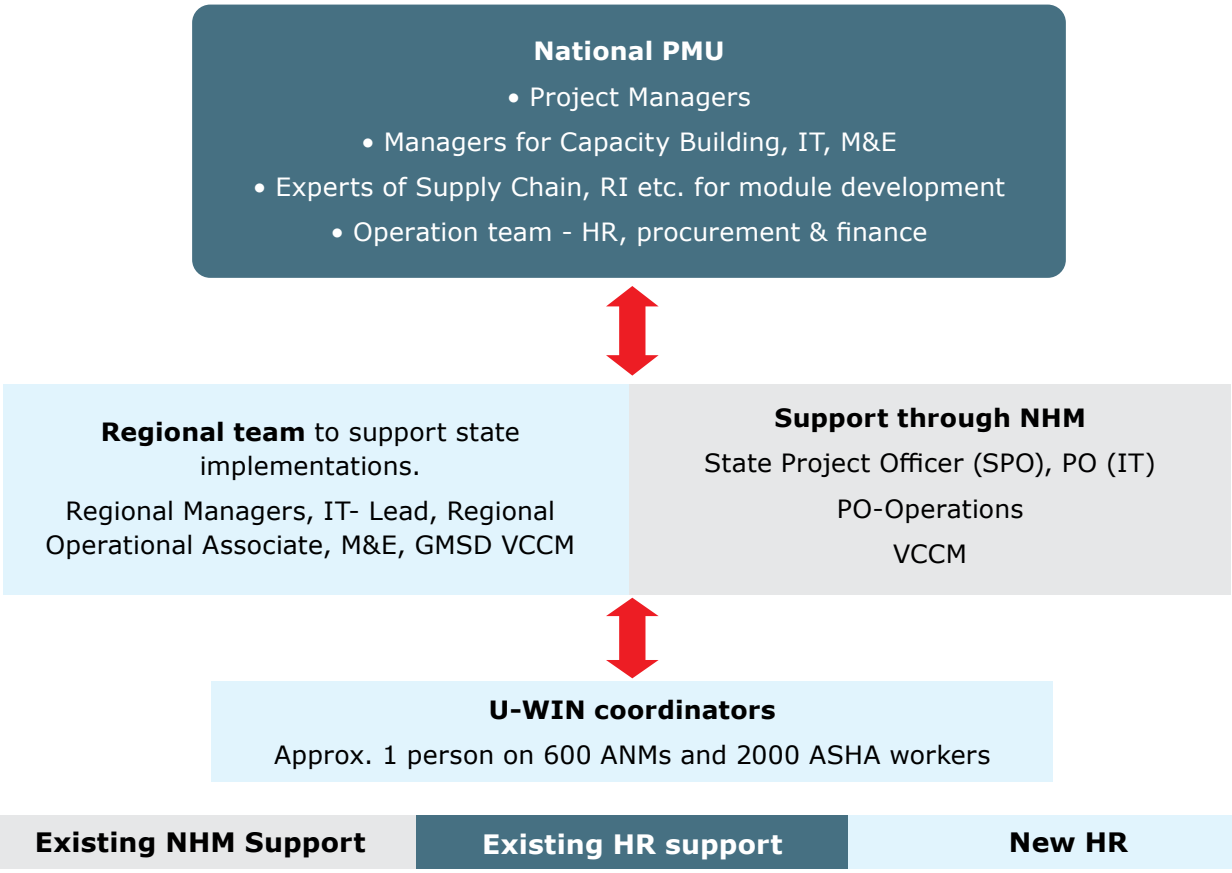
U-WIN coordinator: Approximately 1 person per 600 ANMs and 2000 ASHA workers will be placed for capacity building, handholding, monitoring and on the job training of the personnel handling the IT platform. The coordinator will be placed at Divisional, or District level based on ANM/ASHA load.

The national team will be overseeing the entire activity in collaboration with Regional teams and State teams. The regional officers may be responsible for one or more states direct implementation through NHM SPO. The Regional teams would be coordinating with allocated states & national PMU.

Figure 14: Process of connecting Missed Communities to Health System



Flowchart 1: Structure for Implementing U-WIN



2. Mobilizer incentivization

Context: Universal Immunization Programme (UIP) is entering into a new phase with the roll-out of U-WIN which is a name based digital immunization registry. With the record of immunization digitized, it would enable beneficiaries to access immunization services anywhere in the country and at the same time enable the programme managers to identify due and over-due beneficiaries which can be tracked and vaccinated.

To maximize the utilization of U-WIN as a tool that benefits beneficiaries as well as programme managers, it is imperative to ensure that all infants identifed and registered on U-WIN at birth and if missed then during the earliest community contact and vaccianted with all the vaccines due at 6 weeks as per the NIS (Penta1, OPV1, RVV1, fIPV1, PCV1). If the 6 weeks vaccines are missed due to any reason then it should be provided within 14 completed weeks of age of the child. Keeping the cut off age at 14 weeks will promote immunization within one year and prevent potential zero dose children. Also, bundling all antigens administered at 6 weeks of age together for the eligibility criteria may also promote equal coverages among co-administered vaccines.

In order to identfy zero dose children and ensure that they receive all age approporiate vaccines, an incentive is being provided to mobilizer based on the criteria:

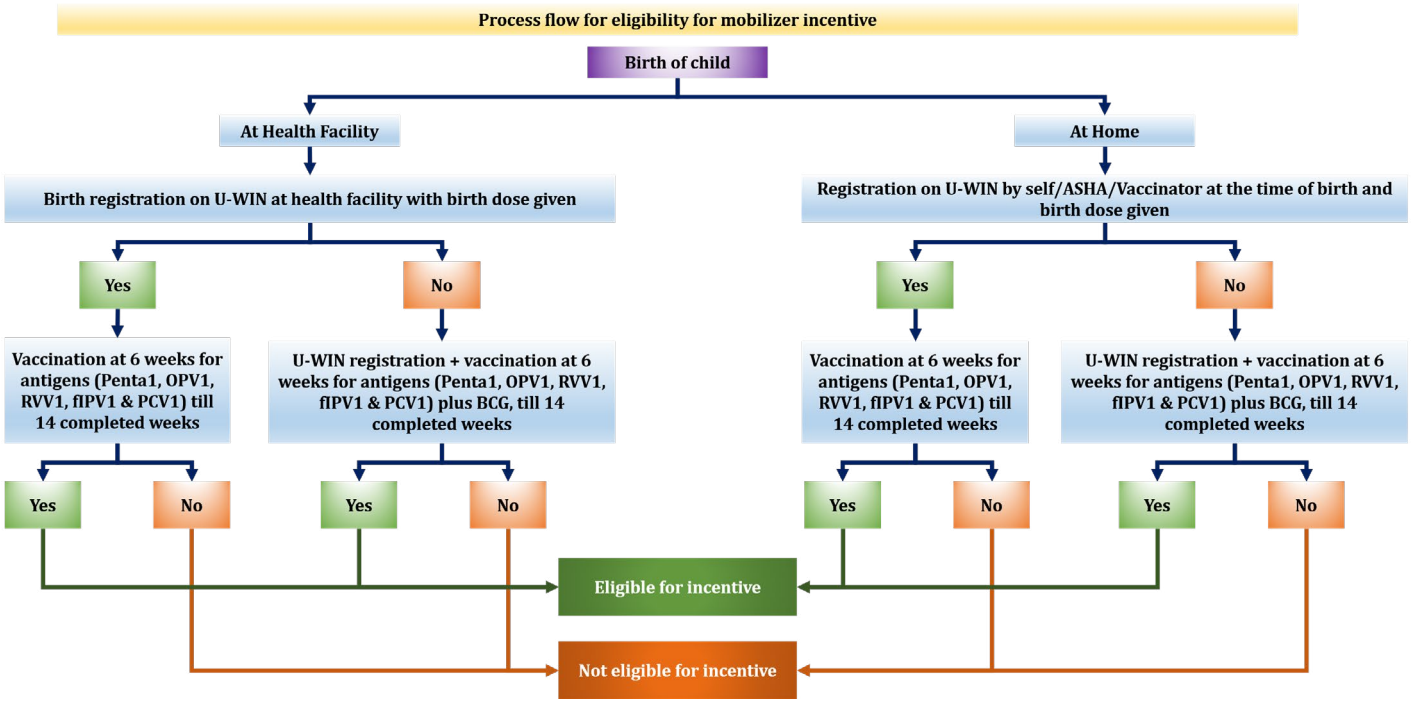
Incentive amount – Rs 25 per mobilizer (ASHA/ AWW/ any link worker or mobilizer).

Eligibility criteria

- Child is registered on U-WIN, either during birth or during first community contact.
- Child has received all the vaccines due at 6 weeks as per the NIS (Penta1, OPV1, RVV1, fIPV1, PCV1) plus BCG
- All the above-mentioned doses have been provided within 14 completed weeks of age of the child
- The record of all these vaccinations is entered in U-WIN.

The detailed flow-chart for vaccination event to be eligible for mobilizer incentive is depicted in **Flowchart 2**.

Flowchart 2: Mobilizer incentivization



Process of payment of mobilizer incentive:

Once the vaccination of an infant with 6 week vaccines is eligible for incentive to mobilizer, the health facility manager for the lowest planning unit of the catchment area will receive the request for approval/verification of incentive on U-WIN. A line list of all such eligible beneficiaries will be created on a real time basis on U-WIN for the health facility manager.

The health facility manager will have the option of batch approval of all such incentives. S/he can also deselect any incentive which s/he doesn't approve.

Once approved, the mobilizer will get a notification of an incentive being payable to her for successful registration and vaccination attributed to her.

As a pre-requisite for payment, the unique identifier for the mobilizer needs to be entered on U-WIN.

All the approved incentives for a planning unit will be visible to the programme managers for the health facility manager of the lowest planning unit and upwards.

The list of all such incentives will be shared by UNDP with the Programme manager at the level of payment and UNICEF. For example, the State where the payment of incentives happens at lowest planning unit, these incentive list will be shared with the accounts manager of the lowest planning unit. While for the States where the payment of incentives is done centrally, the list of incentives will be shared with the concerned official managing payment of incentives at the State.

The concerned official will ensure payment of incentive at their respective levels. The detailed SOP will be shared later with the states.

New Support being provided:

Supporting Partner- UNICEF

The structure engaged for implementing U-WIN and the CSO engagement in every district will be utilized for strengthening registration and vaccination on U-WIN, followed by mobilization incentivization.

3. Improved & Inclusive Microplanning

Background: High-risk areas like urban slums, peri-urban areas, hard to reach, migratory and underserved population have emerged as the major gap areas where the service delivery provisioning is challenging. Lack of tailored service delivery plans as per the need of such communities in terms of suitable time and place, improper infrastructure, insufficient human resource, evolving population patterns, undefined catchment area, informal health care providers, lack of awareness on the importance of vaccination, fear of AEFI, and low trust in public health services have been cited as major bottlenecks in such areas.

These challenges in urban areas are further accentuated due to the very nature of rapid urbanization. Under HSS-2 support, the experience in 14 urban areas/cities suggested that urban areas or cities lack robust & inclusive micro-plans because there were no clear ward-wise boundaries, clear demarcation of UPHC catchment area or ANM area leading to incomplete headcount surveys and due listing, miscalculation of injection load and inefficient communication plans etc. The training of frontline workers on developing robust micro-plans was also found to be lacking.[6] Similarly, the problem of weak microplans in rural areas specially in remote locations, difficult terrain, scattered small villages, riverine settlements, erratic weather conditions, has missed the communities to ensure uninterrupted provisioning of immunization services.

Considering the importance of having good quality robust microplans which are all inclusive, an intensive microplanning updation exercise will be undertaken in the selected 143 ZIP districts which includes 214 urban cities. List of District wise NUHM cities is placed at **Annexure 3**. This intensive microplanning will be supported by **fast-track cascading microplanning trainings** of all the stakeholders including State Immunization Officers, District Immunization Officers, Medical Officers, CHOs, ANMs, ASHA. The other stakeholders such as CSO, and CBO groups (PRI/ULB, VHSNC, MAS, SHG) would be sensitized on the microplanning. While updating microplans, the additional sessions identified during MI & IMI phases may be assessed and made part of the routine microplans.

In addition, **fast-tracked training of all Medical Officers and Health Care Workers** in these 143 districts including 214 urban cities would be undertaken in a time-bound manner on the respective **Immunization Handbook Modules.**

Description of activities:

Microplanning is the basis for the delivery of RI services. The availability of updated and complete microplans at a planning unit (urban/ rural) demonstrates preparedness of a unit and directly affects the reach and quality of services provided. **Microplans are to be prepared for a one-year period, and house-to house survey is to be conducted every six months but RI microplan review meetings are to be undertaken every quarter and updated thereafter.**

The microplan updation exercise will need to ensure that all of the catchment area are clearly defined and mapped, the entire catchment area, specially the urban & peri urban settlements, is demarcated and tagged to health facility. The microplans will be regularly updated to capture details of unmapped areas, migrants, new beneficiaries and missed communities, if any, as identified by CSOs/ ASHAs/ MAS or during house to house monitoring etc. **All formats of the microplans are to be consolidated in digitalized version (excel sheet) at the planning units/ CCP/ UPHC level.**

U-WIN platform will use digitized microplans by the respective program managers i.e., Block/ District Immunization Officers.

Implementation Plan:

National level ToT, followed by state and district level training (for the 143 districts including 214 urban cities across 11 States) on microplanning for Immunization officers, urban nodal officers and medical officers and sub- district/block/ urban area level training on microplanning for Health workers including frontline workers- ASHA/AWW/MAS etc. and supervisors will be undertaken under this initiative in a fast track

[6] https://main.mohfw.gov.in/sites/default/files/Strengthening%20Immunization%20in%20Urban%20Areas-A%20framework%20for%20Action.pdf

mode i.e. within the first year of the project. The trainings are to be followed by frequent review meetings to consolidate the efforts being put in for developing robust microplans.

The microplan updation needs to be synced with the U-WIN registration, identification of missed communities by CSOs and M&M intervention. The reviews with partners held at the block level and district level will provide a platform for synchronizing the same. The communication plan as part of microplans will be developed based on the findings of M& M intervention and BeSD surveys (details in following sections).

Structure for activity implementation

Existing support: The existing structure at the national and the state/ regional/ district/ sub district level involved in Microplanning and Routine Immunization strengthening will carry out the activities planned under this intervention.

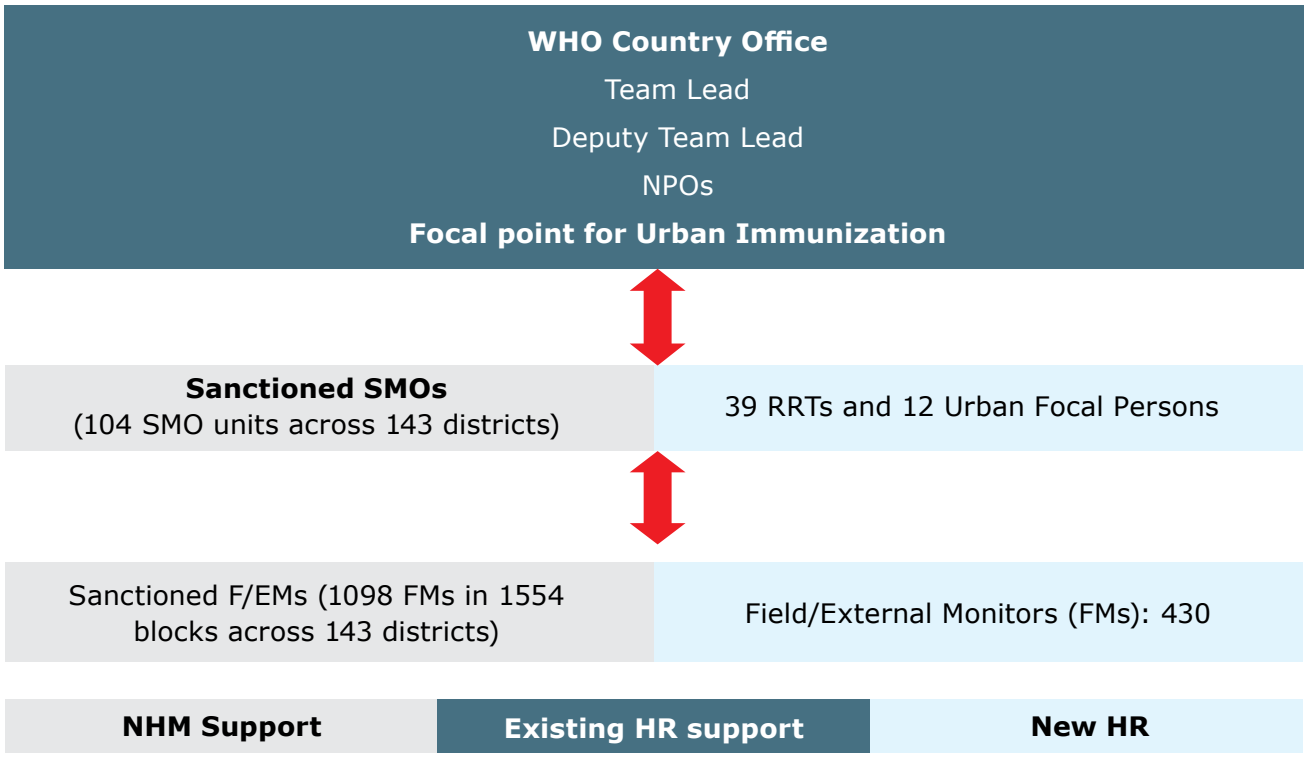
Already existing structure of SMO units will be utilized for all activities under immunization. In states where the Immunization Field Volunteers (IFVs)/ Field/External Monitors (F/EMs) are already approved under NHM PIP will be supporting the activity. Considering the challenges of urban areas and with the intention to intensify focus in urban areas, new field monitors are to be proportionately assigned for urban areas. In places where no new field monitors are being provided under this project, distribution of work time of the existing F/EMs is to be undertaken in accordance with the rural urban population distribution. This rationalization is critical since the performance of the F/EMs will be assessed based on the quantum of monitoring done in urban areas (if applicable).

New Support being provided:

Supporting Partner: WHO

Rapid Response Team (RRT)/ Urban Focal Person(UFP): Out of 143 districts, where SMO unit support is not available for immunization activities including microplanning, surveillance and monitoring, new support is provided as RRT. The district level HR will be responsible for supporting the immunization activities in rural as well as urban areas (**Flowchart 3**).

Flowchart 3: Structure for ensuring Improved & Inclusive Microplanning



In addition, 12 urban focal persons would be deployed in high focus urban cities. Considering the past support and existence of other immunization partners, deployment plan for the UFP will be conveyed subsequently.

Field/External Monitors: Additionally, field level monitors/ volunteers will be provided in areas where there is no existing field level support. The field/external monitors will be supporting the monitoring and mentoring intervention and update the microplans based on the field observations of the marginalized and high-risk areas, specifically urban areas. Details of places where new field/external monitors and RRTs are being provided is placed at **Annexure 6.**

4. Monitoring & Mentorship (M&M) Program

Background

Generating data through field monitoring by supervisors across the country from the immunization session sites (outreach & fixed), planning units, cold chain points, delivery points, house to house survey, local influencer feedback and Task Forces feedback is critical to identify gaps on routine basis and utilize evidence to guide corrective programmatic actions from field level to national level.

In order to supplement and sustain the gains made over the years, there is a need to address challenges to vaccination coverage at the ground level. Achieving high coverage, as well as ensuring safe and quality service delivery is critical to India's UIP. Here, the frontline workers have a great role to play in ensuring access to and delivery of quality immunization services to the beneficiaries and generating confidence in communities. The Frontline health workers (FLWs) like ANMs form the backbone of the immunization system as they are the ones who deliver immunization services to the community. However, ANMs face a multitude of challenges like excess workload, excessive record keeping requirements, tough working conditions which include accessibility/ transport issues in reaching to the remote areas, difficult geographic conditions, social and security issues. The traditional classroom training has a variable impact on improvement of FLW skills & practices hence the need to supplement it through on-the-job mentorship. Likewise, the Cold Chain Handler (CCH) at the last Cold Chain Point (CCP) is a pivotal resource managing vaccines and logistics.

Thus, to guide the health workers and create a more conducive learning environment, coaching them on skills, motivating them and becoming more involved in their activities, the concept of monitoring along with mentoring is being emphasized.

Description of activities:

The intervention is based on the already existing concurrent monitoring and supportive supervision intervention under Universal Immunization Program (UIP). To avoid duplication of platform and multiple datasets, a single unified, govt. owned IT based mobile application (Monitoring & Mentorship App) for all supervisors (Government/partners) with defined SOPs has been developed with an enhanced focus on increasing the sample size of monitoring, touching almost all session sites to make the data more representative and making the supervision more supportive and solution driven for health worker through mentorship component. The monitoring and mentorship intervention will be implemented and reviewed across the country. However, M&M will be reviewed under Zero Dose Implementation Plan for 143 districts in 11 States, with an aim to provide feedback on progress of the program and rectify gaps in the field as well at the programmatic level.

Monitoring:

The monitoring component of the M & M initiative will utilize all monitoring checklists and will include monitoring of **session sites (outreach & fixed), planning units, delivery points, cold chain points, session sites (outreach & fixed), house to house survey, local influencer feedback and the Task Forces at State/District/Block/City level**.

State/District/Block Task Force on Immunization: The Task Force meetings will be assessed on its frequency/regularity, discussion agenda, action taken on previous proceedings.

Planning Unit: The planning unit checklist will be used to evaluate the various thematic components of the Universal Immunization Programme at the planning unit level for analysis and corrective actions.

Cold Chain Point: Monitoring of the Cold Chain Point will be undertaken by identified district monitors/mentors. The CCP monitoring will include assessment across various aspects like Storage Capacity– Cold & Dry; Knowledge & practices of Cold Chain Handler; Maintenance of Equipment & Building; Temperature monitoring; Stock Management; Bio-medical Waste management and Record keeping.

Delivery Point: Regular monitoring of the delivery points will help improve the coverage of birth dose and reduce the missed opportunities for the three vaccine (Hepatitis-B, OPV & BCG) which are to be provided under the program. It will also assess the vaccine storage processes at the delivery points. The monitoring will also observe the registration of the new-born and generation of vaccination record under U-WIN.

Session Site: The objective of RI session monitoring is to observe the preparations, quality, and completeness of vaccination activity. Components of the checklist include head count survey, due list with updation, mobilization efforts, vaccine/logistics availability and interview of caregivers etc. The observations will help to further build the capacity of vaccinators/mobilizers.

House to House: Household monitoring at the villages and urban ward levels, in these specific identified areas, will contribute to the actual identification of zero dose children within these localities. Household level monitoring will also generate some of the behavioural and social issues in play which are responsible for families having zero dose children.

Local Influencer: The local influencer's (1. Sarpanch/Panch/Ward Councillor, 2. Gram Sachiv/Secretary, 3. Teacher, 4. Religious Leader, 5. SHG member/MAS member) feedback on RI services gathered through community monitoring will provide insights on the effectiveness of the various community engagements being undertaken. Household monitoring and local influencer's feedback data will be tracked monthly to identify villages/urban areas with higher proportion of zero dose children for effective targeting of mentorship and CSO engagement.

Analysis of the entire set of M&M data will provide key insights into gaps and barriers to service delivery and access that will help in designing interventions to reach missed children and communities. A brief guidance on

Monitoring and Mentorship

developing M&M plan, along with M&M checklist and SOPs will be shared subsequenlty.

Mentorship:

The novel concept of mentorship will be integrated into the session site and cold chain point monitoring by incorporating a hands-on capacity building component for the identified supervisors (Government & Partners) to undertake need based and customized handholding of ANMs and Cold Chain Handlers during the monitoring visit. This will supplement the existing traditional capacity building initiatives, weekly meetings and self-learning interventions to improve the quality of frontline worker led services delivery. Offline capsular Capacity Building Modules, job aids, RISE platform will also be used as capacity building tools.

The observations made during session site and CCP monitoring will be objectively scored (automatically on the App) to assess knowledge or practice of the health worker (ANM, CCH) and will help in identifying gaps and knowledge or practice as per the thematic areas of UIP covered under the checklists. Accordingly, at the end of a particular visit, hand holding support will be provided to the health personnel through the mentorship component on-the-job, using the job aids developed specifically for this intervention. The monitoring-based scores visible on the M&M dashboard will guide mentoring of Health Workers. Based on the assessment of the ANMs done during the monitoring visit at the session site, performance areas found lacking will be identified and mentorship visits will be prioritized for relatively low scoring ANMs. In addition, the existing platforms of weekly/ monthly meetings will be utilized by the Medical Officers/Programme managers to impart short capsular training on the commonly identified thematic areas to all ANMs. The same approach will be utilized for quality enhancement of Cold Chain Points.

Over a period, performance of the health worker and cold chain point will be tracked through the M&M dashboard which will have real time visibility at block, district, state and national level.

Implementation plan

A government owned IT based M&M application will be used which will have monitoring tools for task forces, planning unit, delivery points, cold chain points, session site, house to house survey and local influencer feedback.

Development of a Quarterly Monitoring & Mentorship Plan for Immunization at block and district levels and adherence to the plan is the critical component of this initiative. The entire existing structure of Immunization program will use M&M platform for monitoring and mentorship purposes. National, States, District & Block level officers will use this data set of M&M for review and corrective actions under UIP.

The Medical Officer I/C at the block level will identify the Monitors (Govt. & Partners) and include them in the block quarterly supervision plan as identified in **Annexure 4**. The block wise monitors will be line-listed, and login credentials will be provided to each monitor in the block. The District Immunization Officer will consolidate the block quarterly Monitoring & Mentorship plan and include the list of district monitors to develop the District Quarterly Monitoring & Mentorship plan. The dedicated login credentials will be provided to the district

level monitors.

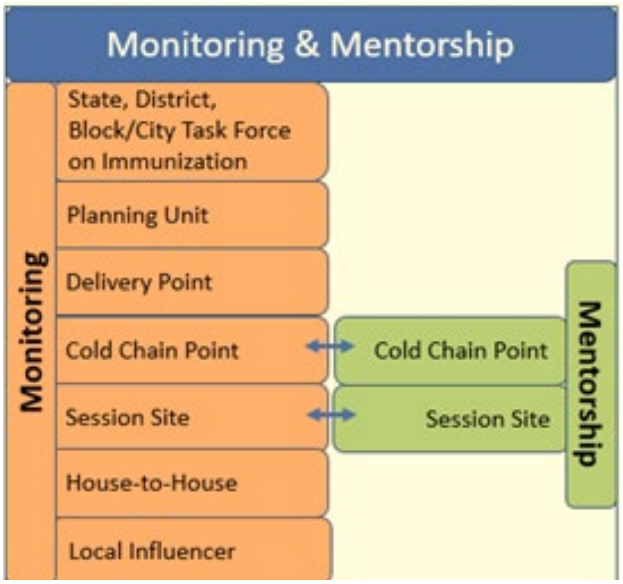
From this pool of identified monitors, a group of mentors will be identified by District and Block officials based on the mentoring capabilities and programme expertise of the monitors. The mentors will specifically monitor and provide mentorship to low performing ANMs and VCCH as per the District Quarterly Monitoring & Mentorship Plan.

The monitors as well as the mentors will be trained on the monitoring component of the M&M initiative. The identified mentors will be imparted an advanced version of mentorship training that will include training on various platforms, tools and methodology of mentoring the health care workers. Capacity building of government supervisors at block, district and state levels will be undertaken through the project to ensure sustained monitoring and mentorship.

To ensure effective implementation of the monitoring and mentorship intervention, quarterly M&M plan for immunization will be developed with quarterly monitoring targets using standard SOPs for implementation. The following principles need to be followed for developing an effective quarterly Monitoring & Mentorship plan at block/UPHC level (**Figure 15**).

- All the ANMs in a block/UPHC level should be monitored at least once a quarter.
- At least 10% of the immunization sessions held in a block/UPHC area every month (both fixed and outreach) should be monitored. This will ensure covering all session sites in a block/UPHC area in a year.
- Do not repeat any session site for monitoring until all the session sites are covered in the block/UPHC area.
- Ensure that no HRA/HRG sites as per microplan are missed in the quarterly supervision plan.
- Low performing ANMs/VCCHs should be prioritized for mentoring with increased frequency
- MO I/C and DIO should review adherence to block and district quarterly supervision plans monthly

Figure 15: Schematic diagram - Monitoring & Mentoring



The following steps needs to be followed to initiate and sustain the Mentorship component in a district:

- Identification and training of mentors in the district.
- Generate baseline scores for all ANMs/ VCCHs during the first quarter of implementation through monitoring visits using M&M tools.
- Identification of low performing ANMs/ VCCHs across the district.
- Development of Mentoring component of the District Quarterly Monitoring & Mentorship plan to cover all the identified low performing ANMs/VCCHs at least once in a quarter.
- At the end of the quarter, the scores of ANMs/VCCHs will be used to modify the next quarterly Monitoring & Mentorship plan.

State level monitors/mentors will prioritize their visits to the low performing blocks in the districts. The SEPIO will ensure development of the State Quarterly M&M plan including govt. and partner monitors/mentors. This will be reviewed every quarter at the State Task Force meeting. Data based on all monitoring indicators will be generated monthly through the mobile/web-based monitoring and mentorship dashboard and reviewed at block

and district level for programmatic feedback on monthly basis. Monitoring of the monitors and mentors as per the approved M&M plan for compliance needs to be undertaken by District Immunization officer and State level monitors/ mentors. **The performance of each monitor & mentor will be measured and assessed through the person specific M&M plans through adherence rate via GIS mapping.** Adherence to the M&M plan will ensure that adequate monitoring data are generated in each district to enable evidence-based decisions. Similarly, National level monitoring plan will be developed which will include Government Officers from the immunization division and the partners' HR supported under this grant. The monitoring plan will focus on the poor performing blocks based on the monitoring data reported through M&M.

New Support being provided:

Supporting Partner: UNICEF

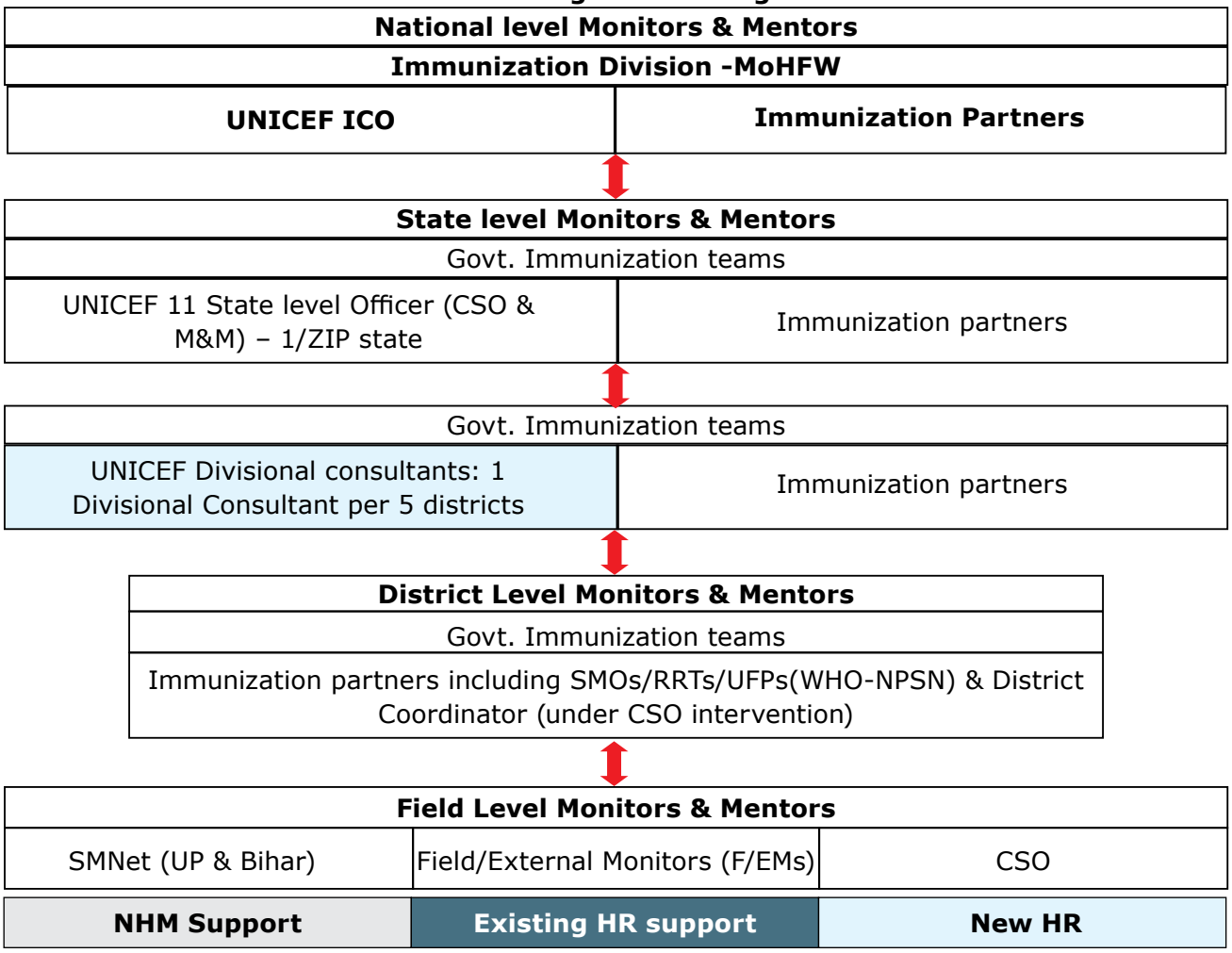
State team: State Level team in addition to monitoring & mentorship visits as per the plan, will ensure sensitization of the state, timely communication to districts, proper state trainings, district trainings and sub-district level trainings to ensure smooth roll out and implementation of the intervention.

Divisional Consultant: One Divisional Consultant for every 5 districts is being provided under the intervention to provide technical support and coordinate for the above-mentioned activities at district level in close coordination with SMO units in these districts. The other district level technical support provided through different partner agencies will support the activity and contribute to the pool of monitors and mentors (**Flowchart 4**).

Flowchart 4: Structure for implementing - Monitoring & Mentoring

New Support being provided:

UNICEF Monitoring & Mentoring Structure



Supporting Partner: WHO

SMOs/Field Monitors: Areas where the structure of SMOs/field volunteers/Field Monitors is not existing, additional support of RRT, field monitors is being provided in districts to ensure that all 143 districts have the requisite manpower for monitoring & mentorship program in addition to other partners & government human resource. Additionally, the existing structure of SMNet (transitioned to NHM) and the CHOs will be utilized for monitoring of adequate number of sessions and households as per the supervision plan.

Other Partners:

All the partners' HR supported under HSS-3 at block, district, state & national level will be part of monitoring and mentoring plans to be developed at each level.

5. CSO Engagement

Context: Engagement of Civil Society Organizations (CSOs) is envisaged with the objectives to improve community's knowledge about vaccination and its benefits; reduce vaccine hesitancy and increase social accountability for vaccination. The CSO engagement approach is based on the intention of maximizing reaching zero dose population and missed communities, by focusing on strengthening community level structures, elected representatives, youth volunteers, front line health workers, local champions, and using them as a lever to reach parents and caregivers through defined contact sessions beyond just typical messaging, this will facilitate and ensure that the zero dose (ZD) children reach the service delivery sites. The big shift is moving away from an external community mobilisation approach to working from within the community, so that the sustainability of the investments can live longer. CSOs will be instrumental in addressing root causes of unvaccinated and partially vaccinated children. Community mobilization activities undertaken by CSOs will be informed by the monitoring and mentorship data and BeSD surveys.

UNICEF will lead the CSO engagement component of the programme in the selected 143 districts, however the CSOs will work in close coordination with the Department of Health at the block, district and state level.

Description of activities: Aim of this intervention is to establish an engagement framework for local Civil Society Organization (CSOs)/Non-Government Organizations (NGOs) to enable the community and the community-based organizations to understand the importance of vaccination this in turn will result in improved demand for vaccination services especially in the identified priority population where the maximum number of zero dose children & under vaccinated children reside. The details of the activities which will be undertaken are as follows:

Design and implement effective social and behaviour change and gender responsive interventions with communities: CSOs will use community-based platforms such as Village Health, Nutrition and Sanitation Committees; Urban Local bodies etc. to promote community engagement and reach zero-dose children and missed communities. It will engage local people and influencers to co-create to reduce barriers, promote positive behaviours and social norms, increase male participation, and generate demand for vaccination and other health services.

CSOs will identify and build capacities of local influencers (such as positive deviant parents, a caregiver, or elderly, who has strong roots in the community and well respected) to promote trust and confidence in vaccines and health services and support the FLWs in dispensing their duties. CSOs will advocate for inclusion of influencers in microplans, and build their capacities to function as immunization ambassadors.

CSOs will also identify local community groups and build their capacities to function as community level immunization monitors; identify and refer any missed child to the FLWs or health services; establish a mechanism for capturing feedback on services and thereafter improving the service delivery and increasing community ownership. These will also provide feedback on the quality of immunization services to the health system.

CSOs will also work to establish local systems to track rumours and misinformation to debunk myths rapidly through online and offline platforms and address vaccine hesitancy.

Strengthen microplanning: In each of the selected area, the CSO will facilitate community participation to support the frontline workers (AAA) and/or mobilizer in identifying and mapping geographies (any new hamlet or settlement that has come up) and linking it with the service delivery and communication micro plans. Similarly, the CSO will also support the frontline workers in identification of unimmunized or under immunized children and linking them with U-WIN or relevant data systems.

Improve the capacities of frontline health workers to build trust and confidence in vaccination and primary health care services: CSOs will equip frontline workers with skills and tools in interpersonal communication and community engagement to help them engage and communicate better with caregivers. They will motivate frontline workers through improved training, monitoring, and supportive supervision. Community platforms and structures will be strengthened so that they can support the frontline workers in convincing hesitant families; and reinforcing positive messages to sustain those who accept vaccination.

Advocacy: CSO representative will actively participate in block, district, and state level review meetings such as BTFI, DTFI, STFI etc. to provide feedback based on the field findings and seek guidance and support for the actions that emerge from the reviews and consultations. They will also promote participation of identified community structures in block and district level reviews for sustainability of the intervention. CSOs will orient district and block level health program managers (including CHOs of HWCs) on using community feedback for immunization demand component. CSOs will also be a member of Community of Practice on Demand (CoPD) and will support in piloting/testing innovative demand promotion models recommended by CoPD.

Implementation plan

CSOs role across different platforms

Member of existing accountable platforms at each level including VHSNC, BTFI, DTFI and STFI.

Resource for capacity building of community for village/area health planning and community-based monitoring

Onboarding of CSOs: UNICEF will select and onboard CSOs in respective districts following a stringent process of programmatic and financial capacity assessment. The focus would be on selecting CSOs that are well versed with the communities, have trustworthy and credible relationships with the community; have expertise in social and behavior change and have robust financial management systems.

Focused Intervention: Within each district, the CSO will be strategically appointed in identified pockets of low immunization coverage, high vaccine hesitancy; difficult to reach and disease outbreaks for intense community outreach and mobilization. Selection of pockets for CSO engagement will be informed by available HMIS, other relevant data and qualitative feedback from the district health department. Learnings and feedback from these CSO engagement areas will be regularly shared at Block and District and Immunization Taskforce Meetings to positively influence block and district wide programming.

Overall, this CSO engagement will be guided and reviewed by Community of Practice on Demand (CoPD) which is being set up at National Level. CoPD is one of the 11 interventions to be implemented under this Zero dose implementation plan. The CoPD intervention is explained in the later section of this document.

New Support being provided:

Supporting Partner: UNICEF

- The structure of UNICEF at National, State, Divisional Level (as mentioned in the M&M Section) will support the implementation of CSO activities.

- One State Officer per State will ensure sensitization of the state, timely communication to districts, proper state trainings, district trainings and sub-district level trainings and coordination and monitoring for implementation of this intervention. The State Officer will be supported by 1 Divisional Consultant per five districts. The Divisional Consultant will be responsible for both the M&M initiative as well as the CSO intervention.
- Each district will be supported by a CSO and its staff structure.
- The existing SMNet in UP and Bihar will work in close coordination with the CSO engaged for the districts.

6. Rapid Immunization Skill Enhancement (RISE)

Background: Rapid Immunization Skill Enhancement (RISE), a capacity-building initiative using digital platform, has been conceptualized and developed by Government of India with support from JSI, for enhancing the knowledge and skills of the health workers on routine immunization. RISE was conceptualized based on needs assessment and a human-centered design approach, including feasibility and willingness of front-line health workers to access and use technology like internet and mobile phone. The RISE platform envisages the following:

- Updating the knowledge of health workers about latest developments in the program and changes in the guidelines quickly. Ensuring quality and maintaining uniformity of the training
- Real time monitoring of trainings and sharing of prompt and quick feedback
- Providing opportunity for repeated refresher for health workers who can access modules whenever required

RISE has many innovative features, including, learning assessments, certification processes, and indicators for measuring the gain in knowledge and the effectiveness of the module. Participants can enhance their knowledge through a self-paced curriculum, completed at their convenience, without the direct involvement of trainers.

Description of activities

The RISE platform has been conceptualized as a learning platform for timely and effective training of immunization workers, complementing the ongoing conventional training by, through leveraging information technology tools like internet and mobile phone.

Rapid Immunization Skill Enhancement (RISE) has already been piloted in 5 districts of 5 states: **Shimla (Himachal Pradesh), Bhopal (Madhya Pradesh), Khordha (Odisha), Pune (Maharashtra) and Kancheepuram (Tamil Nadu) under HSS 2.** Government of India has now decided a phase-wise, pan-India scale-up of RISE to impart routine immunization training to all vaccinators throughout the country. The first phase of scale up has already covered 33 districts, across three states (**Figure 16**). Under the ZIP, the plan is to scale it up in the priority states ("zero-dose" criteria) and effectively use the platform in the states where RISE Pilot had already been conducted. Overall, 236 districts will be targeted under the ZIP (Details enclosed in **Annexure 5**).

The RISE platform covers five learning modules, consisting of key areas impacting

Figure 16: RISE- Pilot & Scale up Plan

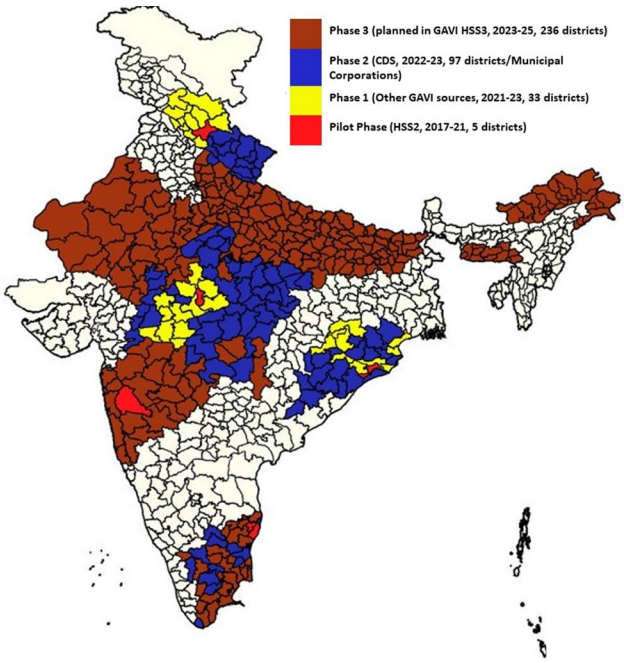


Table 4: Advancements planned under RISE

Decision Support System (DSS) for vaccinators:

Development and maintenance of an innovative, algorithm-based, easy to use Decision Support System (DSS) application for age-appropriate vaccination of zero dose and irregular beneficiaries during immunization sessions, from simple information like date of birth/age of children and current immunization history of the child.

e-learning content for the Medical Officers:

Adaptation & conversion of the forthcoming "Routine Immunization Training Handbook for Medical Officers" prepared by the MoHFW, into an appropriate e-learning content to be delivered through RISE.

the quality of the routine immunization programme – **Immunization schedule and session management, Injection safety and vaccine administration, Principles of cold chain management, Adverse events following immunization, Communication to tackle vaccine hesitancy.**

Additionally, a new chapter, **'Identification and Planning To Cover The Zero-Dose Children'** is being developed to enhance the capacity of the vaccinator/CSOs to identify a "zero-dose" children, missed communities and the measures required to resolve the challenge of zero dose communities.

In addition, RISE will have advanced features as mentioned in **Table 4**.

Implementation Plan

Apart from creating all relevant content, JSI team will conduct State and District trainings and District trainers will organize block trainings. JSI will additionally help in coordination & planning the roll out of the application during "go-live" of RISE in each district, and support Block level orientation sessions on the RISE application. Once the application is operational and working, JSI will provide technical support-trouble shooting, functional support to the learners at the district/block levels to ensure a seamless uptake of the modules.

Sustainability Roadmap: For sustainability in the long run and to keep healthcare workers informed and updated, efforts are being made to include local capacities in the system to manage the RISE platform in future. The states are encouraged to propose the costing requirement of state and district level orientation workshops in the selected districts, block level orientation meeting with the ANMs and supervisors and printing of training materials for RISE in the state's annual Program Implementation Plan (PIP).

New support being provided

Supporting Partner- JSI

Regional/State Program Manager: At the Regional/State Level transitioning during the entire project from one region/state to another on completion of activities in a particular state. The manager will be responsible for coordinating with State, Organizing the District Workshops and Monitoring the progress of the RISE activities in respective states.

Regional/State IT and Data Officer: Position at the Regional/State Level transitioning during the entire project from one region/state to another. The officer will be responsible for supporting the concurrent monitoring of RISE progress in all the districts. Data collection, collation and troubleshooting to support the learners (**Flowchart 5**).

Flowchart 5: Structure for implementing RISE

National PMU - Project Director, Sr. Program Manager, +5 Program mangers/ Managers

Regional/State

Program Manager- 3 positions transitioning during the entire project from one region/ state to another on completion of activities in a particular state.

IT and Data Officer- 3 positions transitioning during the entire project from one region/state to another.

Need based engagement of short-term consultants.

7. Institutionalized Routine Immunization trainings in India

Description of activities: Considering that several new interventions are being undertaken under the Zero Dose implementation plan, need for a robust institutionalized training mechanism also emerged during the sub-national consultations for 11 States. Over the period, it has emerged that regular trainings of health care workers could not be conducted on a regular basis. This results in underconfident and unskilled workforce which lead to weak microplanning, poor session planning, program errors, incomplete due-listing, inefficient mobilization and poor data recording and reporting.

Objective of the intervention is to establish immunization training networks in the form of **'hub and spoke'** model. It will ensure that all immunization trainings are planned at national, state, district, sub-district level training and are conducted as per plan. The structure will support training needs assessment, plan the training calendars, coordinate among training hubs, monitor the training sessions in terms of trainees trained, quality of training, identify training gaps and take corrective actions for the gaps.

The training status will be tracked with state & partners and the training data will be entered in the iTMIS for effective monitoring. A Management Information System (MIS) dashboard will be developed by leveraging iTMIS at NCCVMRC. The status of all types of immunization training will be reviewed by MoHFW for various feedback meetings. It will need to be ensured that the PIP budget for training is utilized in an effective manner.

Implementation plan:

The specific activities of the project are:

1. Building a national Centre of Excellence (CoE) to provide stewardship and oversight on the training and capacity building activities under UIP.
2. Capacity building of existing training institute(s) at state levels to create a hub-and-spoke model for training.
3. Development of a vaccination skill enhancement centre to institutionalize high quality training mechanisms at designated hubs.
4. Development of a management information system (MIS) dashboard to enable real-time monitoring of training quality, participation and timeliness at district, state and national levels.

Activity 1: Building a Centre of Excellence for Immunization

A national CoE for Immunization will be developed at National Cold Chain & Vaccine Management Resource Centre (NCCVMRC) for providing leadership for immunization specific capacity building and training across India. The national CoE will be responsible for orienting master trainers, hub-mentors, developing training calendars in coordination with the immunization division and development partners etc. and documenting overall progress.

Activity 2: Capacity building of existing Training Institute at the state level to create a Hub-and-Spoke Model

State identified institutes such as State Institutes of Health & Family Welfare (SIHFW), Medical Colleges etc. will be developed as hubs or nodal agencies for training at state levels. In addition to the State Immunization Officer, Cold chain, and AEFI officers, the staff and faculty at these institutions will be trained as master training, paving the way for the institutionalization of a system-driven approach to capacity building. Depending on the size of the state and number of priority districts, one or multiple hubs may be created in each state. In the initial stages of the project, hubs will be created keeping in mind the 143 priority ZIP districts in selected states with a high proportion of zero-dose children.

Faculty from these hubs or nodal agencies will be oriented for immunization under the stewardship of the national CoE. Subsequently, these hubs will coordinate and monitor the training of linked health facilities (CHCs, PHCs, etc.) i.e. spokes. The hubs will act as mentors for ensuring quality and timely training are imparted to the immunization health work-force in their states. The on-boarding of

faculty and senior programme staff from these institutions, provides additional opportunities for developing tailored solutions for persistent demand and supply side barriers to immunization.

While the training will be conducted by master trainers, including state immunization program managers and development partners, state-level training coordinators will facilitate and monitor each training and will be responsible for tracking participation, progress and quality assurance of the training conducted. These coordinators will also ensure timely reporting of training data from state hubs.

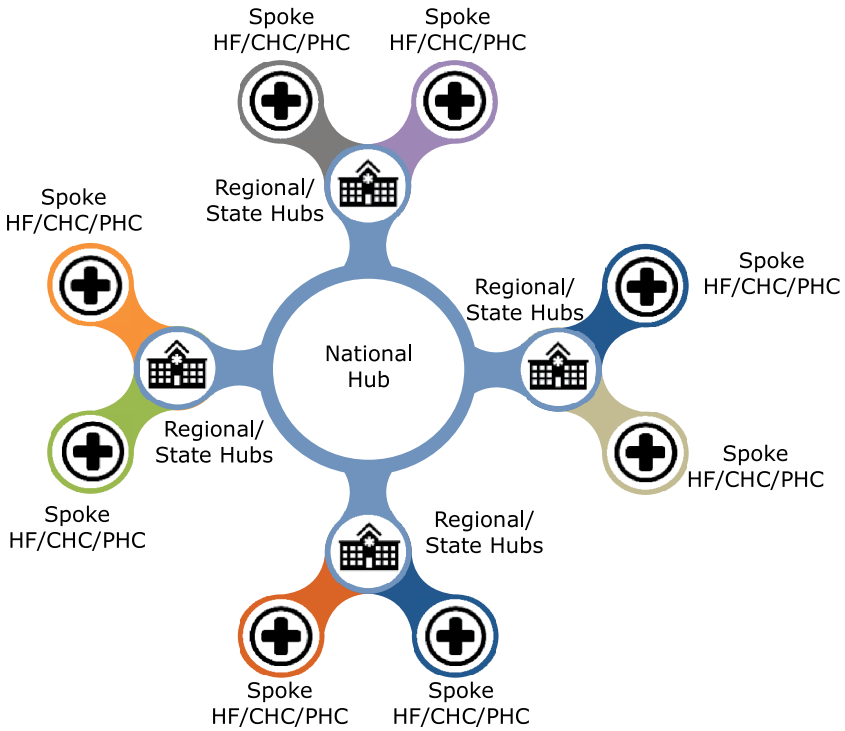
The trainings will be conducted using the updated and existing government guidelines and will cover all thematic areas relevant to Routine Immunization (RI) including the Microplanning, Cold Chain and logistics management, Adverse Events Following Immunization (AEFI) management, waste disposal, data use, supervision and monitoring, behaviour change communication, Vaccine Preventable Disease (VPD) Surveillance, capacity building of health functionaries and financial planning. Newer areas for capacity building will be explored such as training of vaccine handlers and program managers and administrators.

Lessons learned from initial sessions will be used to refine further trainings in an iterative manner with partner and stakeholder feedback. Thus, this mechanism will ensure the systematic adoption of novel digital initiatives such as the RISE and U-WIN applications, spanning multiple health cadres at block, district and state levels (**Figure 17**).

Activity 3: Building Vaccination Skill Enhancement Centres at designated hubs

Each hub will be equipped with a Vaccination Skill Enhancement Centre providing a holistic, blended learning ecosystem, and offering skill-based clinical trainings. The centres will be equipped with practice rooms for practice of clinical skills required for administration of different vaccines. Medical and para-medical personnel will be trained on procedural skills with repeated practice and evaluated until the required minimum standard is ensured. The centres will also be equipped with mannequins, latest job aids, learning resource packages and guidelines. Health providers will have an opportunity for hands-on demonstration of clinical management of Adverse Events

Figure 17: Hub & Spoke Model for trainings



The Trainings are to be cascaded to the front line workers-CHO, ANMS, ASHAs etc.

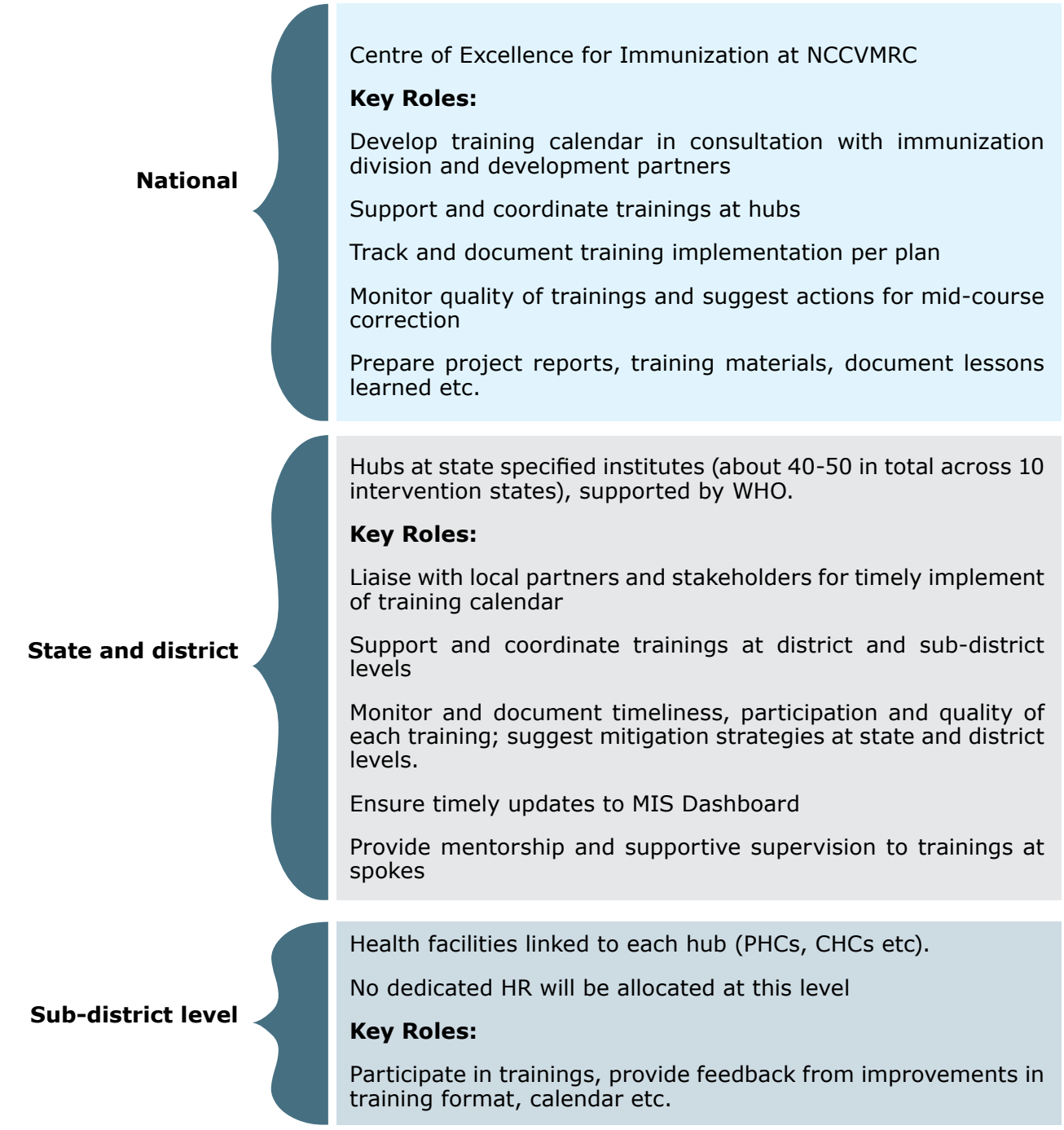
Following Immunization (AEFI) using the AEFI Management Kits. In addition, injection trainer mannequins and learning resource packages, equipped with latest job-aids, manuals and guidelines from the Government of India, will be provided across all 143 priority districts, to facilitate a skills-based hands-on training for health workers **(Figure 18**).

Activity 4: Development of a management information system (MIS) dashboard for real-time monitoring of trainings

Standardized metrics will be used to track the quality and participation of each training and iTMIS will be used to enable real-time monitoring of training participation, timeliness and completion at national, state, district and block levels.

Figure below, summarizes the implementation approach and the roles and responsibilities of the CoE, hubs and spokes in the proposed model.

Figure 18: Implementation Approach of Hub & Spoke Model for Trainings



New support being provided:

Supporting Partner - WHO

National level:

Capacity building: With technical support of WHO India, the center will be undertaking the following initiatives in line with the policies and priorities of MOHFW and states:

- Develop a strategy plan and an action framework for capacity building of healthcare workers and support personnel on immunization including identification of hubs and spokes in the 11 states (would involve assessment and identification of existing potential institutes and medical colleges (preferably government medical colleges) as hubs and assessments of health care facilities as spokes)
- Plan and coordinate with government and the partners on the routine immunization trainings, research activities related to immunization
- Orienting master trainers, hub-mentors, developing training calendars in coordination with the immunization division and development partners etc.
- Monitor and evaluate the "Hub-and-Spoke" model for institutional strengthening.
- Facilitate data coordination and analyzing with the partners, Government officials in 11 states

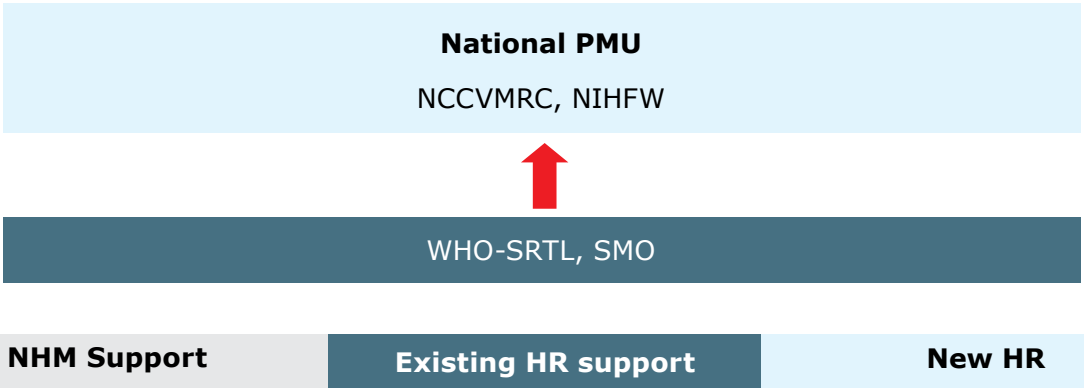
State level:

WHO through Sub Regional Team leads (SRTLs)/ Surveillance Medical Officers (SMOs) with support from other partners will provide the technical guidance for strengthening of hub and spoke model and for trainings (**Flowchart 6**).

The role will be to provide:

- Technical and operational support to multi-sectoral coordination, planning and support for project implementation at state level and district levels.
- Build strong partnerships with and support identified hubs in respective states.
- Coordinate and monitor project implementation at state and district levels over 3 years.
- Conduct training need assessment for RI at different level, plan the training calendars for State, districts & blocks, coordinate among training hubs, monitor the training sessions in terms of trainees trained against the plan, quality of training, identify training gaps and propose corrective actions for the gaps.
- Coordinate with State Government and partners to ensure that the training data is entered in the iTMIS and reported to MoHFW.

Flowchart 6: Structure for implementation of Institutionalization of RI trainings



8. Program Monitoring and Action (PMA)

Background

To reduce the number of Zero dose and under vaccinated children, there is a need to have routine monitoring mechanism on the program performance, this can be ensured by independent monitoring of the identified interventions under the Zero Dose Implementation plan and by measuring the overall outcome of this Implementation Plan i.e., reduction in the number of zero dose children and under vaccinated children. This monitoring data needs to be readily available for necessary and rapid programme action. Although data for routine immunization is captured by the Health Management Information System (HMIS), coverage surveys, concurrent monitoring and name-based registries in U-WIN, however, certain challenges like limited granularity and frequency of data availability exist. To overcome these challenges, monitoring system for generating robust and real-time data on immunization coverage in 143 high-priority zero-dose districts in the country is being developed.

The objective of the intervention is to undertake Program Monitoring and Action (PMA) for reducing zero dose burden which will be through third party. There are two components as below:

1. Program evaluation using WHO cluster survey (Annual district-level);
2. Program progress monitoring for action.

Program evaluation using WHO cluster survey (Annual and district-level for three years)

The evaluation of vaccination coverage is essential for public health management. It establishes baseline levels, tracks trends, and assesses routine vaccination service performance. Surveys identify program strengths and weaknesses, revealing community profiles, awareness levels, and motivations for adhering to the national immunization schedule. These surveys are important to measure intervention effectiveness and offer independent evaluation of program progress. Overall, such programmatic evaluations inform targeted strategies.

Description of activities: For an independent assessment of the immunization coverage levels in 143 ZIP districts in 11 states, WHO India-NPSN will support conduction of a methodical assessment of the immunization coverage levels using WHO cluster survey methodology among children 12-23 months of age in randomly selected clusters, during, 2024-2026. The survey will be done yearly for three years starting in the first quarter of 2024. The expected timeline for the proposed survey to be completed in a district would be approximately 3 months from the start of the preparations (approximately 100 days). The first round is planned for 1st quarter of 2024 will provide the baseline values, second survey in 2nd quarter of 2025 will provide a mid-term status and progress following the interventions undertaken during the previous year, and the third round during 3rd /4th quarter of 2026 will provide the final status and progress on coverage levels including FIC and zero dose prevalence and % change from the baseline values of first evaluation survey.

Program progress monitoring for action (every 6 months)

The intervention is planned to monitor progress of the selected interventions under Zero Dose Implementation Plan. This information on **6 monthly** basis will generate evidence for tailoring program action at sub-state or district levels and empower districts for taking evidence informed decisions. The intervention will plug critical data gaps and provide robust and timely data to evaluate the impact of ongoing interventions. The data will be used during various state & district review meetings such as district and state task force for immunization to take immediate corrective actions.

Description of Activities: Under this intervention, program monitoring will be undertaken using information technology enabled through independent third party to generate evidence and guide program course correction to improve immunization coverage and reduce number of zero dose children.

Supporting Partner - WHO

9. Data Analytics for Routine Immunization Review

Description of activities:

Use of immunization data for corrective action is envisioned through triangulation, validation and advanced analytics of data from various sources. The data sources, also called the Data Lake- HMIS, U-WIN, VPD surveillance, eVIN, NCCMIS, BeSD, Monitoring and Mentorship (M&M), PMA surveys, NFHS, CSO reports etc. will be used to synthesize information, triangulate the data sets, analyse & strengthen the data quality issues, and program the data for taking evidence based programmatic action.

DATA LAKE

- Monitoring & Mentorship(M&M)
- U- WIN data
- Health Management Information System (HMIS)
- eVIN data
- Behavioural insight studies BeSD survey (baseline, midline & endline)
- Program Monitoring & Action Survey (as available)
- CSO activity report
- VPD Surveillance
- Other relevant datasets for effective triangulation

The data analytics intervention also plans to support the decision makers at the district level to make informed decisions by understanding the gaps in the program implementation. Enhanced data use for reviewing and undertaking corrective measures in the RI programs of the targeted districts will further add value to the monitoring process of the zero-dose cohorts and missing communities. The two major purposes of this intervention are:

1. **Strengthening Review System to Improve Vaccination Coverage**
2. **Strengthening Data Quality to Improve Vaccination Coverage**

The details of activities to be undertaken is as follows:

1. **Strengthening Review System to Improve Vaccination Coverage:** Strengthening of Review System to Improve Vaccination Coverage is planned by enhancing usability of data and strengthening the existing decision making process. The activities that will be undertaken are as follows:

a. Enhancing usability of data

I. Ensuring Availability of Tools

- Landscaping of existing sources of immunization related data and dashboards/ bulletins.
- Analysis on availability of RI review tools/ templates and current use of data for decision making focusing on reducing zero dose at block, district and state and national level.
- Alignment of the data collected through various sources, comprehend the varied methodology adopted for collecting data and representativeness of the data.
- Co-create easy to use data backed analytical tool formats on focused RI indicators - dashboards/bulletins/checklists as needed at different frequencies and for review meetings at all levels (e.g., including finance and logistics planning, Surveillance, AEFI).
- Co-create action progress trackers, record of proceedings, and decision monitoring formats/tools to ensure better tracking of follow up activities post review meetings.

II. Capacitation and Uptake on tools

- Standard SOPs will be developed to capacitate FLWs and program managers at block, district, state and national level on usage of rolled out analytical tools.
- Capacitation of FLWs and program managers at block, district and state and national level to use these analytical tools and draw insights into regular decision-making process with a view to identify the areas with partially vaccinated and unvaccinated children and take measures to reach the same, will be undertaken.

- Institutionalization of data analytics supported Monitoring and review mechanism by creating Master Trainers/ Theme Champions at the state/district level among program managers, supervisors, and ANMs, etc.

b. Strengthening the existing decision-making process by:

I. Ensuring that timely meetings take place

- Existing review meeting platforms, participants and roles & responsibilities to be landscaped.
- Gap analysis in the review mechanism to be conducted based on prevailing scenario at block, district and state level for RI related decision-making meetings. Advocate for additional meeting platforms or frequencies, if needed.
- Ensure review meetings take place and in a timely manner at block, district, and state level across focus states as per guidelines.

II. Ensure RI is discussed, decisions are taken, and meeting is documented

- Creation of SOPs for review meeting cadence, frequency, participants and roles and responsibilities as per the guidelines.
- Define objectives, agenda and thematic areas for discussing RI indicators aimed at reducing zero dose at block, district and state level context.
- Identification of ways of collaboration with other health/education departments (MH, CH) for problem identification and integration in decision making and implantation action.
- Ensure uptake of analytical tools to drive the usage of data and facilitate qualitative insight building on zero dose identification.
- Ensure uptake of record of proceedings tools to minutize review meetings across block, district and state level.

III. Follow Up on decisions taken

- Track and monitor decisions based on the tracker tools and ensure regular follow up post review meetings.

2. Strengthening Data Quality to Improve Vaccination Coverage: Strengthening of Data Quality is planned by undertaking following activities to improve data availability, sufficiency, quality, consistency and accuracy:

Ensuring Data availability and sufficiency

Availability

- Ensure availability and uptake of standardized data recording/reporting tools with FLWs and data handlers/managers.
- Ensure availability and uptake of data reporting and management tools with program managers at block, district and state level.
- Explore external population/habitat-based data sources (ICDS, HBNC panchayat databases such as Samagra IDs, CRS) to identify and include missing beneficiaries in U-WIN through data triangulation tools.

Sufficiency

- Landscape existing RI data systems as per guidelines and prevailing data process flow from FLW & ANM to district/state.
- Conduct sufficiency and gap analysis of data systems for entire from last mile to district/state with necessary RI related components on data recording, reporting and validation mechanisms.
- Standardize pen-paper based/digital formats on data recording.
- Develop new recording/reporting formats as needed based on gap analysis (e.g., session tracking, microplans adherence, etc.)

Improving data consistency and accuracy

Data Validation Tools & Mechanisms

- Co-creation of data validation tools to identify incompleteness, inconsistencies and probable errors to improve data quality.
- Institutionalization of Data Validation Committees at block, district (D-DVC) and state level and ensure timely DVC meetings.

- Capacitation of Data Validation Committee (DVC) members at block, district and state level on validation tools and mechanisms.
- Ensure data reporting mechanism from vacant data reporting sites.
- Ensure availability of data validation mechanisms and tools with program managers at block, district and state level.
- Institutionalization of data validation mechanisms and tools with program managers at block, district and state level by creating Master Trainers at the district/ state level.

Capacity building of FLWs, Data handlers & Supervisors

- Co-creation of training modules on RI data recording and reporting processes for FLWs, ANMs and data handlers.
- Co-create supervision checklists, guidelines on corrective measures to facilitate support to FLW & ANM supervisors and ease in monitoring and supervision of data completeness.
- Capacitate FLWs, ANMs and data handlers on RI data flow, standardized recording mechanisms and reporting processes.

Capacity building of Program Managers

- Co-creation of training modules on data reporting and analysis, roles & responsibilities for program managers.
- Co-create mechanisms to enable and empower district/block program managers to facilitate support in identifying data inconsistencies and inaccuracy.
- Capacity building of program managers on RI data flow, reporting mechanisms and processes, new data tools and templates.

Interventions:

Strengthening the review mechanism viz. STFI, DTFI, Block (at state, district, and block levels) review through data-based feedback, by triangulation of data from various sources for programmatic performance analysis and tracking the progress of the project from national to sub-district level.

Capacity building of state RI cell staff, NHM staff, and data handlers at national (Immunization Division/ITSU), state, district, and block levels on building of data summaries, bulletins using programmatic indicators through tools and trainings to improve data processes.

Dashboards and reports for detailed strategic planning and monitoring of new initiatives on system strengthening and introductions from national down to SHC / VHSND level for ease of visualization and understanding.

Implementation Plan:

Under this intervention, one District Nodal Person for data analytics is being provided to work in close association with the District Immunization Officer. The Nodal person will support to ensure conduction of monthly Routine Immunization review meetings under the District Immunization Officer (DIO) wherein participation of all the implementing stakeholders like existing routine immunization structure through NHM or existing partners etc., U-WIN coordinator, Divisional consultant for Monitoring & Mentoring and CSO engagement, WHO – SMO/ RRT/ UFP, Vaccine and Cold-Chain Manager, CSO engaged for the district and others needs to be ensured. Participation of training Nodal at state level will be desirable. Participation of RISE consultant also needs to be ensured if the district is underway of rolling out RISE platform.

Purpose of this meeting is to review the Routine Immunization Program with special focus on the progress made under the various interventions being supported through the Zero Dose Implementation plan. The same can be adapted to the local context and needs.

The district level support being provided under this intervention will provide a landscape view of the current situation of all aspects

of the immunization program including the immunization coverage, details of areas of low immunization coverage, microplanning, adherence to microplanning, status of registration of U-WIN, status of training, status of supply chain of vaccines and logistics, community feedback, field level observations, VPD surveillance report, survey reports and findings etc, to enable the District Immunization Officer to understand the gaps, picture the solution in consultation with the entire immunization team and take corrective measures accordingly. During these reviews, in addition to the programmatic indicators, indicators pertaining to data quality also need to be reviewed, viz. Data Quality Assessment or other processes of a similar nature.

Similar type of landscaping and situation analysis needs to be reviewed in the DTFI with suggested corrective measure so that concrete actions can be taken to improve the immunization coverage of the area.

The action points that will emerge from the district level review meeting and DTFI will be captured by the District Consultant (under this intervention) in a predefined format. Follow up and facilitation for execution of the action points will be ensured by the District Consultant (under this intervention). Action Taken report on all the actionable points will be reviewed at the respective discussion platforms in every follow up meeting. The consolidated action taken report for all the districts under the Zero Dose Implementation Plan will also be reviewed at the STFI Meetings and the National Pre-IAG and IAG meetings.

Support on the same lines will be provided in the 11 focus states to the state programme and health leadership for programme planning, review, and decision-making across the above-mentioned aspects of RI and RI programme review and data processes.

This intervention will be guided and reviewed by Community of Practice on Immunization Data which will be instrumental in decision-making, review, and process improvement under the aegis of the Immunization Division and is detailed out in the Review Mechanism section of this implementation plan.

New Support being provided:

Supporting Partner: UNDP

The role of district level personnel: Support the district officials and block stake holders to review the various programs by conducting regular analysis and reviewing the available data and present to the district and block stake holders.

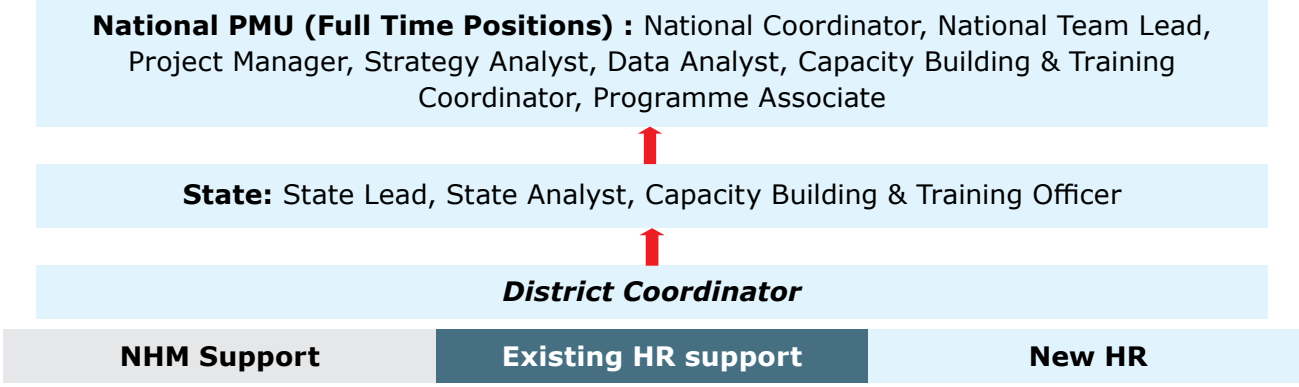
Facilitate review of missed RI session and support in planning of alternate sessions on time.

Regular follow up and tracking of action points and decisions made in review meeting platforms across levels. And ensure that action points and decisions made implemented as required by supporting and facilitating issuance of guidelines by the district time to time.

Enable and empower program functionaries to conduct regular RI data quality check, data analysis and use it to decision making by supporting them on the use of data analytics tools and template

Regularly support and supervise activities at the session site, block and district level to identify challenges in data quality.

Flowchart 7: Structure for implementing Data Analytics for RI Review



Regularly engage with healthcare workers and block/district officials, and address gaps through coordination with the overall immunization team and concerned government officials (**Flowchart 7**).

All proposed HR support at all levels will be catalytic in nature and is not intended to be transitioned to the government budget lines unless expressly asked for by the government; all competencies will be transitioned to existing government / UIP personnel through continuous capacity building over the course of the project.

10. Community of Practice on Demand

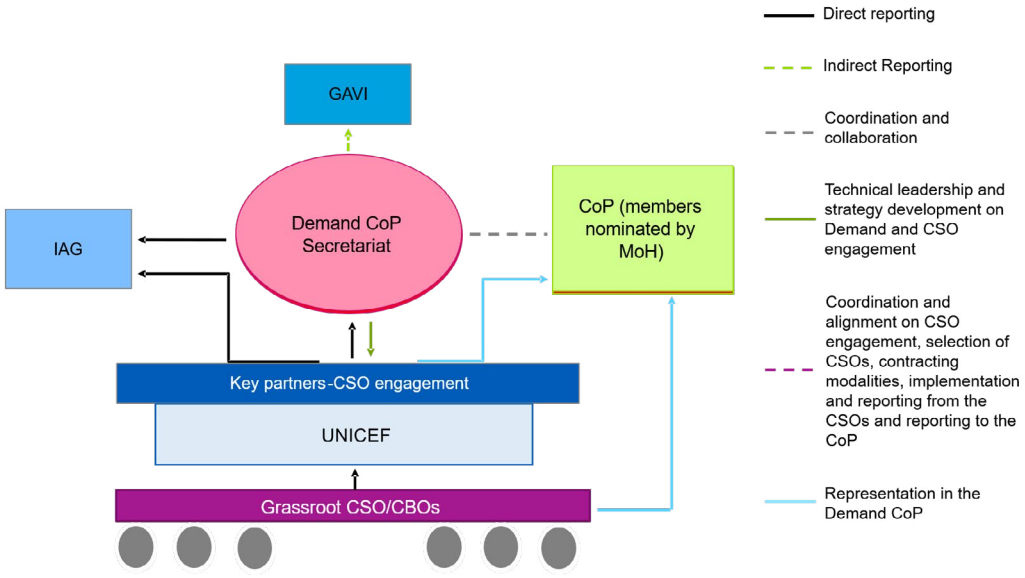
Description of activities:

ZIP approach has a strong and intentional focus on demand generation and social and behaviour change during this strategy period. The plan is to focus on setting and operationalizing an inter-connected and comprehensive ecosystem on demand and CSO engagement geared towards impact, systems strengthening, muti-sectoral convergence and sustainability, with a clear and strong connection with the overall governance and delivery mechanism. A visual of the demand and CSO engagement ecosystem, developed through the consultative process, can be seen in **Flowchart 8**.

Salient features on the Demand CoP-CSO engagement ecosystem

- A Communities of Practice secretariat will be set up to support MoHFW and partners with experience in public health and specifically in immunization program, along with experience in social & digital marketing, research, behaviour change and monitoring, learning & evaluation. This would be a catalytic element in the entire system, geared towards shifting away from the usual traditional approaches at demand generation. The CoP secretariat will provide technical leadership, operational guidance and coordination within the entire ecosystem, reporting into IAG, MoHFW and Gavi.
- The CoP secretariat, will anchor the Community of Practice on Demand (CoP-Demand) which is envisioned as a group of nominated technical and immunization experts, and will also include CSO representatives involved in community engagement, other department etc. The CoP- Demand will inform appropriate and context-specific program design and interventions for demand in different geographies and sub-population based on the behavioural insights of the barriers driven from systematic desk review data and formative research studies (both qualitative and quantitative information in selected regions and cohorts of the project-districts) and establish a human-centred

Flowchart 8: Vision on the Demand CoP-CSO-ecosystem Functioning



design (HCD) approach. The overarching approach of CoP- Demand will be to guide development of demand strategy and ensure coordinated implementation of all demand-related interventions.

- The CoP secretariat will bring in latest social and behavioural change thinking, using an evidence-based approach to design interventions, the impact of which will be measured by an independent evaluation. The CoP secretariat will also drive a strong learning and monitoring agenda and drive inter-sectoral linkages through the entire development phase.
- The CoP secretariat will also lead on proof-of-concept pilots and utilize social data in selected places which can test and inform interventions for addressing gender disparities and mainstreaming gender with immunization, and will be, finally tailored to undertake gender-responsive approaches in the project. The CoP secretariat will introduce robust monitoring system through IT-based support to keep the implementing partners and CSO constantly informed about the progresses, bottlenecks, gaps, and immediate course correction requirements.
- As shown in the visual above, the CoP secretariat will feed into the CSO engagement strategy and ensure coherence in the demand system. The CSO engagement approach would be based on evidence with an intention of maximizing reaching zero dose population and missed communities, by focussing on strengthening community level structures, elected representatives, youth volunteers, front line health workers, local champions, and using them as a lever to reach parents and caregivers through defined contact sessions beyond just typical messaging, to facilitate and to ensure that the ZD children reach the service delivery sites. The big shift is moving away from an external community mobilisation approach to working from within the community, so that the sustainability of the investments can live longer.
- This approach through the CoP and CSO engagement will also work through looking at the existing gender barriers in the communities and applying tailored interventions based on evidence and insights, to overcome these barriers through a cohesive demand generation approach. Additionally, this will create a strong base for HPV introduction in terms of community readiness.
- UNICEF in consultation with state health authorities will work across the geographies under the technical leadership and directives of the CoP secretariat, to steer this massive shift.
- The onboarded CSOs in their respective districts, will then work at the community level. The focus would be on selecting CSOs who are embedded or well versed with the communities and have trustworthy and credible relationships with the community.
- The representatives of these grassroot CSOs will be a part of the CoP nominated by the MoHFW. This will ensure a strong element of grassroot-up advocacy, ownership, and accountability at all levels.
- The CSO engagement process will adhere to common parameters from an end-to-end perspective, deliverables, monitoring, and reporting. The technical and the programmatic oversights of this will be led by the CoP secretariat, under guidance from the MoHFW and IAG.

Activities:

The CoP will:

- With the approach to ensure coherence in the demand system the CoP will drive the technical agenda on demand and provide technical guidance to all immunization teams in the country from Central to State to Village level.
- The CoP will test proof-of-concept pilots to feed into intervention design. The CoP shall seek to synergize its learnings through pilot interventions for specific target groups/ communities and suggest standardized solution templates for nation-wide application. Along with this the pilot interventions will also conceptualize, assimilate and systematize various delivery channels for sustainability and scale.
- The CoP will integrate human-centered design (HCD) research to identify and address zero dose and full immunization specific barriers to guide potential solutions.

- Utilize social data to inform interventions for addressing barriers to immunization for identified priority population groups by using gender lens, deprivation lens of marginalized communities.
- Develop demand side strategies for new vaccine introductions.
- CoP will develop and design tailored, and context specific behaviour change tools, assets, and knowledge products to support interventions.
- CoP will create an accountability and results framework to drive impact on the ground through the grant recipients.
- It will also facilitate generation of behavioral insights regarding specific communities/ geographies to feed into interventions, and regularly assess effectiveness of and evaluate activities on demand through third-party engagement.
- The CoP will be a centre of excellence to create scientific result-based strategies and contextual behaviour intervention tools to achieve desired results.

The CoP Secretariat will function as the techno managerial support to anchor the functioning of CoP- Demand and also undertake the following activities:

- Support in the development of demand strategy and coordinate the implementation of all demand-related interventions, including civil society organization (CSO) engagement.
- Behavioural Insight (BI) Studies
- Human Centred Design (HCDs) Pilots
- Development of Creative Communication Assets and Behavioral Aids
- Communication assets in vernacular languages
- Undertaking proof of concept pilots
- **Urban intervention 40 cities:** The geographical and socio-cultural diversities across the focused states and targeted sub-populations generally determine variations in the social and behavioural barriers to immunization. This knowledge is critical to design tailor-made interventions for different contexts of the zero-dose cohorts to enhance demand for the RI services and continue refining the interventions in course of the grant with the support of monitoring data and key observations made during the intermittent evaluation surveys.

New Support being provided:

Supporting Partner: UNDP

Refer to **Flowchart 9** for structure

Flowchart 9: Structure for implementing CoPD

11. Behavioural and Social Drivers (BeSD) Survey:

To improve the uptake of preventive health services, it is critical to understand community's perceptions and the determinants of community's health seeking behaviour. Similarly, to understand the reasons for low vaccination uptake, it is important to understand that what people are thinking and feeling, their motivation, and the social processes and practical issues that drive or hinder vaccination to develop evidence-informed strategies that increase uptake. This process enables programs to design, target and evaluate interventions to achieve greater impact with more efficiency and to examine and understand trends over time.

While many factors affect uptake, the behavioral and social drivers (BeSD) tools focus primarily on proximal factors that are measurable in individuals, specific to vaccination and potentially changeable by programs. Assessing said drivers of vaccination could also be useful to understand why communities including children remain unvaccinated against vaccine-preventable diseases.

Partner (WHO-NPSN) will be supporting to conduct a Behavioral and Social Driver (BeSD) assessment among community actors to identify reasons for low uptake, enablers and related barriers and scope of improvement. This assessment will help capture direct insights from the community which will help better formulation and customization of community engagement and demand generation intervention.

The BeSD assessment will act as a value addition to the M&M tool (which captures only 5 priority questions), as the assessment captures:

- Community perspective on the influence of religious/community leaders on decision making, caregivers' satisfaction, mothers' autonomy, multipronged social reasons of low access, etc. which are not covered in the scope of concurrent monitoring.
- Periodic insights from caregivers, DIOs, FLW and influencers/leaders in order to engage communities in deriving root cause analysis and informing interventions.
- Insights from a wider base of respondents by targeting caregivers of 0-5 years of children vis-à-vis caregivers for 0-2 years of children as under M&M program.

Supporting Partner: WHO

Chapter 7:
Human Resource Structure

Understanding the Human Resource (HR) structure will be instrumental in taking forward the envisaged activities under each of the project activities. The overarching principle will be to utilize the existing resources for Immunization most effectively while ensuring no duplication of effort and no wastage of resources. Some of the guiding principles for HR engagement are as follows:

- **The HR supported under HSS-3 is for project only & no HR under HSS-3 will be taken forward.**
- **Human Resource Recruitment:** To ensure 50% Gender ratio & local sensitivities
- HR visibility- During periodic reviews (validated by DIO)
- HR attrition to be monitored & shall be< 5%
- All HR to be recruited within Quarter 1 of initiation (wherever applicable)
- All training budgeted under HSS 3, to be ensured in year 1 of initiation.
- Field level HR poaching to be avoided

The HR being supported under ZIP will be tracked through a Management Information System for which a Partner Mapping Tool (PMT) has been developed. The PMT will capture the recruitment status and the vacancy status for all the positions at all levels from block, district, division, state and National level. The same will be reviewed under the quarterly Immunization Action Group (IAG) meetings under the chairpersonship of AS & MD (NHM) & Co-chairpersonship of JS (RCH).

Partner Mapping Tool

Background:

Under Universal Immunization Program, numerous immunization development partners are engaged in relentless efforts to implement India's routine immunization programs. These partners have positioned human resources across various levels: National, State, Regional, District, and Block. While each partner is aware of their allocations, real-time information about their deployments/vacancy is not readily accessible to the Ministry of Health and Family Welfare (MoHFW), States and Districts. This data is crucial for strategizing field plans for routine immunizations and optimizing the use of resources provided by these partners, more so with the roll out of the Zero Dose Implementation Plan.

Currently, the MoHFW is updating information about the human resources deployed by development partners, but this process is manual, relying on Excel-based line lists, and is contingent on traditional communication methods like calls or emails. Consequently, there is often a discrepancy between the actual support provided and the information available to the MoHFW, as it lacks real-time updates.

Another significant challenge is the limited information regarding field employees supporting the routine immunization program. Basic details such as names and contact information are inadequate for efficient and effective utilization. Access to comprehensive information, including roles and responsibilities, funding sources, core verticals, qualifications, and contract durations, could transform these basic details into a powerful planning tool.

With these considerations in mind, the MoHFW envisioned the development of a partner mapping tool.

Description of tool: The Partner Mapping Tool (PMT) has been innovatively designed to equip the Ministry of Health and Family Welfare (MoHFW) and States with comprehensive information about the human resources deployed by various development partners. By aggregating this data, the PMT offers MoHFW a detailed panorama of the available human resource support, enabling them to make informed decisions and optimize resource allocation.

In this system, every development partner is assigned secure individual user credentials. Each partner is then responsible for regularly updating the PMT web application with detailed, name-wise human resource information. This encompasses not only basic contact details and duty stations but also extends to intricate roles, core verticals, additional responsibilities, funding sources, contract durations, and other pertinent data.

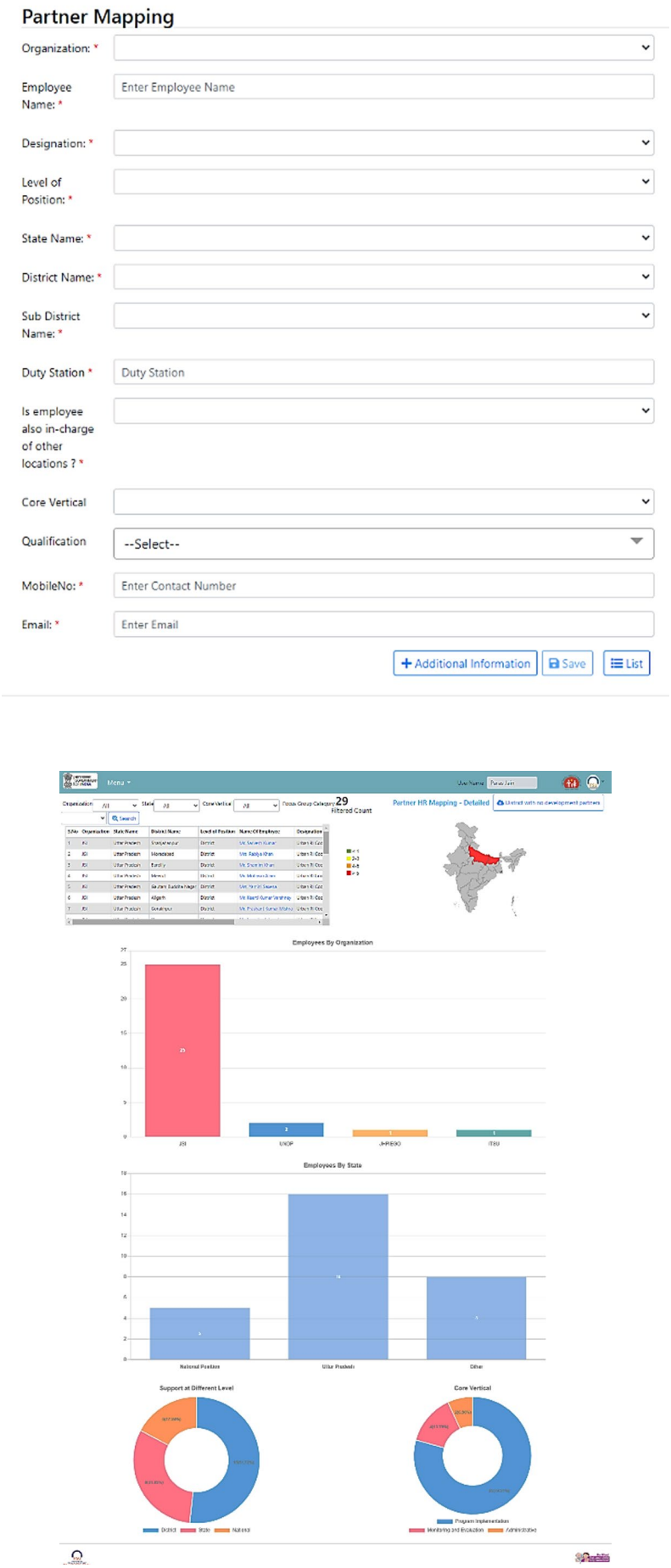
Furthermore, the PMT serves as a valuable analytical tool for the development partners themselves. It provides them with comprehensive insights into their human resource allocations, thereby enhancing their capability to track and manage their contributions more effectively. This tool is instrumental in bolstering the efforts of development partners, who are dedicated to enhancing immunization services and fortifying health systems at the grassroots level.

Key Features of the PMT:

- **Secure Access:** The PMT ensures security by providing individually secured user credentials for each participating development partner or organization.
- **Name-wise HR Form:** The HR information forms within the PMT are designed to be customizable, user-friendly, and intuitive. This facilitates easy and accurate data entry, allowing development partners to efficiently input data.
- **Comprehensive Employee Listings:** Users at both the individual and national levels can generate detailed lists of employees, encompassing various dimensions such as organization, state, district, position level, and core vertical.
- **Focus-Group Categorization:** A unique feature of the PMT is its focus-group category. Users can create customized groups based on state, district, or block, which can then be utilized as filters for more targeted analysis throughout the tool. For instance, a group like the 143 ZIP districts can be a specific focus group.
- **Real-Time Data Dashboard:** A standout feature of the PMT is its real-time data dashboard. This innovative aspect visualizes the entered data on a Geographic Information System (GIS) map, enabling quick and insightful graphical representations of various key indicators. This feature is pivotal in providing a comprehensive and immediate understanding of human resource deployment across different regions.

Supporting Unit: The Partner HR Mapping tool has been developed by the Immunization Technical Support Unit, in close collaboration with the MoHFW department. The immunization development partners will be updating the portal on real time basis. The information from the Dashboard will be reviewed at the Pre IAG & IAG platforms to assess the human resource placement status. A snapshot of the PMT tool is given in **Figure 19**.

Figure 19: Snapshot of Partner Mapping Tool



Chapter 8:
Review Mechanism

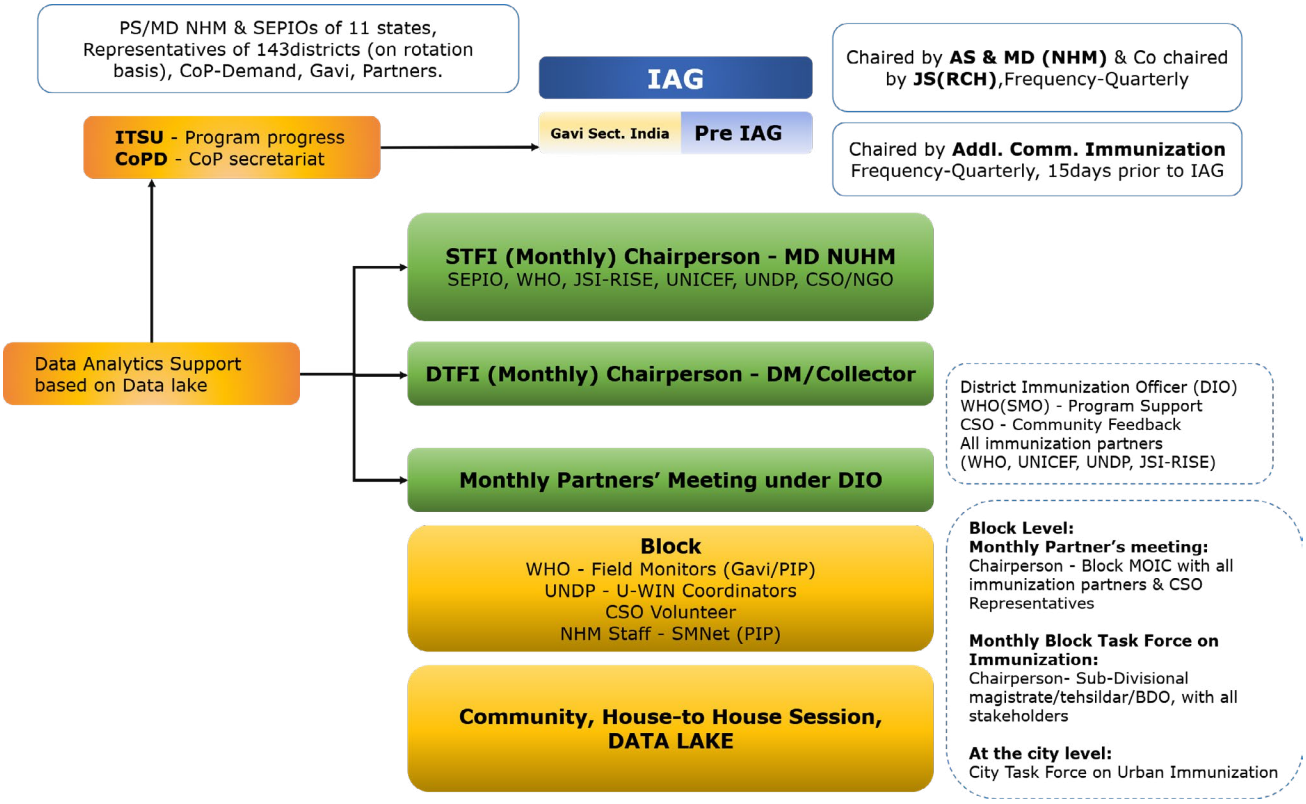
Regular and effective reviews will be the essence of the entire Zero Dose Implementation Plan (ZIP). Immunization coverage data as reported through HMIS, national surveys, U-WIN and Monitoring & Mentoring will be triangulated periodically to identify areas with high number of zero dose/unvaccinated and partially vaccinated children. Insights gathered from other interventions like CSO engagement, survey findings, community monitoring will be reviewed comprehensively to suggest evidence based actionable points. The relative levels and the quarterly changes in session site, household and community-based monitoring indicators will be used to geographically target the immunization services, quality of interventions and evaluate the CSO performances at the identified zero-dose sites. In terms of accountability and reporting mechanisms, the following will be the framework:

- **At the Block Level:**
  - **Monthly Partner's meeting** Under chairpersonship of Block Medical Officer in Charge supported by data analytic intervention, with participation from all immunization partners (WHO, UNICEF, UNDP, JSI-RISE) and CSO Representatives.
  - **Monthly Block Task Force on Immunization:** Under the chairpersonship of Sub-Divisional magistrate/Tehsildar/(Block Development Officer) BDO, with all the stakeholders, other concerned departments and partner agencies.
- **At the city level:**
  - **City Task Force on Urban Immunization:** For Metro cities and cities where urban local bodies are the implementing authority for NUHM to be constituted under the chairpersonship of Executive Officer of the municipality.
- **At the district level:**
  - **Monthly Partner's meeting** Under chairpersonship of District immunization Officer (DIO) supported by data analytic intervention, with participation from all immunization partners (WHO, UNICEF, UNDP, JSI-RISE) and CSO Representatives.
  - **Monthly District Task Force on Immunization:** Under the chairpersonship of District Magistrate (DM), with all the stakeholders, other concerned departments and partner agencies.
  - The data analytic intervention project will support the review meetings with data triangulation and data analytics.
- **At the state level:**
  - **Monthly State Task Force on Immunization:** Under the chairpersonship of Mission Director (National Health Mission). The data analytic intervention project will support the review meetings with data triangulation and data analytics.
- **At the National Level:**
  - **Quarterly Meeting of Pre Immunization Action Group (Pre IAG):** Every Quarter, progress of the activities under ZIP will be reviewed by the Pre IAG (15 days prior to IAG meeting), chaired by the Additional Commissioner (UIP) with representation from partners, CSOs and Gavi Secretariat-India (with

support from ITSU). The objective of this meeting will be to review the progress of all the interventions under the project against pre-set indicators, for mid-course correction. This platform of review is critical for bringing together the proceedings of CoP Demand also.

- **Quarterly Immunization Action Group (IAG) and quarterly programmatic and financial reporting:** The project implementation will be reviewed quarterly by the Immunization Action Group, which will be chaired by the Additional Secretary & Mission Director (NHM) and co-chaired by Joint Secretary (RCH). The IAG will have representation of Mission Directors of all the high priority states, representation from all the implementing partner organizations, representatives of some CSOs/ NGOs, CoP- Demand and Gavi Secretariat-India (with support from ITSU). Detailed ToRs of IAG are placed at **Annexure 8**.
- For this review, State program officers will partcipate in quarterly IAG and will share accountability for progress made. Participation of the District immunization officers will be ensured on a rotational basis, such that all the 143 Districts are represented at least once during the project period. Virtual mode may be used for such participation. Gavi Secretariat representatives will attend physically when feasible.
- These meetings will serve as the main forum for monitoring progress and course-correction. They will provide a regular opportunity to understand risks and challenges, agree on priorities and identify any changes that may need to be made. Similarly, quarterly programmatic and financial reporting from grant recipients will also be undertaken.
- The standardised reports which include updates on financial utilisation, key metrics (which will extend beyond the grant linked KPIs noted above and are linked to standardised dashboard to be used at national and State level for monitoring purposes), progress on activities and description of challenges / barriers experienced (both programmatic and financial) will be utilized for the quarterly IAGs as well as annual reviews (**Flowchart 10**).

Flowchart 10: Review Mechanism of IAG/Pre-IAG



- **Monitoring plan:** A regular monitoring mechanism including monthly field visits followed by feedback to the state and national level will be operationalised. Facilitation of required interventions and rapid assessment of the requirement of similar interventions in the districts beyond the intervention areas and action accordingly will also be mandated by the IAG and discussed during the review meetings.
- **UIP Review of states:** Progress of the interventions will be reviewed at all platforms of Regular state/ regional review of the Universal Immunization program.
- The human resource placement of all immunizations partners with their presence at national, state, district and block levels will be mapped. A partner mapping digital tool has been developed for this purpose and has been detailed in the previous chapter.

Establishing synergies:

ZIP will be implemented by a consortium of MoHFW-Gavi secretariat, national and sub-national program managers, partners, CSOs and community players. The team members of the consortium will play complementary roles to each other with a well-defined synergy, plan and coordination which will enhance the effectiveness of the project-interventions to reach the objectives outlined.

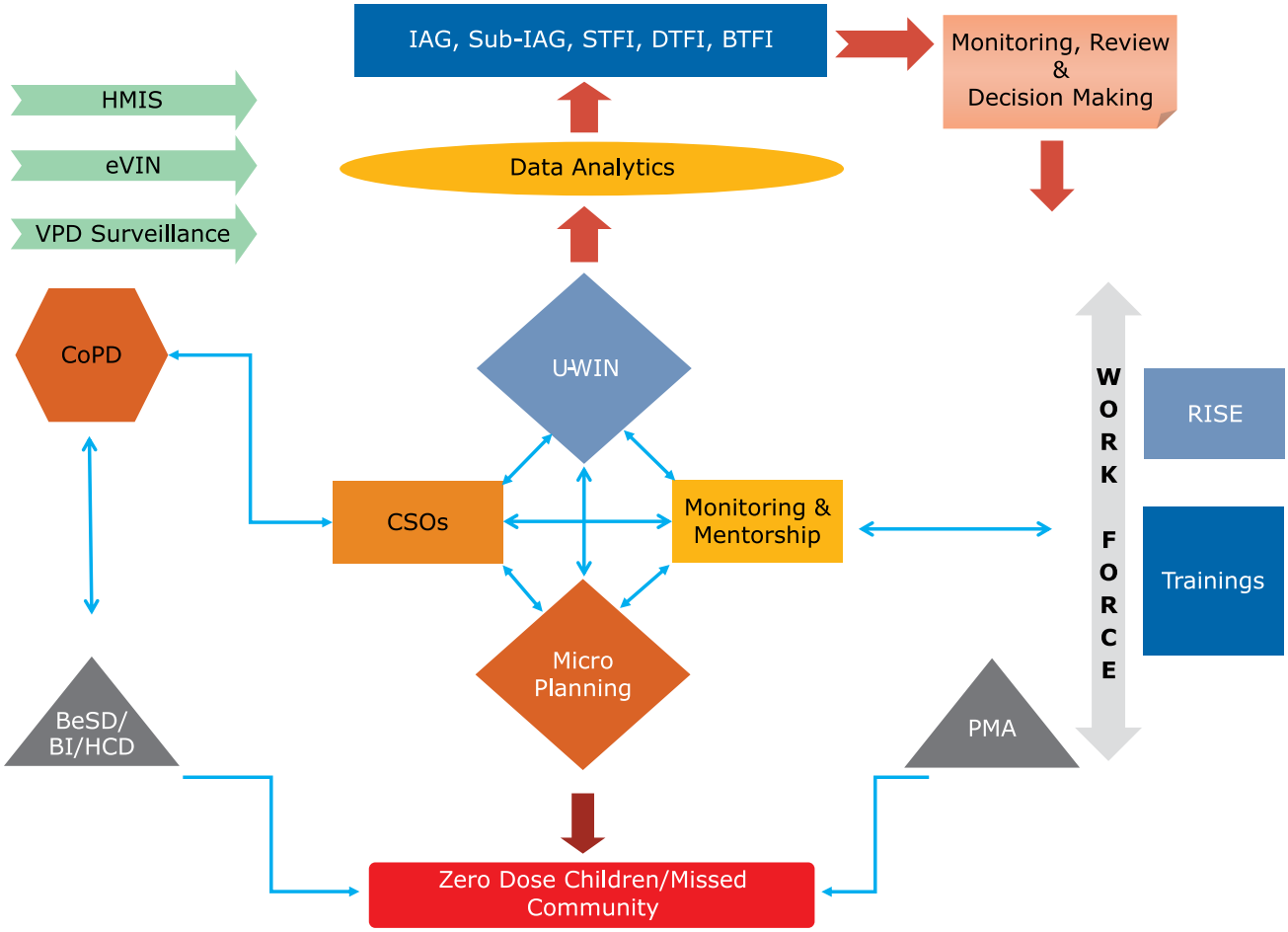
To further synergize the activities under ZIP, Gavi Secretariat-India (with support from ITSU) based at Immunization Division of MoHFW, will work to review, assess the impact of activities allotted to Immunization partners in these identified districts, prepare the progress report and share with MoHFW. Progress on laid out input, process, output and outcome indicators will be consolidated in consultation with all the implementing agencies and the same will be reviewed in the Pre IAG and IAG for relevant action. The data analytic intervention team will support in the assimilation of data points and field findings e.g., Conducting STFI/DTFIs, quality of review meetings, field monitoring reports etc., triangulation of such data points with existing program data sets and infer actionable information for review by Pre IAG and IAG.

The activities under CoP Demand will also be conducted in synchrony with other activities under the program and the findings of the various interventions under this CoP Demand will be integrated at this platform for further escalation to Pre IAG and IAG.

Efforts will also be made to replicate the learnings from the intervention districts to other parts of the country as well as synchronise the other UIP activities with the interventions in the ZIP districts.

ZIP will also ensure optimum and rationalized distribution and utilization of its resources to value the multi-donor initiatives in RI program (**Flowchart 11**).

Flowchart 11: Establishing synergies: Flow of Information



Chapter 9:
Leveraging ZIP Interventions for Nationwide RI Strengthening

The interventions being undertaken in the 143 high impact districts under ZIP will be leveraged to strengthen routine immunization across the nation. The renewed focus on areas with low immunization coverage as identified by the analysis for the Zero Dose children will also help in reaching out to the partially vaccinated children. The lessons learnt from the implementation of interventions in select geographies will be replicated and used for expansion to other geographies, as has been done in the past.

The interventions planned under this partnership are in true sense health systems strengthening interventions, wherein in addition to reaching the Zero Dose children, the systems will be capacitated to reach each and every child with all doses of vaccines under UIP, as per the National immunization Schedule. The targeted interventions will also provide impetus to the shift towards focusing on delivery of quality immunization services.

U-WIN: The Electronic Immunization Registry, U-WIN will not only help to reach and connect the Zero Dose children to the health systems but also ensure full and timely vaccination of all children and pregnant women. The U-WIN platform will be instrumental in integrating the immunization services with the PHC services. Realizing the criticality of U-WIN, the intervention is being undertaken with a pan India scope and is not restricted to the 143 high impact districts.

Improved & Inclusive Microplanning: CSO engagement, data analytics and M&M intervention will help in bringing the left-out population into the system by including them in the microplan and reach them with all the health care services including the Immunization services.

Monitoring & Mentorship: Based on the already existing concurrent monitoring & supportive supervision activity under Universal Immunization Program (UIP), with enhanced focus on the mentoring the ANMs and VCCHs. This is a critical intervention to provide feedback on the progress of the program, rectify gaps and improve knowledge & skills of field level health functionaries on-the-job.

CSO Engagement: CSO Engagement has been well identified as a critical initiative for voicing the concerns of the community and making the immunization service delivery more responsive and acceptable to the community. The experience with the CSO engagement will help in replicating the same in other areas and developing a sustainable model.

BeSD: The surveys planned under ZIP will give insights on the behavioural and social drivers for immunization which will enable evidence to policy decisions for impactful communication strategy.

CoP-Demand: The structure of CoPD which is envisaged as the think tank for demand activities, will not only steer the Demand and Community mobilization agenda for the high impact districts, rather will guide the communication policy of UIP.

Strengthening of Review Mechanism & Data analytics: The intervention to strengthen data analytics will not only be restricted to the high impact districts, but also strengthen the capacities of national and sub national staff to equip them to use data for action. The planned increase in robustness of review mechanism will enable overall UIP strengthening.

Strengthening the Training platform under UIP & RISE: The capacity building initiative is not restricted to the 143 high impact districts. The intervention to institutionalize the capacity building intervention will have a complete state approach. The RISE platform is envisaged to have a pan India expansion. All efforts will be made to assess the feasibility of incorporating the lessons learnt in the Annual PIPs, supporting the states in proposing PIPs, facilitating in the implementation of the proposed interventions and review the progress made in the proposed interventions in the PIPs.

Annexures

Annexure 1: Immunization Agenda (IA) 2030 - Goal, Indicators & Targets

Impact Goal		Indicator	2030 Target
1.Prevent Disease: Reduce mortality and morbidity from vaccine-preventable diseases for everyone throughout the life course	Save lives	1.1 Number of future deaths averted through immunization	50 million future deaths averted globally
	Control, eliminate & eradicate VPDs	1.2 Number and % of countries achieving endorsed regional or global VPD control, elimination and eradication targets	All countries achieve the endorsed regional or global VPD control, elimination and eradication targets
	Reduce VPD outbreaks	1.3 Number of large or disruptive VPD outbreaks	All selected VPDs have a declining trend in the global annual number of large or disruptive outbreaks
2. Promote Equity: Leave no one behind, by increasing equitable access and use of new and existing vaccines	**Leave no one behind**	**2.1 Number of zero dose children**	**50% reduction in the number of zero dose children at country, regional, and global levels**
	Provide access to all vaccines	2.2 Introduction of new or underutilized vaccines in low and middle income countries	500 vaccine introductions
3. Build strong immunization programmes: Ensure good health and well-being for everyone by strengthening immunization within primary health care and contributing to universal health coverage and sustainable development	Deliver across the life course	3.1 Vaccination coverage across the life course (DTP3, MCV2, PCV3, HPVc)	90% global coverage for DTP3, MCV2, PCV3, and HPVc
	Contribute to PHC/UHC	3.2 UHC Index of Service Coverage	Improve UHC Index of Service Coverage at country, regional, and global levels

Annexure 2: List of Districts identified for ZIP

s. no.	State	Count of District/ Cities*	District
1.	**Arunachal Pradesh**	12	Longding, West Kameng, East Siang, East Kameng, Papumpare, Lower Subansiri, Changlong, Siang, Namsai, Upper Subansiri, Kamle, Upper Siang
2.	**Bihar**	25	Champaran West, Champaran East, Darbhanga, Purnia, Sitamarhi, Araria, Katihar, Bhojpur, Patna, Begusarai, Madhubani, Kishanganj, Nalanda, Supaul, Saharsa, Nawada, Bhagalpur, Saran, Vaishali, Gaya, Madhepura, Siwan, Munger, Jamui, Banka
3.	**Haryana**	1	Nuh
4.	**Jharkhand**	1	Sahebganj
5.	**Madhya Pradesh**	15	Gwalior, Shivpuri, Morena, Barwani, Sehore, Vidisha, Rajgarh, Mandsaur, Balaghat, Damoh, Singrauli, Rewa, Bhind, Panna, Satana
6.	**Maharashtra**	4	Pune, Nasik, Thane, Gr. Mumbai
7.	**Meghalaya**	7	North Garo Hills, East Khasi Hill, West Khasi Hill, West Jaintia Hills, East Garo Hills, Ri-Bhoi, South West Khasi Hills (new district)
8.	**Mizoram**	1	Lawngtlai
9.	**Nagaland**	1	Mokokchung
10.	**Rajasthan**	16	Alwar, Jodhpur, Bikaner, Bharatpur, Barmer, Churu, Bhilwara, Nagaur, Sikar, Jaipur, Jalor, Udaipur, Ajmer, Sawai Madhopur, Rajsamand, Jaisalmer
11.	**Uttar Pradesh**	60	Kanpur(Nagar), Jaunpur, Kushinagar, Gorakhpur, Deoria, Ballia, Allahabad, Unnao, Kheri, Lucknow, Bareilly, Bijnor, Ghazipur, Maharajganj, Aligarh, Sitapur, Moradabad, Banda, Pilibhit, Ambedkar Nagar, Ferozabad, Meerut, Barabanki, Bulandshahar, Amroha, Ghaziabad, Gonda, Azamgarh, Amethi, Bahraich, Etah, Shahjahanpur, Hathras, Farrukhabad, Raebareli, Saharanpur, Badohi, Varanasi, Hardoi, Chandauli, Kasganj, Sultanpur, Basti, Jalaun, Siddharthnagar, Baghpat, Kanpur(Dehat), Balrampur, Kannauj, Jhansi, Fatehpur, Badaun, Etawah, Hamirpur, Mirzapur, Chitrakoot, Sonbhadra, Kaushambi, Mathura, Gautam Buddh Nagar
	Grand Total		**143 across 11 states**
Note:- U-WIN will be Implemented across all districts of India.			

Annexure 3: Mapping of NUHM cities under ZIP districts

s. no.	State	Districts	NUHM Cities
1.	Arunachal Pr.	East Siang	Pasighat
2.	Arunachal Pr.	Papumpare	Itanagar
3.	Bihar	Begusarai	Begusarai
4.	Bihar	Bhagalpur	Bhagalpur
5.	Bihar	Bhojpur	Arah (Bhojpur)
6.	Bihar	Champaran East	Motihari (East Champaran)
7.	Bihar	Darbhanga	Darbhanga
8.	Bihar	Gaya	Gaya
9.	Bihar	Katihar	Katihar
10.	Bihar	Munger	Munger
11.	Bihar	Nalanda	Biharsharif (Nalanda)
12.	Bihar	Nawada	Nawada
13.	Bihar	Patna	Patna
14.	Bihar	Patna	Danapur
15.	Bihar	Purnia	Purnea
16.	Bihar	Saharsa	Saharsa
17.	Bihar	Saran	Chapra (Saran)
18.	Bihar	Siwan	Siwan
19.	Bihar	Vaishali	Hajipur (Vaishali)
20.	Jharkhand	Sahebganj	Sahibganj
21.	Madhya Pradesh	Balaghat	Balaghat
22.	Madhya Pradesh	Barwani	Sendhwa
23.	Madhya Pradesh	Barwani	Barwani
24.	Madhya Pradesh	Bhind	Bhind
25.	Madhya Pradesh	Bhind	Gohad
26.	Madhya Pradesh	Mandsaur	Mandsaur
27.	Madhya Pradesh	Morena	Morena
28.	Madhya Pradesh	Singrauli	Singrauli

s. no.	State	Districts	NUHM Cities
29.	Madhya Pradesh	Damoh	Damoh
30.	Madhya Pradesh	Gwalior	Gwalior
31.	Madhya Pradesh	Gwalior	Dabra (Pichhore)
32.	Madhya Pradesh	Panna	Panna
33.	Madhya Pradesh	Rajgarh	Biaora
34.	Madhya Pradesh	Rewa	Rewa
35.	Madhya Pradesh	Satana	Satna
36.	Madhya Pradesh	Sehore	Sehore
37.	Madhya Pradesh	Sehore	Ashta
38.	Madhya Pradesh	Shivpuri	Shivpuri
39.	Madhya Pradesh	Vidisha	Vidisha
40.	Madhya Pradesh	Vidisha	Basoda
41.	Madhya Pradesh	Vidisha	Sironj
42.	Maharashtra	Gr. Mumbai	Mumbai
43.	Maharashtra	Nasik	Nashik
44.	Maharashtra	Nasik	Malegaon
45.	Maharashtra	Nasik	Manmad
46.	Maharashtra	Nasik	Sinnar
47.	Maharashtra	Nasik	Deolali Cantonment Board
48.	Maharashtra	Pune	Pune City
49.	Maharashtra	Pune	Pimpri Chinchwad
50.	Maharashtra	Pune	Khadki Cantonment Board
51.	Maharashtra	Pune	Pune Cantonment Board
52.	Maharashtra	Pune	Lonavala
53.	Maharashtra	Pune	Talegaon Dabhade
54.	Maharashtra	Pune	Dehu Road Cantonment Board
55.	Maharashtra	Pune	Baramati
56.	Maharashtra	Thane	Thane
57.	Maharashtra	Thane	Kalyan Dombiwali

s. no.	State	Districts	NUHM Cities
58.	Maharashtra	Thane	Navi Mumbai
59.	Maharashtra	Thane	Mira Bhaindar
60.	Maharashtra	Thane	Bhivandi Nijampur
61.	Maharashtra	Thane	Ulhasnagar
62.	Maharashtra	Thane	Ambarnath
63.	Maharashtra	Thane	Badlapur
64.	Meghalaya	East Khasi Hill	Shillong
65.	Meghalaya	West Jaintia Hills	Jowai
66.	Meghalaya	West Khasi Hill	Nongstoin
67.	Nagaland	Mokokchung	Mokokchung
68.	Rajasthan	Ajmer	Ajmer
69.	Rajasthan	Ajmer	Kishangarh
70.	Rajasthan	Ajmer	Beawar
71.	Rajasthan	Ajmer	Nasirabad
72.	Rajasthan	Bharatpur	Bharatpur
73.	Rajasthan	Alwar	Alwar
74.	Rajasthan	Alwar	Bhiwadi
75.	Rajasthan	Barmer	Barmer
76.	Rajasthan	Barmer	Balotra
77.	Rajasthan	Bhilwara	Bhilwara
78.	Rajasthan	Bikaner	Bikaner
79.	Rajasthan	Bikaner	Nokha
80.	Rajasthan	Bikaner	Dungargarh
81.	Rajasthan	Churu	Churu
82.	Rajasthan	Churu	Sujangarh
83.	Rajasthan	Churu	Sardarshahar
84.	Rajasthan	Churu	Ratangarh
85.	Rajasthan	Churu	Rajgarh
86.	Rajasthan	Jaipur	Jaipur

s. no.	State	Districts	NUHM Cities
87.	Rajasthan	Jaipur	Chomu
88.	Rajasthan	Jaipur	Kotputli
89.	Rajasthan	Jaisalmer	Jaisalmer
90.	Rajasthan	Jalor	Jalore
91.	Rajasthan	Jodhpur	Jodhpur
92.	Rajasthan	Jodhpur	Phalodi
93.	Rajasthan	Nagaur	Nagaur
94.	Rajasthan	Nagaur	Makrana
95.	Rajasthan	Nagaur	Ladnu
96.	Rajasthan	Nagaur	Kuchaman City
97.	Rajasthan	Nagaur	Didwana
98.	Rajasthan	Rajsamand	Rajsamand
99.	Rajasthan	Sawai Madhopur	Sawai Madhopur
100.	Rajasthan	Sawai Madhopur	Gangapur City
101.	Rajasthan	Sikar	Sikar
102.	Rajasthan	Sikar	Fatehpur
103.	Rajasthan	Sikar	Laxmangarh
104.	Rajasthan	Udaipur	Udaipur (RJ)
105.	Uttar Pradesh	Aligarh	Aligarh (M Corp.)
106.	Uttar Pradesh	Aligarh	Atrauli (NPP)
107.	Uttar Pradesh	Allahabad	Allahabad (M Corp. + OG)
108.	Uttar Pradesh	Ambedkar Nagar	Ambedkarnagar (Mcorp+OG)
109.	Uttar Pradesh	Ambedkar Nagar	Ambedkarnagar Tanda
110.	Uttar Pradesh	Amethi	Amethi(NP)
111.	Uttar Pradesh	Amroha	Amroha (NPP)
112.	Uttar Pradesh	Amroha	Hasanpur (NPP)
113.	Uttar Pradesh	Amroha	Gajraula (NP)
114.	Uttar Pradesh	Azamgarh	Azamgarh (NPP)

s. no.	State	Districts	NUHM Cities
115.	Uttar Pradesh	Azamgarh	Azam Mubarakpur
116.	Uttar Pradesh	Badaun	Budaun (NPP)
117.	Uttar Pradesh	Badaun	Sahaswan (NPP)
118.	Uttar Pradesh	Badaun	Ujhani (NPP)
119.	Uttar Pradesh	Badohi	Bhadohi (NPP)
120.	Uttar Pradesh	Baghpat	Baghpat Baraut (NPP)
121.	Uttar Pradesh	Baghpat	Baghpat (NPP)
122.	Uttar Pradesh	Bahraich	Bahraich (NPP)
123.	Uttar Pradesh	Ballia	Ballia (NPP)
124.	Uttar Pradesh	Balrampur	Balrampur (NPP + OG)
125.	Uttar Pradesh	Banda	Banda (NPP + OG)
126.	Uttar Pradesh	Barabanki	Nawabganj (NPP + OG)
127.	Uttar Pradesh	Bareilly	Bareilly (M Corp. + OG)
128.	Uttar Pradesh	Bareilly	Faridpur (NPP)
129.	Uttar Pradesh	Bareilly	Baheri (NPP)
130.	Uttar Pradesh	Bareilly	Aonla (NPP)
131.	Uttar Pradesh	Basti	Basti (NPP)
132.	Uttar Pradesh	Bijnor	Nagina (NPP)
133.	Uttar Pradesh	Bijnor	Bijnor (NPP)
134.	Uttar Pradesh	Bijnor	Najibabad (NPP)
135.	Uttar Pradesh	Bijnor	Chandpur (NPP)
136.	Uttar Pradesh	Bijnor	Sherkot (NPP)
137.	Uttar Pradesh	Bijnor	Kiratpur (NPP + OG)
138.	Uttar Pradesh	Bijnor	Dhampur (NPP)
139.	Uttar Pradesh	Bijnor	Seohara (NPP + OG)
140.	Uttar Pradesh	Bulandshahar	Bulandshahr (NPP + OG)
141.	Uttar Pradesh	Bulandshahar	Khurja (NPP + OG)
142.	Uttar Pradesh	Bulandshahar	Sikandrabad (NPP)

s. no.	State	Districts	NUHM Cities
143.	Uttar Pradesh	Bulandshahar	Jahangirabad (NPP)
144.	Uttar Pradesh	Bulandshahar	Gulaothi (NPP)
145.	Uttar Pradesh	Chandauli	Mughalsarai (NPP)
146.	Uttar Pradesh	Chitrakoot	Chitrakoot Dham (Karwi) (NPP)
147.	Uttar Pradesh	Deoria	Deoria (NPP)
148.	Uttar Pradesh	Etah	Etah (NPP)
149.	Uttar Pradesh	Etawah	Etawah (NPP)
150.	Uttar Pradesh	Farrukhabad	Farrukhabad-cum-Fatehgarh (NPP)
151.	Uttar Pradesh	Fatehpur	Fatehpur
152.	Uttar Pradesh	Ferozabad	Firozabad (NPP)
153.	Uttar Pradesh	Ferozabad	Shikohabad (NPP)
154.	Uttar Pradesh	Ferozabad	Tundla (NPP)
155.	Uttar Pradesh	Gautam Buddh Nagar	Noida (CT)
156.	Uttar Pradesh	Gautam Buddh Nagar	Greater Noida (CT)
157.	Uttar Pradesh	Gautam Buddh Nagar	Dadri (NPP)
158.	Uttar Pradesh	Ghaziabad	Ghaziabad (M Corp.)
159.	Uttar Pradesh	Ghaziabad	Loni (NPP)
160.	Uttar Pradesh	Ghaziabad	Khora (CT)
161.	Uttar Pradesh	Ghaziabad	Modinagar (NPP)
162.	Uttar Pradesh	Ghaziabad	Muradnagar (NPP)
163.	Uttar Pradesh	Ghazipur	Ghazipur (NPP + OG)
164.	Uttar Pradesh	Gonda	Gonda (NPP)
165.	Uttar Pradesh	Gorakhpur	Gorakhpur (M Corp.)
166.	Uttar Pradesh	Hamirpur	Rath (NPP)
167.	Uttar Pradesh	Hardoi	Hardoi (NPP + OG)
168.	Uttar Pradesh	Hardoi	Shahabad (NPP)
169.	Uttar Pradesh	Hardoi	Sandila (NPP)
170.	Uttar Pradesh	Hathras	Hathras (NPP + OG)

s. no.	State	Districts	NUHM Cities
171.	Uttar Pradesh	Jalaun	Orai (NPP + OG)
172.	Uttar Pradesh	Jalaun	Jalaun (NPP)
173.	Uttar Pradesh	Jalaun	Konch (NPP)
174.	Uttar Pradesh	Jalaun	Kalpi (NPP)
175.	Uttar Pradesh	Jaunpur	Jaunpur (NPP)
176.	Uttar Pradesh	Jhansi	Jhansi (M Corp.)
177.	Uttar Pradesh	Jhansi	Mauranipur (NPP + OG)
178.	Uttar Pradesh	Kannauj	Kannauj (NPP)
179.	Uttar Pradesh	Kannauj	Chhibramau (NPP)
180.	Uttar Pradesh	Kanpur(Dehat)	Akbarpur (NP)
181.	Uttar Pradesh	Kanpur(Nagar)	Kanpur (M Corp. + OG)
182.	Uttar Pradesh	Kasganj	Kasganj (NPP)
183.	Uttar Pradesh	Kaushambi	Manjhanpur (NP)
184.	Uttar Pradesh	Kheri	Lakhimpur (NPP)
185.	Uttar Pradesh	Kheri	Gola Gokaran Nath (NPP)
186.	Uttar Pradesh	Kushinagar	Padrauna (NPP)
187.	Uttar Pradesh	Lucknow	Lucknow (M Corp.)
188.	Uttar Pradesh	Maharajganj	Maharajganj (NPP)
189.	Uttar Pradesh	Mathura	Mathura (NPP)
190.	Uttar Pradesh	Mathura	Vrindavan (NPP)
191.	Uttar Pradesh	Mathura	Kosi Kalan (NPP + OG)
192.	Uttar Pradesh	Meerut	Meerut (M Corp.)
193.	Uttar Pradesh	Meerut	Mawana (NPP)
194.	Uttar Pradesh	Meerut	Sardhana (NPP)
195.	Uttar Pradesh	Mirzapur	Mirzapur-cum-Vindhyachal (NPP)
196.	Uttar Pradesh	Moradabad	Moradabad (M Corp.)
197.	Uttar Pradesh	Pilibhit	Pilibhit (NPP)
198.	Uttar Pradesh	Pilibhit	Bisalpur (NPP)
199.	Uttar Pradesh	Raebareli	Rae Bareli (NPP)

s. no.	State	Districts	NUHM Cities
200.	Uttar Pradesh	Saharanpur	Saharanpur (M Corp.)
201.	Uttar Pradesh	Saharanpur	Deoband (NPP)
202.	Uttar Pradesh	Saharanpur	Gangoh (NPP)
203.	Uttar Pradesh	Shahjahanpur	Shahjahanpur (NPP)
204.	Uttar Pradesh	Shahjahanpur	Tilhar (NPP)
205.	Uttar Pradesh	Siddharthnagar	Siddharthnagar (NPP)
206.	Uttar Pradesh	Sitapur	Sitapur (NPP)
207.	Uttar Pradesh	Sitapur	Laharpur (NPP)
208.	Uttar Pradesh	Sitapur	Biswan (NPP)
209.	Uttar Pradesh	Sitapur	Mahmudabad (NPP)
210.	Uttar Pradesh	Sonbhadra	Sonbhadra (NPP)
211.	Uttar Pradesh	Sultanpur	Sultanpur (NPP)
212.	Uttar Pradesh	Unnao	Unnao (NPP)
213.	Uttar Pradesh	Unnao	Gangaghat (NPP)
214.	Uttar Pradesh	Varanasi	Varanasi (M Corp.)

Annexure 4: Monitoring & Mentorship: Guidance on Developing M&M Plan

Monitoring & Mentorship plan for a block/planning unit should be prepared prioritizing HRA/HRGs in consultation with all partners. Emphasis should be given to monitor urban areas- Sessions as well as house to house.

Monitoring of at least 10% of the sessions every month, should be targeted. Thus, all sessions are to be monitored at least once a year.

To ensure that all ANMs are monitored, the monitoring will be linked to the unique Health Worker ID being developed under U-WIN.

The suggestive plan for monitoring is as below:

Session monitoring

- Three to four RI sessions, including fixed and outreach sessions
    - House to house monitoring in the same session area to be avoided while session is ongoing
    - HtH monitoring must be done in same area if session is found not held (after the session stipulated time)
- If the monitoring plan is for both session and HtH on a given day, then monitor 2 sessions and 2 other areas for HtH monitoring

House to House (HtH) monitoring

- Three to four areas per day (on non-RI day)
- If the monitoring plan is for both session and HtH same day, then monitor 2 areas for HtH monitoring and 2 sessions in 2 other areas (No session and HtH monitoring in same area)

Monitoring of Cold Chain Point (CCP):

The District Immunization Officer should ensure that each CCP in the block is covered at least twice in a year by the designated monitors for CCPs. The monitor should identify the CCP through the Quarterly supervision plan available at the district. The CCPs which have not been monitored earlier during the year, and if all CCPs have been covered, then CCPs with low scores/huge gaps should be prioritized for visit. Once the CCP is identified for the visit, inform the MO I/c at least two days prior to visit to ensure availability of staff on the day of scheduled visit along with all the records. All efforts should be made to ensure availability of Vaccine & Cold Chain handler (VCCH) at the time of visit.

List of Potential Monitors & Mentors:

For block

1. Field/External Monitors
2. SMNet (UP & Bihar)
3. CHO
4. Govt.:
    a. MO (Rural)
    b. Urban PHC- MO
    c. LHVs/ Supervisory cadre(Health Assistant)

At district/ divisional level

1. SMO/RRT/ UFP
2. DMC (UP & Bihar)
3. Data Analytics Focal
4. CSO – District level Representative
5. CEM focal (~40 cities)
6. Divisional Consultant- CSO/ M&M coordinator (1/5 districts)
7. U-WIN coordinator
8. Govt.-
    a. DIO
    b. VCCM & others

The State and National level teams of Immunization Program, including all Partners, to be part of the Monitoring & Mentoring plan

Annexure 5: Expansion of RISE under ZIP

Targeted Geography (aligned with ZIP)

State	Total Districts	ZIP districts	RISE through previous grants	RISE Target under HSS-3
UP	75	60	-	75
Bihar	38	25	-	38
MP*	52	15	49 completed+ **3 ongoing**	0
Rajasthan	33	16	-	33
Meghalaya	12	7	-	12
Maharashtra	36	4	7 districts completed	29
Arunachal Pradesh	25	12	-	25
Nagaland	16	1	-	-
Mizoram	11	1	-	-
Haryana	22	1	-	-
Jharkhand	24	1	-	-
Odisha*	30	0	21 completed + 9 ongoing	0
Tamil Nadu*	38	0	2 completed + 12 ongoing	24
Himachal Pradesh	12	-	12	-
Uttarakhand	13	-	13	-
TOTAL		**143**	**Total: 137 districts/ Corporations**	**236**

*Already completed/started

Annexure 6: Details of HR Support for Improved & Inclusive Microplanning

District ZIP	Existing SMO UNIT & RRT to be engaged	#Sanctioned FMs	#Blocks	Urban Areas	New F/EM to be engaged
Bihar (New Support: 1 RRT, 16 FMs)					
Champaran West	SMO	6	18	2	2
Champaran East	SMO	15	28	1	1
Darbhanga	SMO	10	19	1	1
Purnia	SMO	7	15	1	1
Sitamarhi	SMO	9	18	0	0
Araria	SMO	5	10	0	0
Katihar	SMO	9	17	1	1
Bhojpur	SMO	6	15	1	1
Patna	SMO	25	24	2	2
Begusarai	SMO	10	19	1	1
Madhubani	SMO	12	22	-	0
Kishanganj	SMO	3	8	-	0
Nalanda	SMO	13	21	-	0
Supaul	SMO	8	13	-	0
Saharsa	SMO	12	11	-	0
Nawada	SMO	7	15	-	0
Bhagalpur	SMO	10	17	1	1
Saran	SMO	9	21	1	1
Vaishali	SMO	8	17	1	1
Gaya	SMO	13	25	1	1
Madhepura	SMO	10	14	-	0
Siwan	SMO	6	20	1	1
Munger	SMO	6	11	1	1
Jamui	SMO	3	11	-	0
Banka	RRT	5	12	-	0

District ZIP	Existing SMO UNIT & RRT to be engaged	#Sanctioned FMs	#Blocks	Urban Areas	New FM to be engaged
Madhya Pradesh (New Support: 11 RRT, 126 FMs)					
Gwalior	SMO	0	5	2	7
Shivpuri	RRT	0	8	1	9
Morena	RRT	0	7	1	8
Barwani	RRT	0	7	2	9
Sehore	RRT	0	6	2	8
Vidisha	SMO	0	7	2	9
Rajgarh	RRT	1	6	1	7
Mandsaur	RRT	1	5	1	6
Balaghat	SMO	0	12	1	13
Damoh	RRT	0	8	1	9
Singrauli	RRT	0	4	1	5
Rewa	SMO	0	10	1	11
Bhind	RRT	0	6	2	8
Panna	RRT	0	6	1	7
Satana	RRT	0	9	1	10
Rajasthan (New Support: 5 RRT, 177 FMs)					
Alwar	SMO	1	14	2	16
Jodhpur	SMO	0	10	2	12
Bikaner	SMO	0	7	1	8
Bharatpur	SMO	1	9	2	11
Barmer	SMO	1	8	2	10
Churu	RRT	0	6	5	11
Bhilwara	SMO	0	11	1	12
Nagaur	RRT	0	11	5	16
Sikar	SMO	0	8	3	11
Jaipur	SMO	1	13	4	17
Jalor	RRT	0	8	1	9

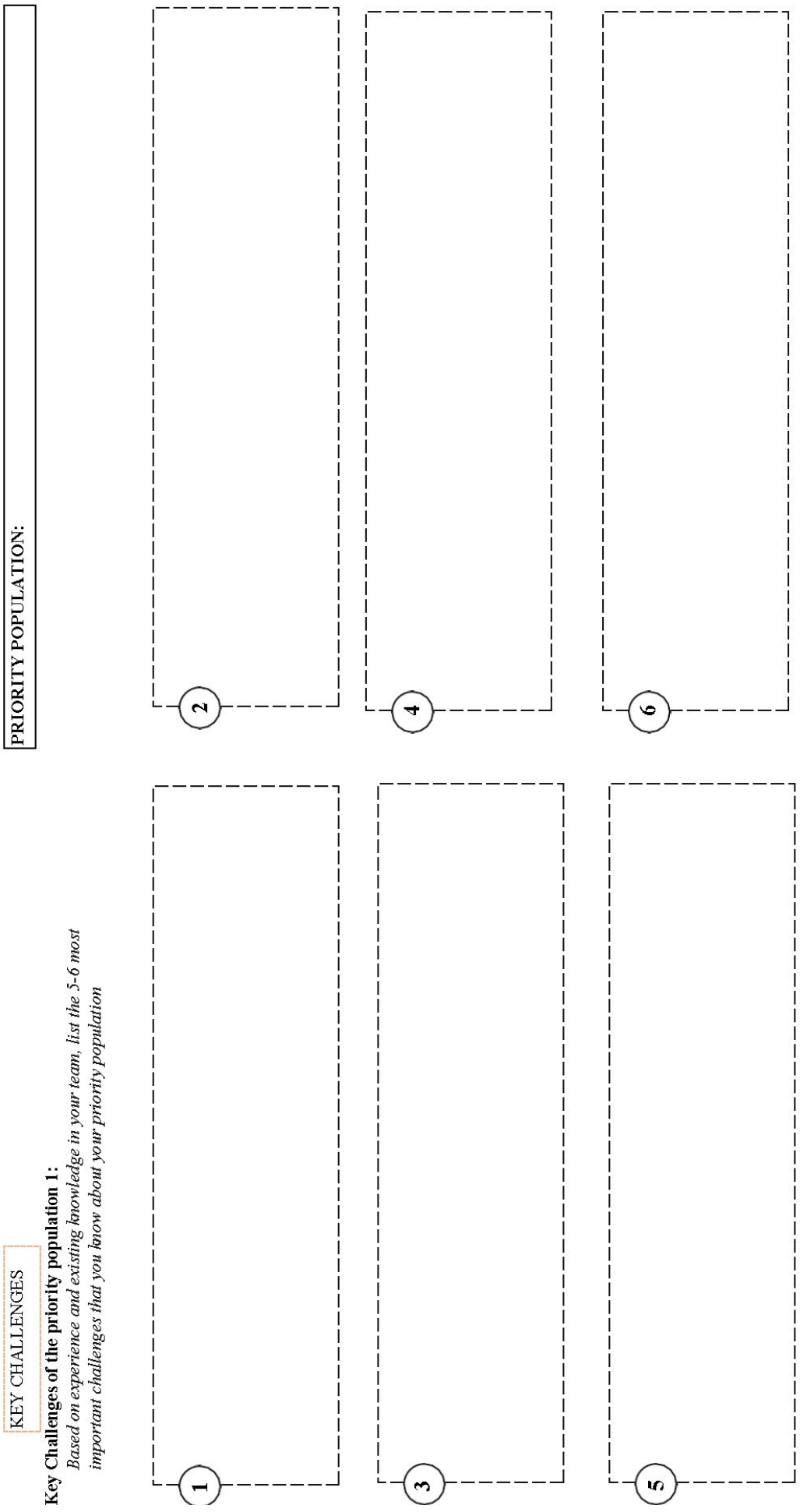
District ZIP	Existing SMO UNIT & RRT to be engaged	#Sanctioned FMs	#Blocks	Urban Areas	New FM to be engaged
Udaipur	SMO	1	12	1	13
Ajmer	SMO	0	8	4	12
Sawai Madhopur	SMO	0	5	2	7
Rajsamand	RRT	0	7	1	8
Jaisalmer	RRT	0	3	1	4
Uttar Pradesh (New Support: 4 RRTs)					
Kanpur(Nagar)	SMO	15	11	-	-
Jaunpur	SMO	22	23	-	-
Kushinagar	SMO	14	15	-	-
Gorakhpur	SMO	24	20	-	-
Deoria	SMO	17	18	-	-
Ballia	SMO	18	18	-	-
Allahabad	SMO	25	21	-	-
Unnao	SMO	17	17	-	-
Kheri	SMO	15	15	-	-
Lucknow	SMO	14	9	-	-
Bareilly	SMO	18	17	-	-
Bijnor	SMO	12	12	-	-
Ghazipur	SMO	17	17	-	-
Maharajganj	SMO	12	12	-	-
Aligarh	SMO	17	13	-	-
Sitapur	SMO	20	20	-	-
Moradabad	SMO	10	9	-	-
Banda	SMO	8	8	-	-
Pilibhit	SMO	9	9	-	-
Ambedkar Nagar	SMO	8	9	-	-
Ferozabad	SMO	10	10	-	-

District ZIP	Existing SMO UNIT & RRT to be engaged	#Sanctioned FMs	#Blocks	Urban Areas	New FM to be engaged
Meerut	SMO	17	12	-	-
Barabanki	SMO	14	15	-	-
Bulandshahar	SMO	15	16	-	-
Amroha	SMO	6	6	-	-
Ghaziabad	SMO	13	5	-	-
Gonda	SMO	17	17	-	-
Azamgarh	SMO	22	23	-	-
Amethi	SMO	13	13	-	-
Bahraich	SMO	15	15	-	-
Etah	SMO	9	9	-	-
Shahjahanpur	SMO	12	16	-	-
Hathras	SMO	8	8	-	-
Farrukhabad	SMO	8	8	-	-
Raebareli	SMO	17	17	-	-
Saharanpur	SMO	12	12	-	-
Badohi	RRT	3	5	-	-
Varanasi	SMO	15	9	-	-
Hardoi	SMO	20	20	-	-
Chandauli	SMO	9	9	-	-
Kasganj	RRT	7	7	-	-
Sultanpur	SMO	20	14	-	-
Basti	SMO	14	14	-	-
Jalaun	SMO	10	9	-	-
Siddharthnagar	SMO	12	14	-	-
Baghpat	RRT	5	6	-	-
Kanpur(Dehat)	SMO	9	10	-	-
Balrampur	SMO	10	10	-	-
Kannauj	SMO	8	8	-	-

District ZIP	Existing SMO UNIT & RRT to be engaged	#Sanctioned FMs	#Blocks	Urban Areas	New FM to be engaged
Jhansi	SMO	13	9	-	-
Fatehpur	SMO	14	14	-	-
Badaun	SMO	14	16	-	-
Etawah	SMO	8	8	-	-
Hamirpur	SMO	9	7	-	-
Mirzapur	SMO	14	12	-	-
Chitrakoot	SMO	6	6	-	-
Sonbhadra	SMO	9	8	-	-
Kaushambi	RRT	8	8	-	-
Mathura	SMO	11	10	-	-
Gautam Buddh Nagar	SMO	8	5	-	-
Maharashtra (New Support: 9 FMs)					
Pune	SMO	12	13	7	8
Nasik	SMO	28	15	5	0
Thane	SMO	18	5	6	0
Gr. Mumbai	SMO	24	24	1	1
Arunachal Pradesh (New Support: 10 RRT, 45 FMs)					
Longding	RRT	0	4	-	4
West Kameng	RRT	0	4	-	4
East Siang	RRT	0	3	1	4
Kameng	RRT	0	3	-	3
Papumpare	SMO	0	3	1	4
Lower Subansiri	RRT	0	2	-	2
Changlong	RRT	0	5	-	5
Siang	RRT	0	5	-	5
Namsai	SMO	0	2	-	2
Upper Subansiri	RRT	0	5	-	5
Kamle	RRT	0	2	-	2

District ZIP	Existing SMO UNIT & RRT to be engaged	#Sanctioned FMs	#Blocks	Urban Areas	New FM to be engaged
Upper Siang	RRT	0	5	-	5
Meghalaya (New Support: 6 RRT, 34 FMs)					
North Garo Hills	RRT	0	3	-	3
East Khasi Hill	SMO	0	12	1	13
West Khasi Hill	RRT	0	4	1	5
West Jaintia Hills	RRT	0	3	1	4
East Garo Hills	RRT	0	3	-	3
Ri-Bhoi	RRT	0	4	-	4
South West Khasi Hills	RRT	0	2	-	2
Mizoram (New Support: 1 RRT, 4 FMs)					
Lawngtlai	RRT	0	4	-	4
Nagaland (New Support: 1 RRT, 8 FMs)					
Mokokchung	RRT	0	7	1	8
Haryana (New Support: 4 FMs)					
Nuh	SMO	1	5	-	4
Jharkhand (New Support: 7 FMs)					
Sahebganj	SMO	5	7	-	7
143		**1098**	**1554**	**98**	**430**

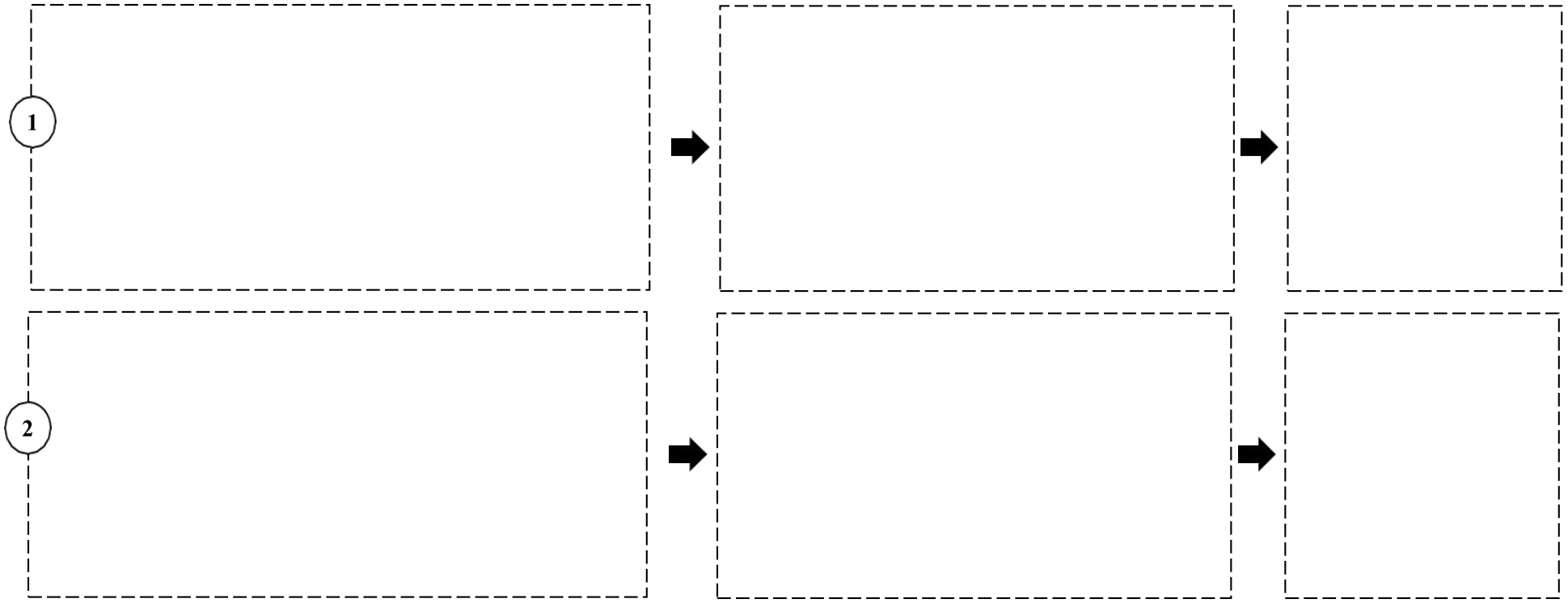
Annexure 7: Template for Full Portfolio Planning



ROOT CAUSE - WHY ARE WE MISSING THEM?

PRIORITY POPULATION :

Root-cause for challenges identified for priority population 1 *Based on experience and existing knowledge in your team, list the 5-6 most important root-cause explaining why we are missing the zero-dose chidlren and missed communities?*	**SUPPORTING EVIDENCE** *List supporting evidence, if any.*	**PRIORITY** *Rank those root causes by priority: 1 = critical & highly aligned, 2 = important & aligned but not critical, 3 = not in alignment/not as critical*
1		
2		



Annexure 8: Immunization Action Group (IAG): Terms of Reference (ToR)

Background

Programmatic review has been an integral part of the Universal Immunization Program (UIP). There have been various opportunities and mechanisms for UIP reviews such as NPCC, SEPIO review meetings, in-State CUIP review, State reviews during campaigns such as IMI, New Vaccine Introduction, Outbreak response, Product Switch. These reviews have been instrumental in achieving significant progress in child immunization indicators under the UIP. While reports suggest that there has been improved full immunization coverage, the progress has been unequal and with a geographical variation. As per the sub-national data, full immunization coverage of children aged 12-23 months is particularly suboptimal in some geographies. In particular, the prevalence of zero-dose children and drop-out children in the country is concerning.

Based on the detailed consultations between MoHFW and selected States, a ZERO DOSE Implementation Plan (ZIP) has been designed which has key interventions tailored for identified challenges to be implemented by selected partners in the low performing 143 districts in 11 States (Annex 1). To conduct a regular and structured review of these interventions under Gavi HSS-3 support, the existing institutional mechanism of IAG has been expanded with the participation of the States, Districts, Partners, local CSOs and CoP-Demand. IAG would have a close oversight on areas related to programmatic, operational, and financial management of the partners who would receive direct funding from Gavi for the implementation of these interventions.

Objectives of the IAG:

Ensure comprehensive review of UIP which includes targeting Zero Dose as well as drop-out children with the aim to achieve FIC for every child in the selected districts.

- Ensure better coordination between UIP and other health programs to deliver wider CPHC services with the goal of achieving UHC
- Provide strategic direction, oversight, and policy advice on implementation, monitoring and evaluation of the ZIP.
- Ensure efficiency, timeliness, and financial prudence in the implementation of interventions by the partners funded by Gavi.

Key functions of the IAG:

- Based on the predefined Monitoring, Evaluation and Learning (MEL) framework, quarterly monitor the progress (physical and fiancial) on the implementation of HSS-3 interventions by the partners.
- Identify the programmatic gaps during the implementation period and advise mid-course corrections.
- Review the results of the evaluation studies on the interventions and further decide on the continuation of the interventions.
- Bring complementarity among Gavi supported partners and other donor supported partners to ensure there is no duplication and more efficiency in the field.
- Address and resolve any emerging issues related to immunization programme strategy and implementation.

Composition

IAG Chair and Co-Chair

Immunization Action Group (IAG) is chaired by Additional Secretary & Mission Director (NHM) & co-chaired by Joint Secretary (RCH) for the overall monitoring & oversight of UIP programme with special focus on the ZIP interventions under Gavi HSS-3. Additional Commissioner (UIP) is the Secretary to the IAG.

IAG Members

The membership of the IAG composed of Mission Director (NHM) and SIOs of the Gavi supported States, HSS-3 partner namely UNICEF, UNDP, WHO, and JSI, and other donor supported parners, NUHM, NCCVMRC, ITSU, CoP-Demand, local CSOs and DIO (on rotation basis), Gavi Secretariat, Geneva, BMGF, USAID, WB.

Frequency of the IAG Meetings

As per the Gavi HSS-3 conditionality, IAG should meet at least every quarter. There could be more than 4 IAG meetings per year if there is an urgent agenda to discuss and take decisions. The date, time, and venue (in-person/virtual) would be intimated to the IAG members in advance (at least 15 days) based on the convenience of the Chair and the Co-Chair of the IAG.

The first IAG meeting would start with a in person meeting at Delhi to provide an orientation on the role and responsibilities of IAG and the next plan of action.

Modalities of IAG Meeting:

All the States need to present the HSS-3 progress in the predefined template following which there would be discussions and decisions.

Meeting minutes and action points

The meeting of the minutes will serve as the official record of the meeting. Immunization Division, MoHFW will draft the minutes of the meeting within seven working days of the meeting. For each agenda item, the minutes should contain a summary of discussions, agreements, and action points/next steps. The action points should state tasks to be undertaken, persons or organizations responsible, as well as when the activities should be completed. The chair-IAG may decide that draft minutes of meetings to be shared with the members for suggestions/inputs. Once finalization and endorsed by the Chair-IAG, minutes of the meeting will be shared the IAG for necessary actions.

Quarterly Meeting of Working Group of Immunization Action Group-WG IAG:

- Every Quarter, detailed review on the progress of the activities and their output under HSS-3 will be undertaken by the Working Group of IAG (15 days prior to IAG meeting), chaired by the Additional Commissioner (UIP) with representation from the implementing partners.
- The objective of this meeting will be to comprehensively review the progress of all interventions under the project against pre-set indicators.
- States may be requested for additional information and validations based on the information provided by the partners during the WG-IAG.

Review of IAG terms of reference

The terms of reference shall be reviewed regularly and revised if needed. Amendments or changes to the terms of reference need the approval of the Chair- IAG and the respective members of IAG shall be informed about any changes or amendments at the next meeting.

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