Be Wise!
Get your child fully immunized

सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

INTENSIFIED MISSION INDRADHANUSH

Operational Guidelines

Zindagi Indradhanush Banayein!

INTENSIFIED MISSION INDRADHANUSH

Operational Guidelines

Beyond 90% Full Immunization in districts by December 2018

A strategic initiative for improving vaccination coverage in identified districts (a PRAGATI initiative).

Contents

सी.के.मिश्रा
सचिव
C.K.Mishra
Secretary

सत्यमेव जयते

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

MESSAGE

It gives me great pleasure to present the Operational Guidelines for Intensified Mission Indradhanush, a PRAGATI initiative for improving vaccination coverage in the identified 118 districts, 17 urban areas and 52 districts of North-Eastern States.

Full Immunization against preventable childhood diseases is the right of every child. With a view to provide this right to every child, the Government of India launched the Universal Immunization Program (UIP) in 1985, one of the largest health programs of its kind, that is providing vaccination against 12 vaccine preventable diseases (8 across the country and 4 sub-nationally).

Launched in December 2014, Mission Indradhanush had provided much needed impetus to UIP resulting in an annual increase of around 7% in full immunization coverage as compared to 1% annual increase in the past. While acknowledging the impact of Mission Indradhanush in improving immunization coverage across the districts over the four phases, Hon'ble Prime Minister through PRAGATI platform, emphasized the need of a supplemental aggressive action plan titled 'Intensified Mission Indradhanush' to achieve the goal of 90% full immunization coverage by 2018 with special focus on urban slum areas and districts with low immunization coverage.

The Intensified Mission Indradhanush will involve immaculate planning to cover all the unvaccinated and partially vaccinated children, greater convergence with other ministries and departments, intensive monitoring during preparation and implementation phase, followed by integration of Intensified Mission Indradhanush sessions into Routine Immunization Microplans.

I am hopeful that the Immunization programme managers and health workers at all levels will work for Intensified Mission Indradhanush with great zeal and enthusiasm, thereby ensuring that our goal of 90% full immunization coverage is achieved by December 2018 and is sustained thereafter through integration into Routine Immunization.

The states are expected to ensure that a well-coordinated effort is put in for Intensified Mission Indradhanush with convergence of all the concerned ministries and departments at all levels to make this drive successful.

I commend the sincere efforts of officers at MoHFW and all the partners, especially WHO, UNICEF, UNDP, ITSU and JSI who have contributed to the development of this document. I am sure that states will find these guidelines very useful for planning, implementing and monitoring of Intensified Mission Indradhanush.

(C.K. Mishra)

Tele : (O) 011-23061863, Fax : 011-23061252, E-mail : secyhfw@nic.in
Room No. 156, A-Wing, Nirman Bhawan, New Delhi-110011

राष्ट्रीय स्वास्थ्य मिशन
डॉ. राकेश कुमार वत्स
अपर सचिव एवं महानिदेशक, सीजीएचएस
Dr.R.K.Vats
Addl. Secretary & DG, CGHS

सत्यमेव जयते

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

Foreword

Increasing immunization coverage is one of the important goals of Ministry of Health and Family Welfare, Government of India and to achieve this many strategies have been adopted and successfully implemented by Govt. of India including Mission Indradhanush.

Mission Indradhanush has led to an accelerated increase in the full immunization coverage at the rate of around 7% per year; however, certain disparities still exist in immunization coverage with certain districts having slow improvement and the urban areas having lesser increase as compared to the rural areas.

To address these inequities, Govt. of India will be implementing Intensified Mission Indradhanush across 118 districts, 17 urban areas and 52 districts in north-eastern states having maximum scope of improvement.

These operational guidelines have been developed to aid the state, district and planning unit officers in designing and implementing the Intensified Mission Indradhanush with greater convergence of all departments while focusing on the intensified efforts for mobilization of beneficiaries.

The state and district officials must ensure that the timelines of various activities is strictly adhered and an enabling environment is created for IEC activities so that the awareness on Intensified Mission Indradhanush reaches the intended beneficiaries even in the remotest corner of the country. The micro-planning process should be through head-count survey of beneficiaries and it should be ensured that immunization services are made available to all the missed-out and left-out children through fixed, outreach or mobile sessions.

I am hopeful that the identified districts will utilize the platform of Intensified Mission Indradhanush and achieve the target of 90% full immunization coverage well before the set date of by December 2018.

Vatsl

(Dr. R K Vats)

Room No. 244, A-Wing, Nirman Bhawan, New Delhi-110 011
Tele : (O) 011-23062985, Fax : 011-23062579, E-mail : asdgcghs-mohfw@nic.in

वन्दना गुरनानी,भा.प्र.से.
संयुक्त सचिव

VANDANA GURNANI, I.A.S.
JOINT SECRETARY
Tel. : 011-23061706
E-mail : vandana.g@ias.nic.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

Preface

India's Universal Immunization Programme (UIP) has made a significant progress in improving reach and the quality of routine immunization across the country, though there still remain challenges of inequity. With an attempt to bridge the gap in immunization, the Ministry of Health & Family Welfare Government of India implemented various routine immunization intensification strategies including its flagship programme "Mission Indradhanush" launched in December 2014, and delivery system strengthening exercises through improved micro-plans.

Inspite of repeated phases of Mission Indradhanush, full immunization coverage in selected districts/cities showed slow progress with sluggish increase in urban areas as compared to rural areas. Hence there is a need for implementing a supplemental aggressive action plan "Intensified Mission Indradhanush" in the identified 118 districts, 17 urban areas and 52 districts of North-Eastern states where district specific focused plan, systematic immunization drive and additional resources will be required for reaching all children with all available life-saving vaccines. It shall be ensured that the microplan of Intensified Mission Indradhanush are integrated into Routine Immunization.

The Intensified Mission Indradhanush drive would be closely monitored at the district, state and central level at regular intervals. It would be reviewed by the Cabinet Secretary at the National level and will continue to be monitored at the highest level under "PRAGATI."

The state governments are expected to solicit support for this drive from all the concerned departments and utilize youth organizations like NCC, Nehru Yuva Kendra, National Service Scheme, and Self Help Groups created under various departments for creating awareness on immunization and mobilization of beneficiaries for Intensified Mission Indradhanush. The District Magistrates and Municipal Commissioners are expected to mobilize resources and manpower from other departments, if needed, for social mobilization activities and monitoring of the drive.

These guidelines will provide broad principles on which the immunization programme managers and health workers will drive this programme and generate awareness on immunization through advocacy at all levels with the stake-holders. It will serve as a tool to ensure proper implementation of the intensified drive in the selected districts and urban for achieving the goal of reaching 90% evaluated coverage/concurrent monitoring by December 2018.

(Vandana Gurnani)

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Dr. PRADEEP HALDAR
Deputy Commissioner (IMM)
Telefax : 23062728, 23062126
email : pradeephaldar@yahoo.co.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

From the Programme Manager

Immunization is one of the most cost effective public health interventions and has been a major tool for reduction of under-5-mortality rate from 69 in 2008 to 45 in 2015. India's immunization programme known as Universal Immunization Programme (UIP) is one of the largest public health programmes in the world. It targets 3 crore pregnant women and 2.6 crore new born annually through more than 9 million Immunization sessions annually.

Despite being a very effective public health tool, benefit of immunization is often limited by its suboptimal reach to community. It was estimated that even though immunization programme has been in place since 1978 in country, only 65.2 % children were getting fully immunized (RSOC 2013-14 data). To address this problem in country, Mission Indradhanush (MI) was launched in 2014 with the goal to increase full immunization coverage >90% by 2020. As a result of implementation of MI, the increase in full immunization coverage has accelerated at the rate of 6.7% per year.

However, it was realized that though the pace on full immunization coverage has been increased with Mission Indradhanush, progress is not uniform in all districts and certain areas, like urban slums not getting the required focus. Government of India decided to accelerate the full immunization coverage to 90% by 2018 instead of 2020 while providing special focus on urban areas and ensuring greater convergence with other ministries. To achieve the target in an accelerated mode, Ministry of Health and Family Welfare has planned to implement Intensified Mission Indradhanush in 118 districts, 17 urban areas and 52 districts of North-eastern states from 7th October 2017 onwards for which the planning process has already been initiated.

Since proper planning is crucial to the success of any endeavor, operational guidelines for Intensified Mission Indradhanush has been prepared to provide guidance to the states. This will help to ensure that all left-outs and drop-outs are covered and brought into the ambit of routine immunization services with sustainable coverage.

I am sure that we all will stand together as always to achieve our target of 90% full immunization coverage and sustain it thereafter thereby ensuring a healthy future to children of our country.

Dr. Pradeep Haldar

LIST OF ABBREVIATIONS

AD	Auto-Disable
AEFI	Adverse Event Following Immunization
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AVD	Alternate Vaccine Delivery
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
BCG	*Bacillus Calmette-Guerin* Vaccine
BRIDGE	Boosting Routine Immunization Demand Generation
CBO	Community Based Organization
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CMO	Chief Medical Officer
CSO	Civil Society Organization
DIO	District Immunization Officer
DLHS	District Level Household and Facility Survey
DPT	Diphtheria–Pertussis–Tetanus Vaccine
DTFI	District Task Force For Immunization
DUDA	District Urban Development Agency
EPI	Expanded Programme on Immunization
GoI	Government of India
HMIS	Health Management Information System
HRA	High-Risk Area
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
ILR	Ice-Lined Refrigerator
IMA	Indian Medical Association
IPC	Inter Personal Communication
ITSU	Immunization Technical Support Unit
JE	Japanese Encephalitis
LHV	Lady Health Visitor
LODOR	Left Out Drop Out and Resistant
MCH	Maternal and Child Health
MCP	Mother–Child Protection (Card)
MCTS	Mother and Child Tracking System
MCV-2	Measles-Containing Vaccine-Second Dose

MD (NHM)	Mission Director, National Health Mission
MI	Mission Indradhanush
MOIC	Medical Officer In-Charge
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
NCC	National Cadet Corps
NGO	Non Government Organization
NPSP	National Polio Surveillance Project
NSS	National Service Scheme
NTAGI	National Technical Advisory Group on Immunization
NYK	Nehru Yuva Kendra
OPV	Oral Polio Vaccine
OVP	Open Vial Policy
PRAGATI	Proactive Governance and Timely Implementation
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RI	Routine Immunization
RMNCH+A	Reproductive, Maternal, Newborn, Child Health and Adolescent Health
RVV	Rota Virus Vaccine
SHG	Self-Help Group
SIO	State Immunization Officer
SMO	Surveillance Medical Officer
STFI	State Task Force for Immunization
ToT	Training of Trainers
TT	Tetanus Toxoid
UIP	Universal Immunization Programme
UNICEF	United Nations Children's Fund
VPD	Vaccine Preventable Disease
VVM	Vaccine Vial Monitor
WHO	World Health Organization

Chapter 1

Background

Immunization against preventable childhood diseases is the right of every child. With a view to providing this right, the Government of India launched the Universal Immunization Programme (UIP) in 1985, one of the largest health programs of its kind in the world, to cater to a birth cohort of 2.6 crore infants, and around 3 crore pregnant women every year. The programme provides vaccination against 8 life-threatening diseases (diphtheria, whooping cough, Haemophilus influenzae type B (Hib), tetanus, polio, tuberculosis, measles and hepatitis B) in the entire country. In addition, vaccination against Japanese Encephalitis (JE) is being provided in the selected endemic districts/states of the country. Rotavirus vaccine (RVV) introduction has been scaled up in nine states, Pneumococcal Conjugate Vaccine (PCV) is being introduced in the routine immunization program of three select states with further expansion planned in a phased manner and Measles Rubella (MR) Vaccine has been introduced in 5 states/UTs following a wide age range (9 months to 15 years) MR vaccination campaign.

India's UIP has contributed significantly to ensure equity to children accessing the public health system through a variety of supply and demand side interventions, though there still remain challenges of inequity. The steady fall of infant mortality from 80 per 1000 live births in 1991 to 37 per 1000 live births in 2015 (SRS) does in part reflect the Govt. of India's dedicated efforts under UIP to reduce child mortality and morbidity.

In spite of all positive changes, there are ongoing challenges for Universal Immunization Programme. Despite being operational for over 30 years, UIP has been able to fully immunize only 65% children (RSOC 2013-14) in the first year of their life. This translates into a cohort of 89 lakhs missed children majorly in hard-to reach and underserved populations. Evidence shows that unvaccinated and partially vaccinated children are most susceptible to childhood diseases and disability, and run a three to six times higher risk of death as compared with fully immunized children.

Committed to improving immunization coverage and addressing the equity agenda, the Ministry of Health & Family Welfare, Government of India, has implemented various intensification strategies including its flagship programme "Mission Indradhanush" launched in December 2014, and delivery system strengthening exercises through improved micro-plans.

Mission Indradhanush aimed to fully immunize more than 90% of newborns by 2020 through innovative and planned approaches to reach all children. It not only aimed to rapidly increase the immunization coverage through special drives during specified months but also focused towards strengthening health systems for addressing equity issues in access to immunization.

Under Mission Indradhanush all the vaccines provided under Universal Immunization Programme are administered to children and pregnant women.

A total of 528 districts covered during the various phases of Mission Indradhanush are shown in Table 1.

Table 1. Period and number of districts covered in different phases of MI.

Phase	Details
Phase-1	April'15 to July'15: 201 districts
Phase-2	October'15 to January'16: 352 districts, 73 districts repeated from Phase-1
Phase-3	April'16 to July'16: 216 districts, 199 districts repeated from Phase-1/2
Phase-4	Feb'17 to May'17 in NE states: 68 districts, 60 districts repeated from Phase-1, 2 & 3 April'17 to July'17 in 19 other states: 186 districts, 163 districts repeated from phase1/2/3

This equity-based programme is built on strategies, tools, techniques and human resources employed in Pulse Polio Programme focussing on identified high-risk populations with traditionally low coverage, such as slum dwellers, nomadic populations and migrant families living in brick kilns and construction sites. The Mission also targets 400,000 high risk areas identified in the polio programme as well as other underserved areas with inadequate health services (vacant health sub-centres, etc.), migrant populations, recent measles/diphtheria outbreaks or high dropout rates. Microplanning for Mission Indradhanush focused on improving coverage and addressing equity issues in access to immunization.

Completing the immunization schedule by each child is critical for protecting them against vaccine preventable diseases and increasing their longevity.

Based on full immunization estimated from Routine Immunization monitoring and Mission Indradhanush data, it is estimated that annually more than 70 lakh (7 million) children in the country do not receive all vaccines that are available under the UIP—the highest number compared with any other country in the world. This is majorly due to sub-optimal recording and reporting of data, which also calls for improvement in the disease surveillance system. It is critical to identify the districts within each state where district specific focussed plan, systematic immunization drive and additional resources will be required for reaching all children with all available life-saving vaccines.

Chapter 2

Rationale of Intensified Mission Indradhanush (IMI)

The first two phases of Mission Indradhanush contributed to an increase in Full Immunization Coverage by 6.7%, as evidenced by Integrated Child Health and Immunization Survey (INCHIS). This increase, however, would not be sufficient to achieve Full Immunization Coverage of more than 90% of new-borns by 2020 as aimed under Mission Indradhanush. Further, Full Immunization Coverage in selected districts/cities that have shown slow progress in spite of repeated phases of Mission Indradhanush.

While acknowledging the impact of Mission Indradhanush in improving immunization coverage across the districts over the three phases, Hon'ble Prime Minister through PRAGATI platform, emphasized the need of a supplemental aggressive action plan to cover all left outs and drop outs in select districts and urban cities with low routine immunization coverage in a specific time-frame (December 2018). These districts should focus on improving immunization coverage through need based interventions in Intensified Mission Indradhanush drives, based on a comprehensive gap analysis, with strengthened involvement of relevant non-health departments and enhanced accountability frameworks. The gains thus achieved need to be sustained through strengthening health systems and microplanning by incorporating IMI sessions into Routine Immunization microplans.

Inter-ministerial and inter-departmental coordination, action-based review mechanism and intensified monitoring and accountability framework will be key for effective implementation of targeted rapid interventions to improve the routine immunization coverage which will ensure that life saving vaccines reach every child.

Under the intensified drive, due attention must be given to:

- Urban slum areas and districts where there is maximum scope of improvement in immunization coverage;
- Due-listing of beneficiaries on the basis of robust head –count surveys which will be validated by supervisors; and
- Improving mobilization of beneficiaries.

IMI would be closely monitored at the district, state and central level at regular intervals. Further, it would be reviewed by the Cabinet Secretary at the National level and will continue to be monitored at the highest level under "PRAGATI".

This Intensified Mission will hence be steered based on the information received from gap assessment, supervision through government, concurrent monitoring by partners, and end-line surveys. States and districts will need to devise coverage improvement plans based on gap self-assessment, which will be reviewed at all levels for adherence to achieving goal of reaching 90% evaluated coverage/concurrent monitoring by December 2018.

Criteria for selection of districts and urban cities

The districts/urban cities have been selected through triangulation of available datasets such as national surveys, HMIS data and WHO concurrent monitoring data. The criteria taken was; estimated no. of children who missed DPT3/Pentavalent3 >13,000 OR DPT3/ Pentavalent 3 coverage <70%.

- These datasets have been analyzed in consultation with the states and partners (WHO, UNICEF, etc.) to identify the weakest 118 districts, 17 urban cities and an additional 52 districts in North Eastern states with highest number of left outs and drop outs.
- Some additional districts were also incorporated based on the states' request.

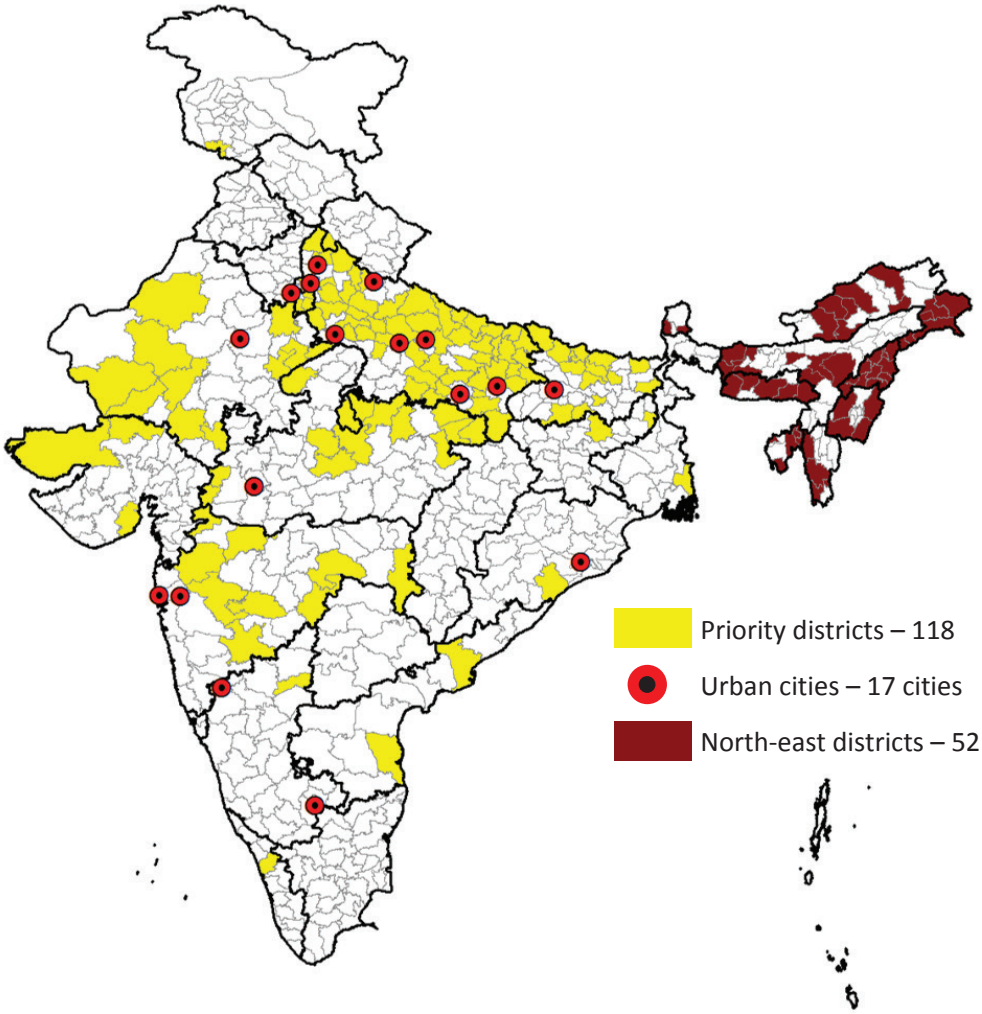


Figure 1. The map illustrates 118 districts, 17 urban cities and 52 NE districts identified by the government for Intensified Mission Indradhanush. The Intensified Mission Indradhanush strategy will target these 187 districts/ urban cities. (This list has been provided in Annexure 1)

Chapter 3

Objectives of Intensified Mission Indradhanush

The main objective of Intensified Mission Indradhanush strategy is to ensure reaching the unreached with all available vaccines and thereby accelerating the full immunization and complete immunization coverage of children and pregnant women in the identified critical districts; and sustain the gains.

With the launch of the Intensified Mission Indradhanush strategy, the government aims to:

- Rapidly build up full immunization coverage to more than 90% by December 2018 in identified districts and urban cities.
- Enhance political, administrative and financial commitment through advocacy with key ministries/ departments and stakeholders towards full immunization coverage for each child.
- Reach all children with all UIP vaccines due for the age as per the national immunization schedule in the geographic area with focus on children up to 2 years of age and pregnant women. However, vaccination will be provided to children up to 5 years of age.
- Sustain the gains made through Intensified Mission Indradhanush through routine immunization by using IT based platforms for further planning and follow-up.

3.1 Schedule for IMI

One phase of Intensified Mission Indradhanush immunization drive, consisting of 4 rounds of immunization will be conducted in the selected districts and urban cities.

Round 1 – 7th October 2017

Round 2 – 7th November 2017

Round 3 – 7th December 2017

Round 4 – 7th January 2018

Intensified Mission Indradhanush immunization drive will be spread over 7 working days starting from 7th of every month. In case the 7th of the month is a Sunday/ holiday, the drive may begin from the next working day. These 7 days do not include holidays, Sundays and the routine immunization days planned in that week. Such routine immunization sessions should be held as already planned.

After the completion of the proposed 4 rounds, the states will be expected to undertake measures to sustain the gains from IMI, through activities like inclusion of IMI sessions in routine immunization plans. The sustainability of IMI will be assessed through a survey, and the decision to conduct another phase of IMI will be based on the findings of this survey.

3.2 Collaboration with other Ministries/ Department/Agencies

The IMI strategy will require support from key ministries and departments; strong leadership through meaningful collaboration between different arms of the government, working closely with the community, civil society and the youth. Other ministries have agreed to provide support for Intensified Mission Indradhanush and the areas of support from these ministries is provided at Annexure-18.

- **Ministries to be involved:** Women & Child Development (WCD), Panchayati Raj, Urban Development, Housing and Urban Poverty Alleviation, Defence, Sports & Youth Affairs, Human Resource Development, Education, Minority Affairs, Information & Broadcasting, Railways, Home Affairs, Labour and Employment.
- **Departments in Ministry of Health & Family Welfare to be involved:** Urban Health division (NHM), Maternal and Child Health division, Rashtriya Bal Swasthya Karyakram (RBSK), Information, Education & Communication (IEC) Division.
- **Mobilizers:** NGOs, Public Relations, CSOs, Rotary International, NSS, National Cadet Corps (NCC), Nehru Yuva Kendra, MSW, along with relevant stakeholders will be involved as mobilizers in the activity.
- Key partners: WHO, UNICEF, UNDP, Global Health Strategies, IPE Global, Rotary International, Technical Support Units (TSUs) established in select states and others as per program needs.

3.3 Focus areas

Intensified Mission Indradhanush strategy includes two broad interventions: **Intensified Mission Indradhanush drive and Routine Immunization System Strengthening** to sustain the gains.

The immunization drive will be implemented in all identified districts and urban cities for ensuring >90% full immunization coverage. Low performing areas will be identified across the entire selected districts/ urban areas for coverage under Intensified Mission Indradhanush, with focus on:

- Areas with vacant sub centres – Auxiliary Nurse Midwife (ANM) not posted or absent for more than 3 months;
- Unserved/low coverage pockets in sub-centre or urban areas, due to issues around vaccine hesitancy of programme reach; sub-centre/ANM catering to populations much higher than norms.
- Villages/areas with three or more consecutive missed routine immunization sessions;
- High-risk areas (HRAs) identified by the polio eradication programme that are not having independent routine immunization sessions and clubbed with some other routine immunization sessions. These include populations living in areas such as:
- Urban slums with migration
- Nomadic sites
  - ◊ Brick kilns
  - ◊ Bconstruction sites
  - ◊ Other migrant settlements (fishermen villages, riverine areas with shifting populations)
  - ◊ Underserved and hard-to-reach populations (forested and tribal populations, hilly areas, etc.).
- Areas with low routine immunization coverage identified through measles outbreaks, cases of diphtheria and neonatal tetanus in the last 2 years.

- The priority for conducting Intensified Mission Indradhanush should be areas with weak routine immunization coverage in the district. This will require deployment of ANMs to areas outside her own sub-centre and block.
- Special attention should be provided to urban settlements and cities identified under NUHM.
- Intensifed Mission Indradhanush should be taken as an opportunity to improve:
  - ◊ Full Immunization Coverage
  - ◊ Complete Immunization Coverage (Measles/ MR 2nd dose and other booster doses)

Chapter 4

Strategy for Intensified Mission Indradhanush

4.1 Proposed single phase of IMI

IMI single phase is being proposed in selected districts and urban cities. All blocks and urban areas in the selected districts will need to be assessed for coverage and accordingly be included in IMI.

Completion of estimation of beneficiaries (based on headcount survey) in areas planned to be undertaken for IMI will be the key to the success of IMI. A high quality headcount survey will help us understand and track who has missed which vaccination and where.

IMI immunization drive will be spread over 7 working days. These 7 days do not include holidays, Sundays and the routine immunization days planned in that week.

Planning should be done in such a way that **all ANMs in district are involved for 7 working days** (in addition to routine immunization days) to visit and conduct sessions for maximum immunization coverage. Need based deployment of ANMs (within or outside block in rural or urban areas) should be done. Mobility support, if required, may be proposed in supplementary PIP for the same.

In earlier phase of MI, it has been observed that MI sessions were conducted where RI sessions were already planned and being held.

Avoid IMI sessions at places where routine immunization sessions are already planned/held in preceding or upcoming 7-14 days.

The IMI sessions will need to be included in routine immunization micro-plans by the end of the four rounds of IMI, the sustainability of which will be assessed through surveys. The districts where poor sustainability is seen, will need to conduct another phase of IMI.

4.2. Assessment of immunization gaps in selected districts and urban cities

A check list has been devised and shared for assessment of health system issues in the selected districts and urban cities. The districts should utilize these check lists to identify gaps, assess if the gaps can be addressed using already available funds and other resources and

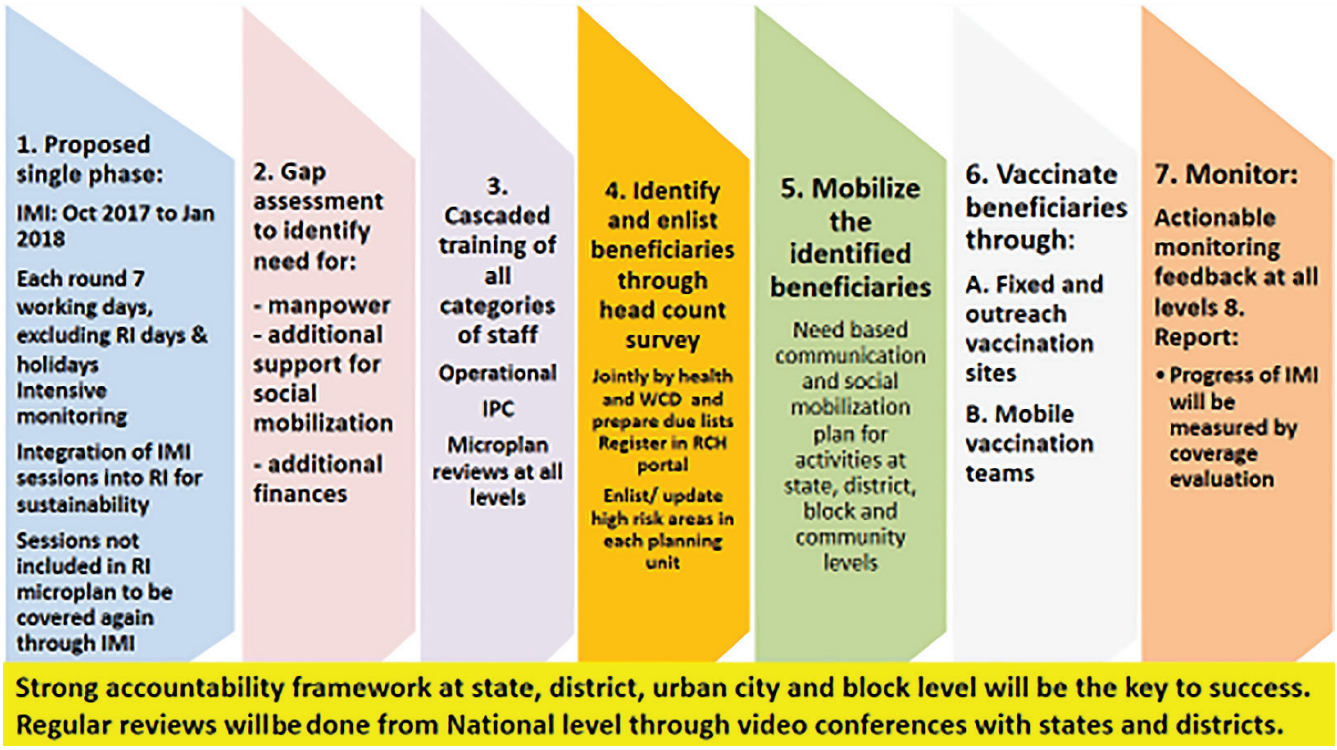


Figure 2. Strategy for Intensified Mission Indradhanush

- Intensified Mission Indradhanush will be implemented for 7 working days in select districts/urban cities.
- Engage all ANMs in the district for need based 7 day plan.
- RI sessions should not be disturbed during the IMI drive and should not be cancelled/ postponed.
- Special efforts need to be made to sustain gains made through this drive by strengthening health systems.

communicate to the state in case of requirement of additional human resource, finances and resources for social mobilization. The districts will also need to prepare coverage improvement plans. This should be made in consultation with partners to address the gaps. Indicators developed for these coverage improvement plans will be regularly tracked through State and District Task Forces. For example, if there is 30% ANM vacancies in a district, this indicator will be tracked and actions taken for improvement till this gap is bridged.

4.3 Cascaded training for all categories of Staff

The roll out of the IMI would require meticulous planning at all levels. This would require an orientation of the authorities at the State, District and Block level and capacity building of the health workers for implementation and the intensified drive to identify and vaccinate each and every child that has been left unimmunized or partially immunized.

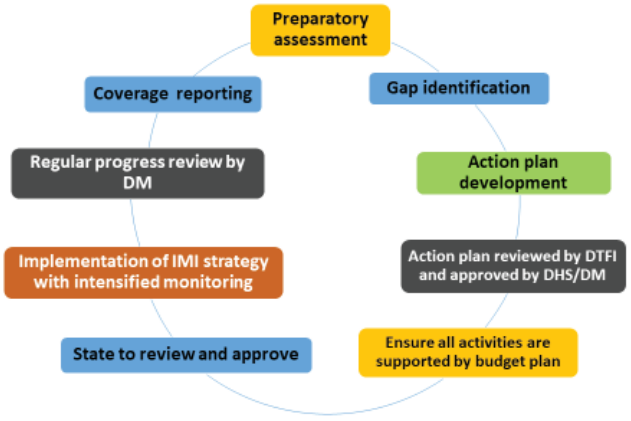
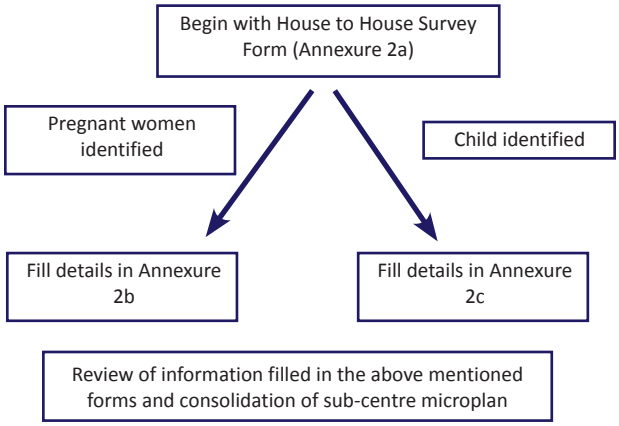


Figure 3. Action plan for IMI

4.4 Identification and enlisting of beneficiaries:

In IMI the identification and enlisting of beneficiaries through headcount survey should be done by ASHA and Anganwadi worker. In the absence of either or both of them, link workers should be utilized for this activity. All beneficiaries identified through head count survey will be registered in the MCTS/RCH portal for facilitating name based tracking in future. Tracking of beneficiaries through due-lists will be critical. Visitors including females who are visiting their parents for delivery/after delivery and are present in the house during the head count survey should also be included in survey due list.

Head-count survey is a critical activity for estimation of beneficiaries. The details of microplanning and head-count survey can be referred in Chapter-3 of Immunization Handbook for Medical Officers 2016 edition. Broadly, head-count process is as follows:



4.5 Mobilize the identified beneficiaries

The identified beneficiaries will be mobilized to session sites by ASHA, AWW and other mobilizers. Ensure engaging with NCC, NSS and NYK volunteers for maximum mobilization of beneficiaries. Ensure that the micro-plans include the names and contact details of volunteers of above mentioned organizations.

Rotary International has been mandated to support IMI activities at all levels. Districts are expected to engage with them on the lines of Pulse Polio Programme.

Maximum engagement with NGOs, CSOs, Religious leaders and Influencers to be ensured across all levels. NCC, NSS, NYK, Rotary International, Religious leaders, Influencers etc. to be on-board and well represented at all the IMI platforms.

4.6 Vaccination of beneficiaries

Meticulous planning will be the key to success of IMI. Beneficiaries will be reached through fixed, outreach and mobile sessions. This is explained in detail in

subsequent sections.

4.7 Monitoring of IMI

Progress and achievements of IMI will be monitored through the following:

- Progress on gaps identified by self-assessment through state and district task forces.
- Concurrent monitoring by immunization partners.
- Endline survey by 30 cluster sampling technique after completion of fourth round of IMI.
- Second survey by 30 cluster sampling technique to assess the sustainability of gains achieved by IMI by November/December 2018.

Details for the above section are provided in chapter 13.

4.8 Reporting of IMI

Daily reporting of coverage by all ANMs to the planning unit concerned, planning unit to district, district to state and state to national level is mandatory. A mechanism for reporting coverage through google sheets is already in place. In case of any technical issues with this mechanism, states may report daily coverage to Immunization Technical Support Unit (ITSU) of MoHFW at immcontrolroom@gmail.com. The reporting formats are annexed as annexure numbers 12 to 15.

The timelines for key activities to be conducted for successful implementation of IMI are given below in table 2.

Table 2. Timelines for key activities of IMI

Activity	Timelines
State steering committee	End June, Late Sep & Late Oct
STFI/DTFI	Once a month
Gap analysis	Mid July
Orientation Workshop for 11 states in Delhi (23 districts) and NE states in Guwahati	20-31 July
State Tot (for 5 major states)	End July-1st week of August
Supplementary PIP for additional requirement	End August
District ToT	1st-2nd week of August
Completion of HW and mobilizer trainings	End August
Completion of Micro plan after head count survey	15 September
Assessment of district readiness by national monitors	**10-20 September**
First round MI	From 7th October

Assessment of District Readiness by National Monitors:

From National level, a team of experts led by senior officials from MoHFW/other ministries (as in Common review of Mission (CRM)), will visit the states/districts a month prior to start of IMI, to assess the preparedness for Intensified Mission Indradhanush. Districts will not be permitted to start the activity without proper preparations in place, else it may affect the performance of activity as well as achievement of target. **On the basis of assessment, a decision will be taken for IMI drive in the respective districts.**

The National monitors will closely follow-up on the progress of IMI activities mainly quality of STFI/DTFI, steps under micro-planning with high focus on estimation of beneficiaries (head-count survey); due-list preparation; deployment of vaccinators and supervisors in areas needing attention; IEC innovations/efforts; feedback/ compliance on concurrent monitoring; and rational projections of district needs in supplementary PIP for IMI.

Post-assessment, the feedback will be shared at district, state and national level.

Chapter 5

Components of Intensified Mission Indradhanush

The two main components of Intensified Mission Indradhanush will be:

- Operational planning
- Communication planning

5.1 Operational planning

The following two operational mechanisms will be utilized to reach out to unreached or poorly reached beneficiaries.

5.1.1 Fixed and outreach sessions

Medical officer in-charge (MOIC) for the block/urban planning unit would need consider the following and do detailed planning to decide sessions to be conducted in the block. In addition, provision for vaccination should be made at health posts, primary health centres (PHCs) and district hospitals on all days of Intensified Mission Indradhanush.

- **Sites for vaccination:** Schools, anganwadi centres, private dispensaries, nongovernment organization (NGO) sites or any other locations that are easily accessible and acceptable to the community can be used as immunization site. In addition, urban health posts; post-partum centres; family welfare centres and local influencer's premises may be utilized in urban areas.
- **Availability of human resources:** All ANMs in district will conduct Intensified Mission Indradhanush session for 7 working days in addition to routine immunization days. The task forces should closely monitor the staff on leave/proceeding on leave during the planning and implementation of IMI.
- **Special strategy for underserved/resistant/ reluctant communities:** Explore availability of local mobilizers working for 15-20 days per month till the end of the fourth round of IMI, extendable till the end of December 2018 based on approval, for implementation of special efforts for mobilization of hesitant communities. These mobilizers should belong to the same community and should be residing in the same areas, as was the learning from polio. Such activity, subject to requirement, may be budgeted in the supplementary PIP. Immunization partners with expertise in communication activities should be engaged to provide need-based training (similar to SMNet CMC training) to these mobilizers.

Explore the possibility of engaging local resident volunteers of NCC, NYK, NSS, Zila Preraks under Swachh Bharat Mission, SHGs, MAS etc. for mobilization of resistant/reluctant communities. The details of roles of other departments may be referred in Annexure-18.

The ANMs should be deployed to other sub-centre area within the same or adjoining blocks or urban areas in the same district. The planning for Intensified Mission Indradhanush drive should be done in the following ways:

- ANMs working in rural areas with less than 7 days of involvement in Intensified Mission Indradhanush in their own sub-centre areas should be deployed to low performing/coverage areas, vacant sub centers or in identified urban areas
- To cover the unreached/vulnerable population groups with limited human resource availability in urban areas, the DIO and urban nodal officer should coordinate with block medical officers to pull out the required number of ANMs from adjoining blocks to conduct the desired number of Intensified Mission Indradhanush sessions in these urban areas.
- Need-based mobility support should be extended to ANMs deployed outside their sub-centre areas.
- Need-based support should be provided for mobile teams in far-flung/scarcely populated/scattered areas.
- Other health staff trained for administering injection available from the same or neighbouring community health centre (CHC)/block/PHC/NGOs (LIONS, Rotary, etc.), retired health workers and staff available from other government agencies such as Medical Colleges, ANM/Nurse Training School, Employee's State Insurance Corporation, Central Government Health Scheme, Armed Forces, Railways, District Urban Development Agency (DUDA)/State Urban Development Agency (SUDA) and Community Based Organizations (CBOs) should be utilized to reach the largest number of children.

Please note: Under Part C of Programme Implementation Plans (PIP) of NHM, as per norms there is a provision to hire vaccinators for urban slum/

marginalized areas/other high-risk areas in district.

- **Timings:** The activity will be conducted from 09:00 Hrs to 16:00 Hrs. However, sessions should be planned based on availability of the target population to maximize the benefits. In urban settings, DTFI or DTFUI may take the decision for flexible timings of sessions at certain places to ensure all beneficiaries are immunized. Remember to ensure functional AEFI management centres on the given day/time of sessions and proper implementation of Open Vial Policy.
- **Team:** A team will comprise of one vaccinator and two mobilizers, payments to both mobilizers should be made as per financial guidelines (Annexure 6). An additional vaccinator will be included in the team if the estimated injection load is more than 60–70 beneficiaries.

5.1.2 Mobile sessions

Mobile sessions should be planned at places where routine immunization coverage is weak and a small number of beneficiaries does not warrant an independent session. These places include peri-urban areas, scattered slums, brick kilns and construction sites. Need-based financial projections may be made and for these sessions, alternate means such as mobile vans should be planned in the format given at Annexure 10.

It is important to ensure that all vaccines are made available at the session sites including BCG, Measles, Rotavirus vaccine and Japanese Encephalitis (JE) vaccines, wherever applicable, and the vaccines that are opened at one site are not used at the next site. The Integrated Child Development Services (ICDS) department & Rashtriya Bal Swasthya Karyakaram (RBSK) school health teams may be involved for these mobile sessions in these hard-to-reach areas. Additional requirement of vehicles for mobile sessions (urban/ rural) may be met through vehicles supported by other departments or hired vehicles, the support required for the same may be projected in supplementary PIP.

5.1.3 Planning considerations

Based on evidence and best practices from the polio eradication programme, the following activities will be critical for the planning and successful implementation of Intensified Mission Indradhanush:

- **Meticulous planning of immunization sessions at all levels:** It is important to plan sessions for identified areas where the reach of immunization programmes is inadequate. Ensure availability of all vaccine and sufficient vaccinators during routine immunization sessions.
- **Intensive training of health officials and frontline workers:** Build capacity of health officials and workers for micro-planning and immunization activities to ensure the highest quality of immunization service delivery to beneficiaries.
- **Supervision of IMI activities:** Appropriate human resource needs to be identified for supervision of IMI sessions, identification of gaps, on job training of staff, collation of reports and replenishment of vaccines at session sites if required. Need based mobility support should be arranged for this activity. All supervisors will attend daily evening debriefing meeting along with monitors at the planning unit similar to polio campaigns.
- **Effective communication and social mobilization efforts:** Generate awareness and demand for immunization services through need-based communication and social mobilization activities (mass media, mid media, interpersonal communication, school and youth networks and corporates). Involve NCC, NYK and NSS volunteers for mobilization of beneficiaries to session sites. These mobilizers are to be included in the micro-plan by name.
- **Establish accountability framework through task forces:** Enhance involvement and accountability/

- Include all immunization sessions held under Intensified Mission Indradhanush (that are not part of routine immunization microplan) into routine immunization microplans.
- The budgetary support required for achieving the objectives under Intensified Mission Indradhanush strategy should be reflected in the district action plan and subsequently in the state supplementary PIP.
- In the supplementary PIP, requirements for improving coverage in urban areas should be reflected under the NUHM component of PIP.
- To achieve the objective of >90% full immunization coverage by December 2018 - the supplementary PIP may project need based requirements for pre-IMI during IMI and Post IMI activities (RI strengthening) during the current financial year.

ownership of state and district administrative and health officials through state and district task forces for immunization. It is important to use concurrent session monitoring data to plug gaps in implementation. State steering committee to review quality of STFI/DTFIs.

- **Explore opportunities under Corporate Social Responsibility (CSR):** Need based support may be sought by states for getting additional support for activities under corporate social responsibility mechanism. This plan would be part of the comprehensive communication and social mobilization planning. The states would need to identify and be specific about the tasks and how their support will be monitored for achieving the objective.
- **Independent monitoring of IMI activities:** to be conducted by partners. Daily evening debriefing meetings similar to polio programme will be conducted at all levels to ensure mid-course corrections. Feedback to district and state task forces is mandatory.

5.2 Communication planning and implementation for Intensified Mission Indradhanush

Strategic and integrated communication in Intensified Mission Indradhanush (IMI) will help communities, parents and key stakeholders to understand the importance of Routine Immunization (RI) in protecting children from life-threatening childhood diseases, increase their confidence in vaccines, address their misconceptions and fears and motivate them to seek immunization services. Only the most appropriate communication approaches, methods or channels based on evidence must be developed. This section provides practical guidance on reaching the unreached with key RI messages and collaborative implementation of communication aimed at achieving 90% full immunization coverage.

5.2.1 Key communication objectives

As identified earlier, the specific goal of IMI is to identify missed children and immunize them with the life-saving vaccines and ensure that they are completely immunized as per their age. Children who have missed vaccinations may belong to one of the LODOR [Left outs, Dropouts, and Resistant] families/communities.

To achieve the above goal, two clear communication objectives for IMI are:

1. Generating support for IMI (creating an enabling environment)
2. Generating demand for RI under IMI (mobilizing parents/caregivers/communities)

The communication activities to achieve these two objectives are broadly divided under the following key strategies, although they are closely linked to each other:

a. Advocacy
b. Media management (news media, social/digital media, personal media)
c. Social mobilization
d. Capacity building
e. Managing crisis

How to know communication is working: Indicators of effectiveness

The communication activities carried out for IMI will be seen to be effective when the following communication indicators are achieved:

1. *Support for promoting RI is achieved from diverse stakeholders (this means advocacy has resulted in gaining support for RI)*
2. *An enabling environment is created that generates confidence in vaccines and demand for immunization (this means RI is accepted and discussed at all levels in society as important and necessary)*
3. *RI is understood and recognized by the targeted communities/caregivers as an important means to protect children from life-threatening vaccine-preventable childhood diseases (this means parents/caregivers and communities have adequate information and confidence to demand RI)*
4. *Any potential crisis has been managed effectively (this means everyone linked to the program are aware and skilled to manage an unfortunate crisis effectively)*

NOTE 1: Advocacy and social mobilization must be conducted simultaneously, not one after the other is over.

NOTE 2: From the start, involve the IEC unit/State IEC Bureau in the development and operationalization of the communication strategy.

5.2.2 Getting prepared: Basic Communication tools for IMI

IMI is scheduled to begin in all identified districts on 7th October 2017. Ensure that there is full preparedness to implement IMI communication (use preparedness checklists). A preparedness assessment will be carried out by national monitors in early September. A quick activity checklist is given below:

1. Make an internal announcement to all stakeholders for getting prepared on the date.
2. Carry out a resource mapping of existing communication capacity (HR, skills and finance) at district and block levels; fill any communication gaps strategically; if necessary, do necessary advocacy at relevant authority for acquiring resources
3. Fix accountability for communication at different levels
4. Ensure availability of the pre-developed IEC/communication tools:
   a. Advocacy kit
   b. IEC package on IMI messaging adapted from MI messaging.
   c. *5 saal, 7 baar* communication package (already shared in open file formats, with guidelines on their use)

Ensure all relevant advocacy and communication tools developed for IMI are available in the required file formats, translated/adapted as required to match the local context, and with clear guidelines on their effective use.

5.2.3 Generating support: Creating an enabling environment for IMI

IMI communication must aim at creating an enabling environment in which high uptake of RI is achieved especially in LODOR families/communities. Enabling environment means there is positive support and discourse for achieving RI goals. An enabling environment generates confidence in immunization and the immunizer. This will only happen when relevant stakeholders are:

◊ Aware of the IMI through adequate visibility

◊ Feel motivated and try to learn how they can support in achieving that mission

◊ Gain the capacity to support any or all IMI activities

◊ Updated on progress being made and any remedial action needed for improvement

◊ Fully aware of preparedness and possible participation for managing any potential crisis and challenging any myths and rumours

5.2.4 Advocacy for IMI

The main objective of advocacy is to ensure support for IMI implementation.

Preparing for advocacy: While it is ideal to create targeted advocacy tools and messages for each different stakeholder, some preliminary preparedness should be made with the following:

- Obtain advocacy letters (to be issued by Health Department at state level/DCs or CMOs at District level to proposed advocacy partners)

Developing a Social media strategy

In recent times, the overwhelming use and power of social media for wider reach and access has been well established. Social media is being used in the immunization sphere successfully to leverage the reach of the programme, influence communities and highlight the programme. At the same time, the recent new vaccine launches and scale-up campaigns have demonstrated vulnerability of social media in spreading negative ideas and rumours on vaccines. Concerted efforts will therefore be need to use social media platforms for IMI to build awareness and trust around vaccines and build a positive environment around vaccines. Therefore, the approach to communication for IMI will be a comprehensive mix of traditional mass media, mid-media, social media/digital media and new media.

- Draft a simple MOU (only if necessary with any advocacy partner)
- Have an advocacy kit. An advocacy kit will comprise the following:
    - ◊ Factsheet on IMI
    - ◊ Presentations for advocacy with different influencing groups
    - ◊ Details of key spokespersons, and activity coordinators at district/block level, including relevant partners and stakeholders

Since advocacy needs to be carried with different levels of stakeholders, the advocacy process may involve one-to-one personal meetings, with or without presentations, advocacy workshops, or piggy-riding during events of potential advocacy partners. See table 3 for various advocacy methods.

Prepare a list of advocacy groups/institutions and advocacy objectives for IMI: For example, advocacy with faith leaders will be for the purpose of mobilizing communities of specific faiths, while inter-sectoral advocacy such as with Directorate of Field Publicity will be done to gain support in disseminating messages widely. The different targeted advocacy groups for IMI will include the following:

- ◊ *Advocacy with Parliamentarians:* local MLAs, MPs
- ◊ *Inter-sectoral advocacy:* This includes relevant departments from other sectors, primarily education, women and child development, rural, urban, tribal, directorate of field publicity, police (for conflict regions), NCC, Dept. of youth and sports (Nehru Yuvak Kendra) etc.
- ◊ *CSO advocacy:* Such as youth networks (NSS, NYK), faith-based groups, Rotary, Lions Club, other national-level and local-level recognized NGOs, traders and occupational leaders
- ◊ *Advocacy with private health service providers:* State chapters of IMA and IAP, private medical institutions

1. **Advocacy with Institutional structures:** Self-Help Groups, Mahila Mandals, Rogikalyan Samiti, Jeevika Group, PRI/Urban Local bodies/ VHSNC, IMA, IAP – meetings with IAP/IMA members, interviews with them, bytes from them disseminated through WhatsApp, use of IAP/ IMA websites .
2. **Advocacy for the Urban areas:** In the urban areas for advocacy , meetings / discussions to be done with Lions , Rotary, Red Cross Society, RWA members, Counsellors, Municipal Corporation members and Ward Members. Members of these groups will be invited for state and district level IMI orientations. IMI communication materials will be made available to these key partner groups.

State-level advocacy will be intersectoral, and include state-level media, and state-level CSO bodies. District-level advocacy will be with district-level departments, local and urban bodies, district-level media, and district-level NGOs. However, advocacy with state chapters may be sufficient in many cases, and therefore state and district need to coordinate these activities effectively. The details of the process of advocacy may be referred at Annexure 17E.

Table 3. Common advocacy methods and kits

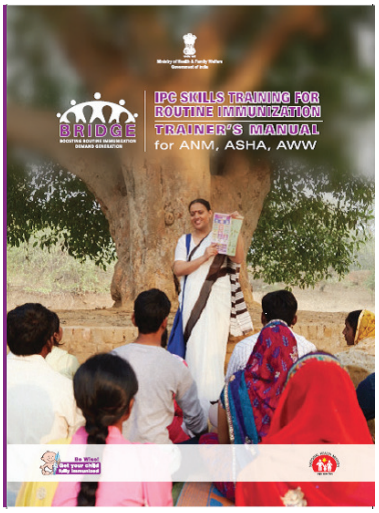
Some common advocacy methods	Advocacy kit
Parliamentary advocacy (through Minister of Health) and use of the MP/ MLAs web pages, facebook pages and Twitter handles	Factsheets (Data and evidence sheets)
One-to-one meetings	Detailed brochure (Printed Information material in English/Hindi/ Local language)
Group meetings (Round-table discussion, workshop, event launch)	PPTs (Power-point presentations)
Network meetings	Videos for group meetings
Influencer access	Customized Messages
Media orientation workshop	Media reports

Planning tool: Use **Annexure 17A** for State-level communication planning, and **Annexure 17B** for District-level planning

5.2.5 Capacity building for Communication for IMI

Capacity building will be a core component of the strategic intervention for IMI. It will help in developing the necessary skills to plan, implement, and monitor IMI, deal with crisis, mobilize communities and make efficient use of resources. Some of the essential capacity building interventions will include the following:

1. IMI communication session as part of State TOTs (Lead trainers will include Senior Programme Managers from the State Health System and supported by development partners). SBCC Master Trainers trained under UNICEF support will be participants at this training.
2. District-level trainings for IMI communication using cascade mode. SBCC trained district-based trainers will be mobilized for participation and to do the trainings at block level for communication.
3. BRIDGE IPC Skills training for frontline workers (ANM, ASHA and AWW) at district and block level. The BRIDGE trainings will be conducted prior to the roll out of the IMI activities as a part of the micro-planning trainings/ review. [Resource: Trainer's Guide and IPC job Aide are already available as tools. Partner support (UNICEF, WHO, JSI, BMGF) will be provided in conducting the Master Trainer TOTs at the State level]. The district-based trainers will then do the block-level trainings for FLWs separately for ANM and ASHA and AWW.
4. AEFI protocol trainings (may be combined with Technical trainings)
5. CSO orientation on communication plan and use of monitoring tools
6. Media spokespersons training on IMI at state and district level



Preparing for capacity building

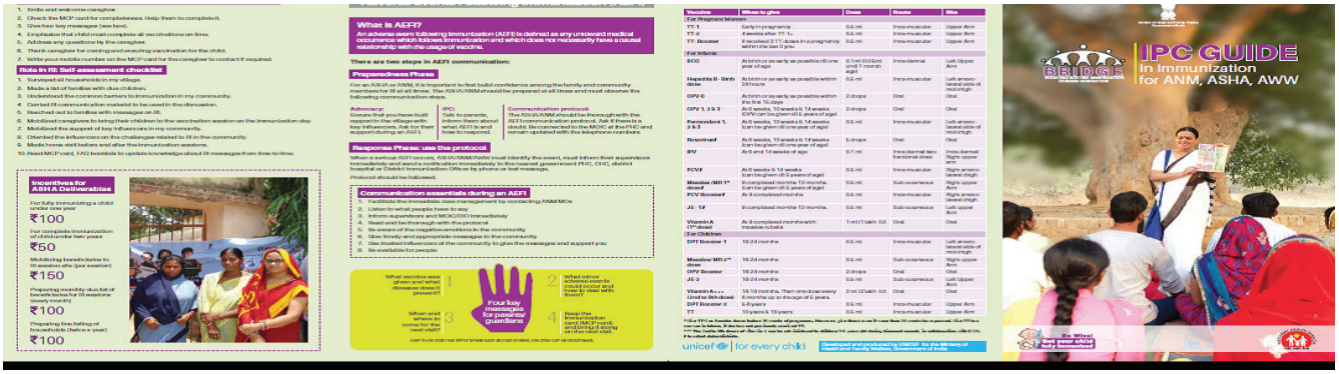
Towards good preparedness for capacity building, the following must be done:

1. *Develop a training calendar:* State will facilitate the development of a Training calendar, clearly indicating the specific objectives of each training, participants list, potential dates for training, trainers' names, training tools and methodology, training duration, venue and budget source. An indicative Training Calendar Template is given below:

Table 4. Template for training calendar

Training Name and Objective:						
Date	**Venue**	**No of Participants**	**Resource person**	**Duration and Tools**	**Budget source**	**Person in charge**

2. *Ensure availability of trainers, and training resources:* These may have to be formalized with necessary letters and approvals. Adequate number of the required training resources must be made available before beginning of the training.
3. *Supportive supervision:* Supervision must be provided during training to ensure quality. Development partner support will be needed for capacity building, therefore state/district should hold planning meetings with the development partners.



Planning tool: Use **Annexure 17A** for State-level communication planning, and **Annexure 17B** for District-level planning

5.2.6 Social Mobilization and Community engagement

Social mobilization brings together the important stakeholders and influencers within the community to partner with the programme for successfully achieving the goals. It uses all communication methods to engage with the communities and families in dialogue to inform, answer questions, clear misconceptions and instil trust in the programme. Social mobilization can make a huge difference in reaching out to all the left outs (children not vaccinated at all) and dropouts (children who started the vaccination but missed subsequent doses) and resistant families.

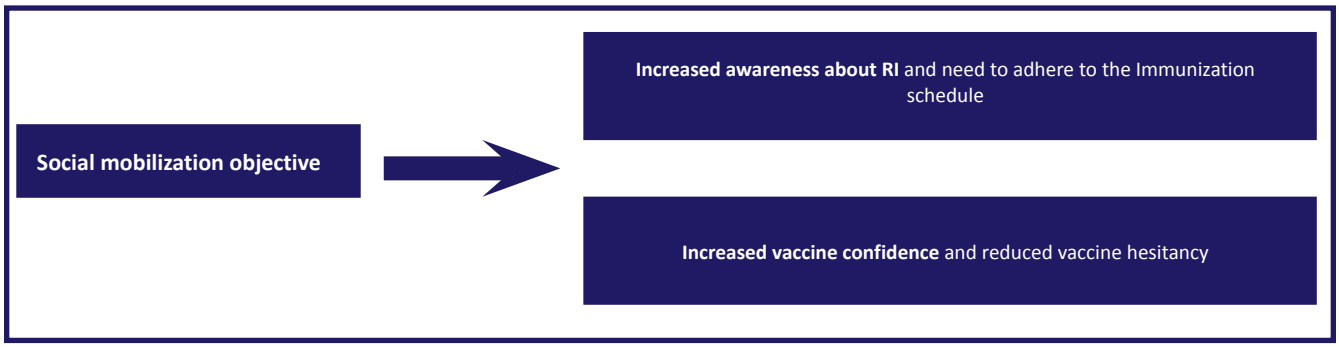


Figure 4. Objectives of social mobilization

Three important factors that will ensure effectiveness of the social mobilization interventions are:

1. **Planning** which includes identification of community needs, identification of LODOR families and communities, locally appropriate communication approaches to reach specific communities, identification of key influencers, and ensuring communication materials and resources are available.
2. **Effective implementation** of the communication plans entails that the frontline workers (ANM, ASHA, AWW, community volunteers and other mobilisers) are well trained before the IMI launch. FLWs, if properly trained and informed, can motivate and generate community interest in the UIP. They are the first contact the community has with the health system and are also the primary respondents to any doubts or myths about RI in the community.
3. **Supportive supervision and monitoring:** Social mobilisation and community engagement planning should have an important component of supportive supervision. This process will ensure that the communication plans are being implemented effectively and also FLWs are supported where they face challenges. A group of supervisors/monitors to be identified, trained on the checklists/formats (see Annexure on Monitoring Formats) and be deployed for monitoring and review meetings.

Key actions for social mobilization.

I. Planning and preparatory phase

a. Training of FLWs, mobilisers and influencers

- Besides conducting training of FLWs on the IMI guidelines, IPC skills training using BRIDGE must be used.
- Orientation identifying and motivating local influencers on IMI, the role of influencers to support FLWs
- Distribution of IEC materials and orientation on the usage of the IEC materials

b. Survey of the community

- As per the IMI guidelines, identify areas which are left out, drop out and resistant.
- Identify community, religious influencers, and occupational influencers who could support in reaching to the specific communities with messages
- Ensure that all pockets of settlements, mobile and migrant groups are listed.
- Update the beneficiary due list for IMI immunization microplans and review at PHC level

II. Implementation of mobilization activities for IMI:

- Target specific communication plans to be developed for high priority urban areas, tribal areas,

underserved areas and pockets with resistant and hesitant population

- For example, urban communication strategy will especially explore engagement with local municipal bodies, CSOs, corporate sector, trader's bodies, and use of mass media resources in urban areas. Implementation of the communication strategies will depend on the partnerships as there may be limited access of ASHAs in urban settings. Engaging with the CSOs to mobilise the urban population as per the appropriate timing will be effective. For urban areas, a nodal officer should be designated to coordinate the activities in the urban areas. In urban areas, ensure that Urban Health Posts, PP centers, Family Welfare Centers are utilized as immunization sites. For other areas, appropriate sites should be identified to fill the gaps. These could be primary schools, AW centers, mosques, madrasas, private clinics, NGO sites, etc. Efforts have to be made that the immunization services are made available from these sites regularly even after the drive.
- **Some of the mobilization activities are listed below:**
- IPC with key influencers including religious leaders, PRI members, Village leaders, VHSNC members
- Engage influencers in community meetings to support IMI campaign and in the implementation of IMI.
- Conduct community/ mothers meetings for IMI and inform the benefits of vaccination
- Organise announcements from religious institutions like Temple/Mosque/Gurudwara/Satsang/Churches prior to IMI session in the village as appropriate to the communities.
- Engage with munshis/ sardars to reach the construction/ brick kilns.
- Organise rallies with school-children in partnership with local CSOs.
- Prepare route maps for drum beating and miking where it is required in the community.
- Mobilization plan of beneficiaries for IMI/RI sessions on the day of the session.
- Ensure updating of immunization card with vaccines given at the session site
- Ensure delivery of the four key messages, including 30 minute waiting after the immunization.

<u>Use of IEC for social mobilization</u>

A package of communication materials is available for IMI which includes materials for mass media, mid-media and IPC, and is to be used strategically with the target audiences prior to, during and post IMI rounds. The package of communication materials would include the following:

Table 5. Overview of activities to be conducted by FLWs for IMI

Before the IMI/RI session day	On the day of RI session	After RI session day
•Update the due list/ microplans •Conduct community/mothers meeting to -inform about the RI session, discuss about the importance of immunization and address the key challneges including AEFI •Make home visits to educate parents for immunization, date , time and venue of the sesion •Make home visits to the drop out and left out families •Remind parents to bring the MCP card to the RI session • Strategic display of IEC materials •Keep the RI card counter foils ready with ANM •Keep a few blank MCP cards for new registrations •Keep a copy of the AEFI protocol ready •Orient the community influencers about RI session and seek their support as required.	•Remind parents in the morning •Organise parents at the session site •Interact with each mother/ caregiver on the vaccines to be given •Assist ANM in filling out the cards •Give four keys messages to the parents •Ensure child & parent waits for 30 minutes after vaccination •Attend to any child that may show signs fo uneasiness • Arrange to mobilise any child who hasnt been bought for the vaccination	•Make follow up home visits upto two days for every child who received vaccination and inspect the child for any significant adverse signs of danger. •Inform ANM and make immediate and necessary actionas per the protocol •Keep your supervisor informed about the daily visits and any developments.

a. IEC package on IMI messaging adapted from MI messaging.

b. 5 saal, 7 baar communication package (already shared in open file formats, with guidelines on their use)

The latest communication campaign **'Paanch Saal, Saat Baar' (5 saal, 7 baar)** will be used all throughout IMI. The package contains different formats of communication for different channels, and can be adapted for different platforms.

1. Digital (TV spots and radio spots)
2. Gif formats for WhatsApp
3. Newspaper advertisements
4. Posters

5. Banners
6. Wall painting

Open files of these prototypes have been shared with states during the BRIDGE workshop, along with guidelines for effective use.

Display of IEC

- ASHAs should receive 5 posters per planning unit (as per MI guidelines). Posters are useful in many ways, especially in creating visibility and reinforcement of key messages.
- Care should be taken while pasting the posters – choose an appropriate site, outside in public view and not indoors, paste at the eye level, neatly. Do not put up too many posters at the same site, it will be a waste of resources.
- Tie up the booth banner at the site to indicate the IMI session site, it helps the communities, caregivers to easily reach the site and also to the monitors in reaching the session site.

Detailed guideline of the use of the communication materials for IMI will be communicated to the states as an addendum.

Use the IEC norms used for MI rounds.

5.2.7 Crisis management

Specifically in RI, there are two kinds of crises that the state and districts need to be prepared for, as these have the potential to derail the IMI programme. Preparedness for a crisis is the best measure to avoid any untoward event, and this means having a strategy in place and being well prepared. The programme management team, specifically at the Block and District levels, need to have a crisis management plan to avert any such incidents. A Crisis Communication plan needs to be prepared at the state and district level to prepare for crisis.

Myths and rumours management

Various forms of myths and rumours about the impact and quality of vaccines are created due to ignorance. Social media such as Facebook, YouTube, Twitter and WhatsApp are often used to spread rumours. Those parents/caregivers or communities who have inadequate awareness about RI or low vaccine confidence irrespective of any previous experience with vaccines, are prone to getting easily influenced by such myths and rumours. The programme management team, specifically at the Block and District levels, need to have a crisis management plan to avert any such incidents. This means doing the following activities:

1. Be alert and closely monitor every single communication about RI on various media.
2. Have a well-coordinated internal communication channel so that any negative communication is identified, collected, assessed, and information about it is conveyed to appropriate authorities in the protocol ladder to take immediate action.
3. Ensure all existing information about vaccines/RI has reached every family/community.
4. FLWs have been able to meet parents and caregivers and counsel about vaccination.
5. Ensure there is strong media relations, and media has been sensitized about the impact of negative media reporting on the RI programme.

AEFI management

The challenge of adverse events following immunization (AEFI) post vaccination is an unfortunate event, which dampens and derails the Immunization programme. Often lack of clear information and communication about AEFI leads to rumours and fears among caregivers, larger community and stakeholders. In such situations, spokespersons trained in AEFI media management

protocols need to be deployed for addressing the media as per the SOPs. Influencers need to be used for addressing the crisis at the community level.

For mitigating the impact of AEFI in the community, the following needs to be undertaken:

1. *Training on AEFI protocol:* Every person responsible for implementation of IMI must be made fully aware of the AEFI protocol and ensure it is followed thoroughly. The AEFI protocol is provided and clearly laid out in all training curriculums for both medical officers and health workers.
2. *Media preparedness and management:* An AEFI has the potential to be reported in the media and public in a manner that creates more panic, especially if there is a severe illness or an unfortunate death which may or may not be associated with immunization at all. Hence, having a preparedness plan with media is always useful. For this, frameworks for media briefs/ press releases need to be prepared in advance using the templates provided in the AEFI Media Communication Protocol.

5.2.8 Media strategy

The media strategy includes a comprehensive media management plan, including the following:

1. Conduct of media workshops
2. Regular monitoring of media reports
3. AEFI sensitization workshops for media
4. Positioning articles on RI in the media by different stakeholders and influencers
5. Providing media with spokespersons.
6. Advocacy with media owners who have the widest reach in the said districts
7. Leverage the *'Zile ka Hulchul'* program of All India Radio and leverage the trained district radio stringers (training ongoing since last three years by UNICEF)
8. Setting up a system of regular interaction with national media

Preparedness for media will include having a media kit ready with factsheets and contacts for different stakeholders

Social media for IMI

The platforms of social media, Facebook, Twitter, YouTube and WhatsApp will be used to generate positive conversations around IMI and benefits of complete immunization, with emphasis on the monitoring of online conversations to amplify positive messages. A proactive and sustained strategy will be used for sharing of positive messages around the disease burden and the need for full immunisation. Outreach will be done through Twitter and Facebook through existing twitter handles and websites and pages of MoHFW, PIB, partners and identified social influencers. Monitoring of negative conversation, myths, rumours in social media will be done regularly and positive content will be shared regularly to counter and dissolve these through seeding of positive and factually correct information on immunization.

5.2.9 Monitoring

Communication monitoring system will capture most of the input and process indicators and a few output indicators related to communication initiatives for IMI. The communications activities will be monitored at three levels by the government and development partners. This includes:

- Session Site level communication monitoring for IMI
- PHC/ Planning Unit level communication monitoring tool for IMI: This tool will be used for pre assessment (30 days & 15 days before IMI campaign) and during IMI campaign.
- District-level communication monitoring for IMI: This tool will be used for pre-assessment (30 days & 15 days before IMI campaign) and during IMI campaign.

IMI communication monitoring format have been included in NCCMIS website (http://www.nccvmtc.org/ss/login.asp) and monitors will directly enter their monitoring data into the website using state specific user id and password (see Annexure on monitoring formats). Once the data entry has been done, user can see the report and analyze data from the website. Monitoring feedback will be shared with field level workers and monitors will ensure that immediate corrective measures are taken through a supportive supervision approach. This analyzed data and monitoring feedback will also be shared with all the concerned officials for action.

Roles and responsibilities in operationalizing IMI communication at national, state and district level is given at Annexure 17F.

Prepare a **Gantt chart** for all activities with **7th October** as start date for IMI implementation.

Chapter 6

Steps for Roll-Out of Intensified Mission Indradhanush

The GoI has set up a national level inter-ministerial committee to ensure intersectoral coordination between the different ministries/departments and all the partners as well as review the planning, implementation, support and monitoring of the programme. Regular scheduled meeting of all planned committees is to be held at each level with clear objectives, agenda and action points with review of the action taken on the discussions in the previous meeting. The minutes are to be shared with all participants in a time bound manner. It should be ensured that the tasks are completed in a time bound manner to avoid any loose ends.

Review mechanism: Cabinet Secretary, Govt. of India will review the activity. Reviews will also be conducted under "PRAGATI".

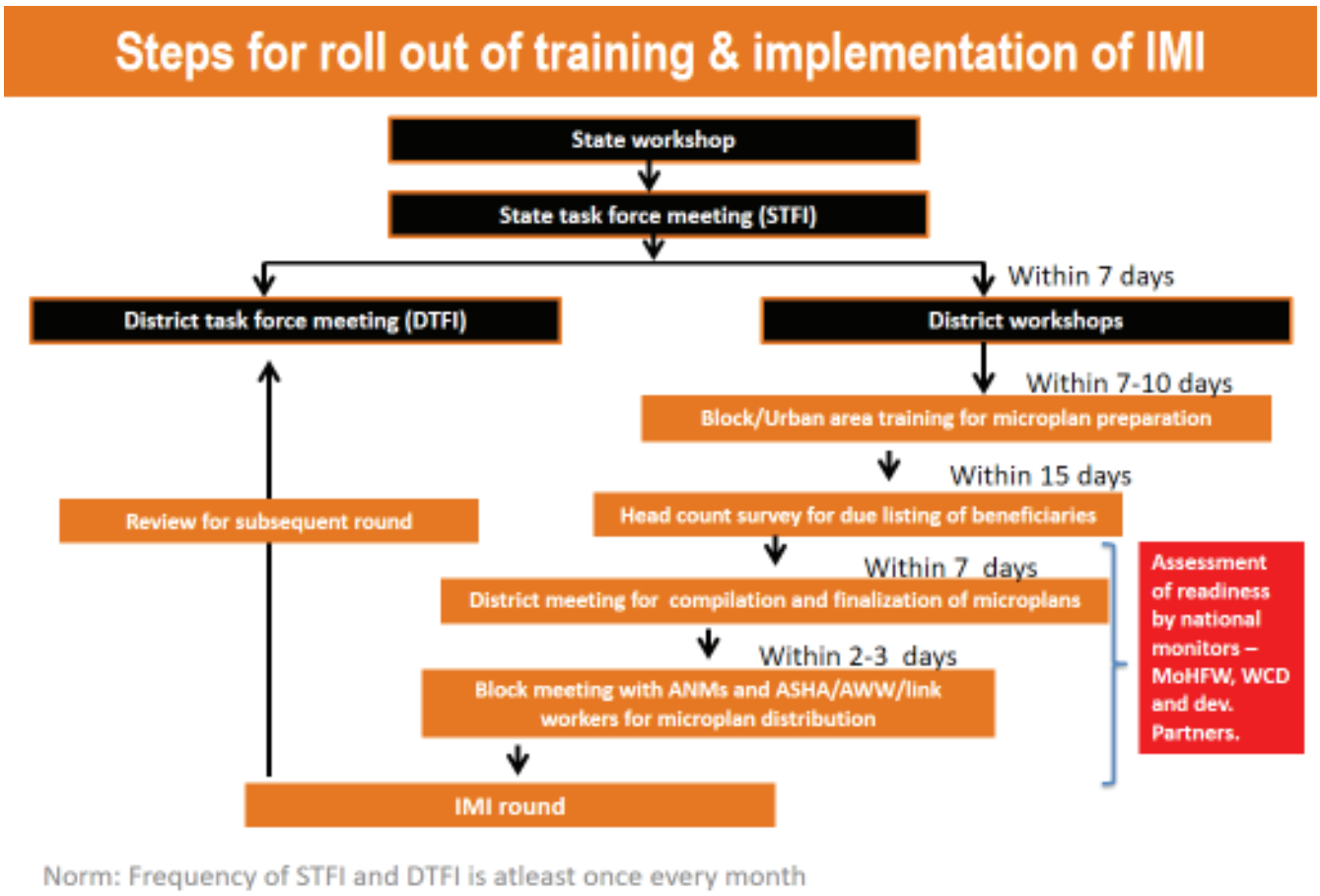


Figure 5. Steps for roll out of training and implementation of IMI

Chapter 7

State-Level Activities for Intensified Mission Indradhanush

The following activities should be undertaken at the state level for the successful implementation of Intensified Mission Indradhanush:

7.1 Establish State Steering Committee for Immunization

The task forces for immunization at state and district levels were constituted on the polio model;

Chairperson: Chief Secretary

Convener: Principal Secretary, Health

Members:

Government Departments: Health, Women & Child Development (WCD), Panchayati Raj, Urban Development, Housing and Urban Poverty Alleviation, Defence, Sports & Youth Affairs, Human Resource Development, Education, Minority Affairs, Information & Broadcasting, Railways, Home Affairs, Labour and Employment, Mining, Tribal Affairs and any other relevant departments

Development partner – WHO, UNICEF, UNDP, JSI, Rotary International, CORE, BMGF, IPE Global etc.

Frequency: Once in preparatory phase, once just before the first round to review preparedness and once after each round to review the recently concluded campaign and suggest recommendations for corrective actions to be taken in the next campaign.

Activities to be conducted:

- Ensure accountability framework – Regular STFI, DTFI
- Ensure active engagement of other line departments for IMI.
- Mobilize human/other resources and coordinate planning and other activities with other departments.
- Institute reward/recognition mechanism for achievement of best performing district/block/ urban ward

Role of key government departments at State level in Intensified Mission Indradhanush:

The non-health departments may identify their HR at state level and district level that may support the Intensified Mission Indradhanush through IEC activities and social mobilization. Departments/PSUs having their own hospitals/dispensaries may support through identifying their infrastructure and human resource in the selected districts that could be utilized for delivery of immunization services, specially in urban areas.

The detailed roles expected from other departments is given at annexure-18.

7.2 Meeting of State Task Force for Immunization (STFI)

The task forces for immunization at state and district levels were constituted on the polio model to critically review the current status of routine immunization, identify programmatic gaps, decide strategic actions to improve the coverage of UIP and monitor the implementation of these actions.

This institutional mechanism plays a pivotal role in improving and delivering high quality immunization coverage across all states. Task forces meet periodically to review routine immunization programme performance through a detailed review of administrative and monitoring data, microplanning, training status of frontline workers, and vaccine and cold chain management, with a special focus on high priority areas. They also identify operational constraints and ensure corrective operational steps to improve routine immunization coverage.

Critical activity: Intensified Mission Indradhanush preparedness / progress review

A video conference by Principal Secretary/Mission Director with Intensified Mission Indradhanush districts (DM/CMO/DIO/ Urban Nodal officer/ weak performing Block MO in charges and partners) will help in better understanding the progress in terms of planning and implementation.

STFI to closely monitor quality of DTFIs

Frequency: at least once before each round

Chairperson: Principal Secretary, Health

Co-chair: Mission Director, National Health Mission (MD NHM)

Member Secretary: State Immunization Officer (SIO)

Members; State-level partner agencies, CSOs, key departments, religious leaders

Timeline: First meeting within 2 days after receiving official communication from the national level. Conduct meetings following completion of each round to review coverage data, monitoring feedback and any other issues, and to plan for the next round.

Frequency: Once every month during preparation phase, once before every round during implementation of IMI and once during IMI rounds for mid-course corrections.

Review mechanism: State Steering Committee and MoHFW will review the activity. Activities to be conducted:

- Provide technical guidance, including funding and operational guidelines, and fix timelines for districts to plan and implement immunization weeks.
- Communicate with district magistrates for conducting meetings of DTFI and district workshop for Intensified Mission Indradhanush after the state workshop.
- Involve other relevant departments including ICDS, PRI and key immunization partners such as World Health Organization (WHO) India, National Polio Surveillance Project (NPSP), United Nations International Children's Fund (UNICEF), Rotary International, Reproductive, Maternal, Newborn, Child Health and Adolescent Health (RMNCH+A) lead partners and other organizations at state and district levels. CSOs, including professional bodies such as IMA and IAP, should also be involved.
- Ensure identification of the nodal officer for urban areas in each district. He/she will facilitate microplanning in urban areas of the district.
- Develop a media plan and ensure adequate number of IEC materials (as per prototypes) and updated planning and reporting formats are printed and disseminated to districts in time. Ensure that these materials are printed in local languages if required.
- Deploy senior state-level health officials to each district identified for monitoring and ensuring accountability framework. They should visit these districts and oversee the activities for the roll-out of Intensified Mission Indradhanush, including participation in DTFI meetings and assessment of district preparedness.
- Track districts for adherence to timelines, including microplanning, indenting of vaccines and logistics, and roll out of Intensified Mission Indradhanush. All districts should conduct these drives on a common date.
- Fix date and time and conduct video conferences with districts and urban local bodies to review and resolve issues related to microplanning, vaccines and logistics, human resources availability, training, waste management, AEFI and IEC/BCC. District participants will include district magistrate, chief medical officer (CMO), district immunization officer (DIO) and nodal officer for the urban area.

Review and need based approval of additional fund requirement through supplementary PIPs by districts:

  - ◊ Mobility support to health workers for conducting vaccination sessions in places outside area of posting
  - ◊ Mobility support for supervisors
  - ◊ Vehicles for mobile vaccination teams
  - ◊ Need based hiring of vaccinators in both rural and urban areas
  - ◊ Support for communication activities
  - ◊ Timely tracking of approval, receipt and disbursal of funds up to level of frontline HW and mobilizers
  - ◊ Any other support needed by the districts

- Review each round of Intensified Mission Indradhanush and guide corrective actions.
- Ensure inclusion of Intensified Mission Indradhanush sessions in regular routine immunization plans.
- Minutes and actions taken report of each meeting should be circulated to officials concerned and communicated to MoHFW, GoI.

7.3 State workshops and review

The objective of state workshops is to build capacity of district officials like the health Directors, SIOs, by the National team. These workshops also aim at strengthening social mobilization among communities, and ensuring accountability and effectiveness of government programmes.

Responsibility: State Immunization Officer

Technical support: Key development partners such as

WHO India NPSP, UNICEF and others

Financial support: Through NHM

Timeline: To be completed by end-July.

Participants: DIO and one MO from each district, representatives from partner agencies WHO, UNICEF, UNDP, Core etc.

Review mechanism: MoHFW will be actively involved and would review the activity.

Activities to be conducted:

- The district trainers will be oriented on the details of the intensified drive and conducting planning exercises that emphasize on head count survey and preparation of due list of beneficiaries with special focus to the vulnerable areas.
- Train district-level trainers on use of updated planning formats for Intensified Mission Indradhanush, reporting and recording tools such as revised immunization component in mother-child protection (MCP) card, registers, due lists and tally sheets, inclusion of identified beneficiaries in MCTS/RCH portal, immunization tracking bag (one per session site to be used by ASHA/AWW).
    - ◊ State health authorities and partners should intensively monitor training for quality and attendance and share findings with STFI.
    - ◊ Post district-wise progress of training status on the website of the state health department.

Details of trainings to be conducted at state level are given in Table 5.

Table 5. State-level workshops and review

S.No.	Trainees/ Participants	Trainers/ facilitators	Duration	Timeline
1.	**MOs:** DIO and one MO from each district (two persons per district). Also include SMOs of WHO India NPSP, UNICEF district coordinators and others such as state programme manager (NHM), state IEC consultant, state ASHA coordinator, state cold chain officer, state data manager, state M&E coordinator (NHM), state finance & accounts manager (NHM). These trainings will be conducted in states with large number of districts. **Financial support: NHM**	National level officers, SIO with support from state cold chain officer, HMIS and MCTS coordinators, IEC consultant and partners such as WHO India NPSP, UNICEF and others	One-day workshop	Last week of July
2.	**Intensified Mission Indradhanush media sensitization meeting:** Workshop for sensitization of media (print/ electronic). **Financial support: NHM**	SIO with support from UNICEF, Rotary, WHO India NPSP and other partners, state IEC consultant and media officer. Principal Secretary to chair and MD NHM to co-chair the meeting.	Half-day workshop	At least 1 week prior to the launch
3.	**Intensified Mission Indradhanush review workshops:** Review of districts to be done in between the rounds of Intensified Mission Indradhanush by meetings/ video conferencing with DIOs. **Financial support: NHM**	SIO with support from UNICEF, Rotary, WHO India NPSP and other partners. Principal Secretary to chair and MD NHM to co-chair the meeting.	Half-day workshop	Between the rounds

ASHA: Accredited Social Health Activist; DIO: District Immunization Officer; HMIS: Health Management Information System; IEC: Information, Education and Communication; MCTS: Mother and Child Tracking System; MD NHM: Mission Director, National Health Mission; MO: medical officer; SIO: State Immunization Officer; SMO: Surveillance Medical Officer

Chapter 8

District-Level Activities for Intensified Mission Indradhanush

The following activities should be undertaken at the district level for the successful roll-out of Intensified Mission Indradhanush.

8.1 Meeting of District Task Force for Immunization (DTFI)

The District Task Force for Immunization had been constituted to enhance involvement and accountability/ ownership of the district administrative and health machinery in the routine immunization programme, ensure inter-sectoral coordination, review the quality of routine immunization microplans, tracking and mobilization efforts, plan for vacant sub-centres, training status and vaccine logistics, with a special focus on high-risk areas.

Chairperson: District Magistrate

Member Secretary: DIO

Responsibility: CS/CMO

Members: CS/CMO, District-level partner agencies, CSOs, key departments including WCD, PRI, Urban Development, Cantonment boards, NCC, Sports & Youth Affairs, Education, Minority Affairs, Information & Broadcasting, Railways, Home dept., Labour dept., Mining, Tribal Affairs and any other relevant departments and organizations , & religious leaders

Frequency: One DTFI meeting every month during preparation phase, once before every round during implementation phase and once during the rounds for mid-course correction.

Review mechanism: STFI

Activities to be conducted:

- Monitor the planning and implementation of each round in the district for progress made and problem solving.
- Monitor training attendance from the high risk areas

Role of District Magistrate/District Commissioner/Municipal Commissioner in Intensified Mission Indradhanush:

District Magistrate/District Commissioner/Municipal Commissioner will lead planning, convergence with other departments, implementation and review of IMI activities followed by integration of IMI sessions into Routine immunization microplans for sustainability of the gains achieved.

Critical activities to be reviewed:

1. Lead DTFI
2. Ensure microplanning based on head-count surveys for estimation of beneficiaries.
3. Optimal engagement of relevant departments
4. Gap assessment followed by need based action plans.
5. Ensure timely disbursal of funds at all levels
6. Requisition of required human resource and infrastructure including vehicles if needed of relevant departments for implementation and monitoring of the campaign.
7. Use monitoring information for action.
8. Robust communication planning at all levels
9. Ensure engagement with CSOs and leverage CSR support for IMI.
10. Review the performance of activities and support redressal of issues.
11. Implementation phase monitoring indicators: FIC, Penta-3, MCV2.
12. Supervision by Health, WCD & other relevant departments.
13. Ensure award and recognition for good performers.

- Ensure identification and accountability of senior officers in the blocks and the urban cities. They will facilitate microplanning in the district.
- Involve other relevant departments including ICDS, PRI and key immunization partners such as WHO India NPSP, UNICEF, Rotary International, RMNCH+A lead partners and other organizations at state and district levels. CSOs, including professional bodies such as IMA and IAP, should be involved. Involve the local and religious leaders.
- Ensure adequate number of printed IEC materials (as per prototypes) and updated reporting and recording tools (MCP cards, registers, due lists, tally sheets) are printed and disseminated to blocks/ planning units in time. Ensure that these materials are discussed and used in the sensitization workshops.

Critical activity: Intensified Mission Indradhanush preparedness / progress review

A DTFI meeting chaired by DM with CMO/DIO/ All Block MOIC especially weak performing Block MOICs, partners, others will help in reviewing and providing directions for better planning and implementation.

DTFI to ensure identification of urban nodal officer(s) for planning and implementation of intensified Mission Indradhanush and routine immunization activities.

- Deploy senior district-level health officials to priority blocks for monitoring and ensuring accountability framework. They should visit these blocks and provide oversight to activities for roll-out of Intensified Mission Indradhanush, including participation in training, monitoring of activity and participation in evening review meetings.
- Ensure availability of required doses of all UIP vaccines and other logistics. This will require a headcount for estimation of beneficiaries in all areas where Intensified Mission Indradhanush sessions are planned.
- Track blocks and urban areas for adherence to timelines, including microplanning, indenting of vaccines and logistics and launch of each round of Intensified Mission Indradhanush.
- Communicate to Principal Secretary (Health) in case dates of Intensified Mission Indradhanush rounds need to be changed due to exceptional circumstances.
- Review microplans to ensure engagement of all ANMs for 7 working days in addition to routine immunization days.
- Monitor progress on key activities such as need based action plan based on gap assessment, communication planning, cold chain and vaccine logistics planning, head count survey completion, validation of head count survey, status of due list preparation, monitoring of activities and timely coverage reporting . Accountability to be fixed for each activity at all levels.
- Ensure timely MCTS/RCH Portal data entry for each enlisted beneficiary and validated HMIS reporting by blocks/district.
- Ensure timely vaccine stock entry into eVIN after each session day (wherever applicable)
- Share key qualitative and quantitative feedback at state level for review
- Vaccines and logistics, human resources availability, mobility of vaccinators when conducting session outside sub-centre area, training, waste management, AEFI and IEC/BCC.
- Review each round and guide corrective actions. Ensure full immunization with focus on coverage with 2 doses of Measles Containing Vaccine.
- Ensure inclusion of Intensified Mission Indradhanush sessions in regular routine immunization plans
- Conduct daily evening feedback meetings during the round at the district for sharing feedback and initiating corrective actions.
- Minutes and action taken at each meeting should be documented and circulated to officials concerned and communicated to MoHFW, GoI.

For roles of other departments, refer to Annexure 18

District Review Committee

The district review committee would be headed by the Chief Medical Officer/ Civil Surgeon.

Convener: District Immunization Officer

Members: District-level partner agencies, CSOs, key departments

Timeframe: To meet twice each month during the IMI phase and daily during each round.

Responsibility: Support the DTFI in their roles outlined and timely implementation of all activities

- Review the microplans, areas to be covered, deputation of staff, IEC, social mobilization plans of all blocks and the urban areas,
- Ensure reporting as per the designed formats.
- Ensure training of all vaccinators and supervisors in the district and each block
- Availability of funds and logistics
- Conduct supervisory visits in the field to assess preparedness and implementation.

8.2 District workshops

The objectives of district workshops are to train block-level officers on the strategy of micro-planning for Intensified Mission Indradhanush, conducting head count survey and preparing due lists. These medical officers will also be oriented in the field of organizing training for frontline workers on the immunization aspects for Intensified Mission Indradhanush. This would be conducted under the supervision of the DM and the CMO.

Responsibility: DIO and Nodal officer in the urban area. He will prepare a training calendar for each type of district-level training as given in Table 2 and communicate the same to DTFI.

Technical support: Key development partners such as WHO India NPSP, UNICEF and others.

Financial support: NHM will support all district workshops in all districts, including workshops for MOs, one-hour training of NHM officials, half-day trainings of data handlers and cold chain handlers and media workshop.

Timeline: To be completed by end July/1st week of August'17.

Participants: Two MOs from each block and urban planning unit.

Review mechanism: DTFI and STFI.

Activities to be conducted:

- Train block-level trainers on use of updated planning formats for Intensified Mission Indradhanush, reporting and recording tools such as revised immunization component in mother-child protection (MCP) card, registers, due lists and tally sheets, immunization tracking bag (one per session site to be used by ASHA/AWW).
- This pool of trainers will conduct sub-district level training of the health workforce including health workers and supervisors (ANMs, lady health visitors [LHVs] and health supervisors) and community mobilizers (ASHAs, AWWs and link workers).
- Sensitize key district-level NHM officials on Intensified Mission Indradhanush.
- Submit progress on training status of each level of functionary to the state immunization officer before the first round of Intensified Mission Indradhanush. Repeat trainings in weak performing areas, with focus on weak performing vaccinators/mobilizers.
- Details of training to be conducted at the district level are given in Table 6.

Table 6. District-level workshops

S.No.	Trainees/ Participants	Trainers	Duration	Timeline
1.	**MOs:** Two MOs per block/urban planning unit. Nominations to be forwarded to DIO. Others include district programme manager (NHM), district IEC consultant, district ASHA coordinator, district cold chain handler, district data manager, district M&E coordinator (NHM), district accounts manager (NHM) **Technical support : WHO** **Financial support : NHM**	DIO and another MO trained at state level and partners (WHO India NPSP, UNICEF and others)	One-day workshop	End July/1st week of Aug'17
2.	**Programme/Accounts managers (NHM):** District and block programme and accounts managers and other officials handling NHM funds **Financial support: NHM**	DIO and trained MO, with support from district programme manager, district accounts manager, district M&E coordinator and partners (WHO India NPSP, UNICEF and others)	1 hour	After completion of district MO workshop
3.	**Data handlers:** One data handler involved in immunization data entry (HMIS and MCTS data) per district/block/planning unit **Financial support: NHM**	DIO and other MO trained at state level. District M&E Coordinator (NHM) and partners (WHO India NPSP, UNICEF and others)	Half-day workshop	Within 1 week after completion of district workshop
4.	**Vaccine and cold chain handlers:** Block/planning unit to identify and nominate at least two persons per vaccine storage point. Nominations to be forwarded to DIO. **Financial support: NHM**	DIO and trained MO with district cold chain handler and partners (WHO India NPSP, UNICEF and others)	Half-day workshop	Within 1 week after completion of district workshop
5.	**Intensified Mission Indradhanush media workshop:** Workshop for sensitization of media (print/electronic). DIO, with support of partners, to prepare the agenda and list of invitees. **Financial support: NHM**	DIO with support from UNICEF, Rotary, WHO India NPSP and other partners, district IEC consultant, media officer. District Magistrate to chair the meeting.	Half-day workshop	At least 1 week before launch

ASHA: Accredited Social Health Activist; DIO: District Immunization Officer; HMIS: Health Management Information System; IEC: Information, Education And Communication; MCTS: Mother And Child Tracking System; NHM: National Health Mission

Note: Refer to Annexures 3a, 3b, 3c and 3d for agenda and tips for trainers at Serials 1, 2, 3 and 4, respectively.

Chapter 9

Block-Level Activties For Intensified Mission Indradhanush

The following activities should be undertaken at the block level for roll-out of Intensified Mission Indradhanush

9.1 Training of frontline workers

As part of the intensification of routine immunization in India, training of frontline workers has been further stepped up with the objective of enhancing the operational and interpersonal skills of these workers. The goal of this training is to improve the coverage and quality of routine immunization services by reaching children that have missed their due vaccine doses.

Responsibility: Block MOIC

Technical support: Training will be conducted by two MOs trained at district level with support from key development partners such as WHO India NPSP, UNICEF and others.

Financial support: These training sessions will be supported through NHM funds as per guidelines.

Timeline: To be completed within 1-2 weeks of district workshop

Participants: Health workers (ANMs, LHVs, health supervisors) and social mobilizers (ASHAs, AWWs and link workers)

Review mechanism: DTFI

Activities to be conducted:

- Training of ANMs/LHVs/Health Supervisors
  - ◊ In sub-centres with two ANMs, a clear division of area between the two ANMs must be done to ensure maximum output and accountability. Sub-centre with delivery facilities may plan accordingly.
  - ◊ Updated reporting and recording tools, including Intensified Mission Indradhanush microplanning and reporting forms, revised counterfoil of MCP card, tracking bag, due lists, tally sheets and registers will be shared during the training workshops.
  - ◊ One-page info kit on Intensified Mission Indradhanush planning and operationalization will be provided to ANMs during the training.
  - ◊ Printed IEC materials, including street and session site banners and posters, will be provided to ANMs for display at session sites.
  - ◊ Preparation of microplans by each ANM for conducting Intensified Mission Indradhanush sessions within own block.
- Training of mobilizers (ASHAs, AWWs and link workers)
  - ◊ Block ASHA coordinator and Child Development Project Officer will support MOs and representatives from partner agencies in conducting these training sessions.
  - ◊ Mobilizers will be trained on headcount for estimation of beneficiaries.
  - ◊ Mobilizers will be expected to conduct this survey in their assigned area, and if required, outside their area as well. Financial support will be provided for conducting this exercise as per norms (Annexure 6).
  - ◊ Financial support will also be disbursed by MOIC of the block for mobilization of beneficiaries to session sites by mobilizers (ASHAs/AWWs/link workers) as per attached norms (Annexure 6).
  - ◊ Details of trainings to be conducted at the block level are given in Table 7.
- Communication training of ANM, ASHA and AWW (BRIDGE)
  - ◊ All ANMs, ASHAs and AWWs need to be trained on a 4 hour communication package aimed at enhancing IPC skills.

Urban / Corporation Task Force

Level: Corporation/ Urban Area

Committee: Corporation/ Urban Task Force for Immunization

Chairperson: Municipal Commissioner/Mayor/ Corporator/District Magistrate or any other senior officer in Urban area

Convenor: Nodal officer in-charge for urban immunization

Frequency of meeting: Once every month

Members: Mahila Aarogya Samitis, key departments, CSO, religious leaders, urban health facilities and private hospitals/practitioners

The committee would overlook the activities in the urban areas with special focus to the vulnerable population in the urban slums and migrants staying in camps. Nodal officer in-charge for urban immunization will be responsible for the urban component under supplementary PIP for IMI.

Table 7. Block/Planning units-level training workshops/ToTs

S.No.	Trainees	Trainers	Duration	Timeline
1.	Health workers (ANMs, LHVs, health supervisors) **Financial support : NHM**	District and block master trainers (DIO and two block-level MOs trained at district level) Training to be conducted in small batches of 30–40 trainees	One day for each workshop	For initiating micro-planning in planning units. Within 2 weeks of completion of district-level workshop
2.	Mobilizers (ASHAs and AWWs) **Financial support: NHM**	District and block master trainers (DIO and two block-level MOs trained at district level, supported by ASHA coordinators and others) Training to be conducted in small batches of 30–40 trainees	Half-day for each workshop	For initiating micro-planning in planning units. Within 2 weeks of completion of district-level workshop
3.	IPC training of ANMs, ASHAs and AWWs (BRIDGE) **Financial support: NHM**	District trainers	Half day for each training	Before mid September 2017

ANM: auxiliary nurse midwife; ASHA: accredited social health activist; AWW: anganwadi worker; DIO: district immunization officer; LHV: lady health visitor; MO: medical officer

Notes: 1. Refer to Annexures 4 and 5 for agenda and tips for trainers for Serials 1 and 2, respectively.

2. Submit progress report on training status of each level of functionary to DIO.

Chapter 10

Steps For Preparation of Microplans for Intensified Mission Indradhanush Strategy in Identified Districts And Urban Cities

Microplanning forms the base for the delivery of routine immunization services to the community. The availability of an updated and complete microplan at a planning unit (urban and rural) demonstrates the preparedness of the unit and directly affects the quality of routine immunization services provided.

Microplans developed to make the Intensified Mission successful will draw on the lessons learned from polio eradication towards systems strengthening, vaccine cold chain management, regular surveillance and monitoring of the plans to reach all children.

Within 2-3 days of completion of district workshops, there should be cascaded trainings to train health workers and mobilizers for headcount survey. After training, these mobilizers will be given 10-15 days for completion of head-count surveys. On the basis of these headcount surveys, beneficiaries will be identified for preparing the due-list and identifying injection loads which will be utilized to develop micro-plan for each sub-centre area for the areas where IMI sessions are warranted. MOIC/CDPO should ensure through ASHA facilitator and ICDS supervisor, that head-count survey of vacant sub-centres is also done and ensure mobilization of ANMs having less than 7 working days of activity in IMI to cover vacant sub-centres/urban areas. On the basis of this, block micro-plan will be formed which will be compiled at the district level. At the district level, if there is need for mobilization of ANMs from one block to another or to urban areas, this mobility needs to be ensured and after assuring that all the areas in the district are covered, the district microplan will be collated. The following steps should be undertaken for preparing a complete microplan for Intensified Mission Indradhanush sessions. (Figure 6)

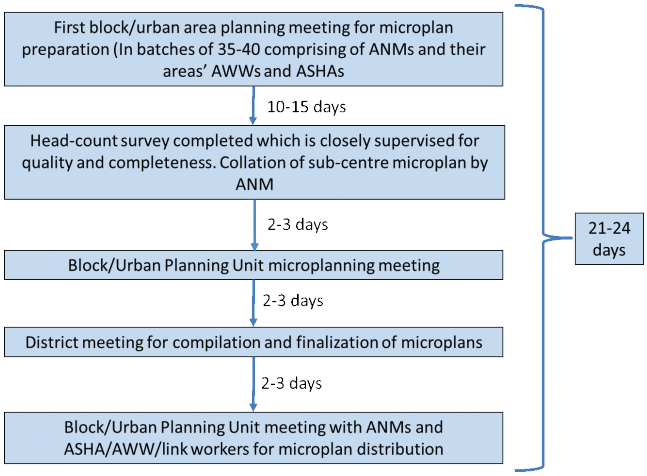


Figure 6. Steps for preparing a complete microplan

Step 1. First block-level microplanning meeting: Identification of areas that require sessions under Intensified Mission Indradhanush

Facilitators: Two MOs from the block trained at district level, with support from partners including WHO India NPSP, UNICEF and others. Nodal officer will coordinate this activity in urban local bodies.

Participants: ANMs/LHVs/ health supervisors/key NHM officials/ASHA/AWW/at block level

Timeline: To be completed within 2–3 days of district workshop

Activities to be conducted:

- Prepare a master list of all villages/hamlets/ HRAs etc. using the existing routine immunization microplans, polio microplans, census list of villages/ hamlets, list of polio HRAs (slums, nomads, brick kilns, construction sites and other non-migratory HRAs), list of areas with measles or diphtheria outbreaks in the last two years (with any reported measles death) and monitored areas for routine immunization with sub-optimal performance.
- ANMs should be provided blank microplanning format 1 (Annexure 7) in A3 size paper to list all areas and subsequently identify areas requiring additional sessions under Intensified Mission Indradhanush in their own sub-centre areas.

During the following 2-3 days, ANMs should list all HRAs (villages, hamlets, slums, nomadic sites, brick kilns, construction sites, other high-risk settlements) on

the ANM microplanning format 1 (Annexure 7). Once all areas are listed, ANMs will identify areas where the number of unvaccinated (left outs) and partially vaccinated (drop outs) children up to 2 years of age is high and require additional sessions. ASHA/AWW/link worker support for headcount survey should be trained for enlisting of beneficiaries

Step 2. Block/Urban health unit microplanning meeting

Facilitators: Two MOs from the block trained at district level, with support from partners including WHO India NPSP, UNICEF and others. Nodal officer will coordinate this activity in urban local bodies.

Participants: ANMs/LHVs/health supervisors/ICDS supervisors, key NHM officials at block level

Timeline: To be completed within 2-3 days of the first block microplanning meeting

Activities to be conducted:

- ANMs will bring filled microplanning format 1 (Annexure 7) during training at the block level. This will be reviewed by the trainer and amended if required.
- Block/health post MO IC will identify areas that require additional routine immunization sessions from all sub-centres. MO IC will enlist all such areas in microplanning format 2 (Annexure 8) and also determine whether these sites will be covered through outreach sessions or mobile sessions.
- Each ANM will prepare a roster using microplanning format 3 (Annexure 9) for additional sessions in her own sub-centre area in consultation with the Block MOIC. For Intensified Mission Indradhanush days, she can be assigned areas outside her sub-centre area for a maximum of 7 days of Intensified Mission Indradhanush activity.
- Once the ANM has prepared her roster for areas requiring additional Intensified Mission Indradhanush sessions in her own sub-centre area, MOIC will identify areas in the block that require an additional session but have not been included in any ANM's roster. This may happen in vacant sub-centre areas where the ANM is on long leave or absent for any other reason. MOIC will assign such areas to other ANMs in the block for the remaining days of the Indradhanush round. This assignment should be done keeping in mind the travel time and feasibility of this assignment. These assigned sessions will be included by ANMs concerned in their roster for the round.
- Such ANMs working in other sub-centre areas may be supervised by a different supervisor.
- Plan to engage all ANMs during the Intensified Mission Indradhanush drive.
- ASHAs/AWWs/link workers will be assigned to each session in consultation with the block ASHA coordinator. The ASHA manager will ensure that headcount is conducted for estimation of beneficiaries in additional areas assigned to a mobilizer. Ensure that this is a time-bound activity (1 week) and its progress is monitored by DTFI. MOIC will monitor and provide oversight to this activity. A reasonable sample of due-list thus prepared on the basis of head-count survey will be verified by supervisory staff for every planning unit.

In urban areas:

- Identify Nodal officer for immunization activities in urban areas for Intensified Mission Indradhanush
- Gap assessment done separately for urban cities and projecting needs in supplementary PIP for Urban Health
- Estimated Urban city population and the number of beneficiaries for IMI need to be estimated for planning purposes
- Listing/ revision of lists of high risk areas (planning unit wise) in urban cities
- Mapping resources in urban areas (CSOs/ NSS/NYK/ Urban NGOs etc)
- Nodal officer will demarcate the urban area into the catchment area of available health posts. He/she will then identify the available health human resource (ANMs/public health nurses/health supervisors) in each health post.
- Considering 2–3 polio team days as one unit, each U-PHC/health post in-charge will map and list each such unit in microplanning format 1 (Annexure 7). Use Polio microplans for enlisting beneficiaries in urban areas.
- Once all areas are listed, U-PHC/health post in-charges will identify areas where numbers of unvaccinated (left outs) and partially vaccinated (drop outs) beneficiaries require additional sessions /areas with high routine immunization coverage will not be included in this planning). All such areas will be listed in microplanning format 2 (Annexure 8).
- Need based support will need to be provided for:

- ◊ Conducting review meetings,
- ◊ Hiring of vaccinators (if required),
- ◊ Mobility of health workers beyond their areas of posting,
- ◊ Incentives for mobilizers (ASHA/AWW/Link worker/volunteers in case of absence of other mobilizers),
  - * Enlisting of beneficiaries and microplanning
  - * Mobilization of beneficiaries to session site
- ◊ Alternate vaccine delivery,
- ◊ Mobile team for sparsely populated/hard to reach areas,
- ◊ Special urban social mobilization and communication plan,
- ◊ Award mechanisms, etc.

- For urban cities listed under 1057 cities identified under NUHM – coverage reporting and monitoring in these cities should be done separately to have better sense of progress and gaps needing further attention
- Collaboration with NGOs and departments in urban cities will be the key.

Step 3. District-level microplan finalization meeting

Facilitators: CMO/DIO and trained MO with support from partners including WHO India NPSP, UNICEF, UNDP, Core and others

Participants: Two MOs from each block and urban nodal officers

Timeline: To be conducted within 2–3 days of block/urban health unit microplanning meeting

Activities to be conducted:

- Each block medical officer-in charge (MOIC) and nodal officer (in urban areas) will carry microplanning Form 2 of his/her block/urban area along with microplanning Form 3 (ANM roster for Intensified Mission Indradhanush) for all ANMs in the block.
- Nodal officer in urban areas will discuss the number of sessions that have not been assigned to any ANM/vaccinator.
- DIO will assess the number of sessions in each block and all urban areas that have not been assigned to any ANM/vaccinator. He/she will also assess the number of ANM days available with each block/urban area that may be handed over to another block/urban area.
- ANMs with one or more days available during Intensified Mission Indradhanush week can be assigned to another block/urban area for conducting routine immunization sessions during this drive. This assignment should be done keeping in mind the travel time and feasibility of this assignment.
- These assigned sessions will be included in the ANM roster (microplanning Form 3) of ANMs by their MOICs concerned.
- Such ANMs working in other sub-centre areas may be supervised by a different supervisor.
- This meeting will also allow the DIO to review the requirement of mobile units for conducting vaccination sessions in blocks/urban areas.
- DIO will also assess the requirement of hiring vaccinators for conducting sessions during this drive.

Step 4. Block/U-PHC meeting with ANMs, ASHAs, AWWs and link workers for microplan distribution

Facilitators: Two MOs from the block/urban area trained at district level, with support from partners including WHO India NPSP, UNICEF, UNDP and others. Nodal officer will coordinate this activity in urban local bodies.

Participants: ANMs/LHVs/health supervisors/key NHM officials at block level

Timeline: To be completed within 2 days of district microplan finalization meeting

Activities to be conducted:

- MOICs of blocks/U-PHCs/urban health posts will conduct this meeting with their ANMs/health workers/hired vaccinators after the district-level microplanning meeting.
- By this time, each ANM roster (Annexure 9) will be filled with the following:
  - ◊ Areas included in ANM's sub-centre with weak routine immunization coverage, where she will conduct routine immunization sessions

on the two routine immunization days designated by the state. Sessions that ANM will conduct in the neighbouring block/urban area on the remaining days of Intensified Mission Indradhanush round. During these days, she will be supervised by the supervisor designated for that particular area.

- The ANM concerned will need to discuss details (how to reach designated area, where to pick up vaccines) with the supervisor of the area. Details of the mobilizer (name and contact number) will be available in the ANM roster for Intensified Mission Indradhanush rounds.
- Each ANM will send her tally sheet to the block through the alternate vaccine delivery (AVD) mechanism on a daily basis so that reports can be compiled and submitted to the district on a daily basis.
- Monitoring feedback for the ANM will be shared with the MOIC of the planning unit where she is working for the day. MO will share feedback of the MOIC of the block where the ANM is posted.

Chapter 11

Vaccines & Logistics Management

An effective vaccine, logistics and cold chain system is an essential prerequisite for successful running of an immunization programme. It is critical for immunization services to ensure the availability of appropriate equipment and an adequate supply of high-quality vaccines and immunization-related materials to all levels of the programme. It is important to ensure correct implementation of relevant strategies. The key areas of logistics support include vaccine management and monitoring, cold chain management and immunization safety.

Any new vaccine introduced will be a part of Intensified Mission Indradhanush.

If vaccine, logistics and cold chain programme is well managed, it can help save on programme costs in ensuring programme implementation efficiently without sacrificing the quality of service delivery. Poorly managed logistics systems can lead to high and/or unnecessary vaccine wastage rates, stock outs, or improper management of waste, resulting in significant operational programme costs, as well as a negative impact on public health.

Vaccine stores at all levels (state, regional, district, primary health centers (PHCs), community health centers, other cold chain storage points) need to forecast their vaccine needs for the stipulated time period to ensure that the right amount of vaccines, logistics and cold chain equipment are available to vaccinate all eligible infants at a given time in a given area. Each of these levels should monitor the stock of vaccine and syringes in order to assess the lead-time and re-ordering levels.

Analyze eVIN data recorded in these districts (if applicable) for real-time information on vaccine stocks and flows, and storage temperatures across all cold chain points in the states with IMI districts. This will minimize vaccine wastage.

- Compare vaccine wise consumption of previous three months and monitored months from the inception of IMI strategy.
- Estimation of vaccine wise per month wastage based on eVIN and HMIS/MCTS/RCH Portal data.
- Use of NCCMIS and eVIN dashboards in review meetings at all levels will be made mandatory. Use available data for corrective action.
- Use of opened vaccine vials will be monitored through eVIN monitoring system and efforts will be made to reduce vaccine wastage.

11.1 Estimating vaccines and syringes needed

- Logistics including auto-disable (AD) syringes and MCP cards available under the existing UIP programme will be used for Intensified Mission Indradhanush.
- As each AD syringe is packed separately, hence, maximum permissible wastage rate for AD syringes equal to vaccine doses supplied including wastage.
- Estimation of vaccine and logistics requirements should be done on the existing formats, based on the estimation of beneficiaries.
- PHCs and districts need to forecast their vaccine needs for the stipulated time period to ensure that the right amount of vaccine, AD syringes and cold chain equipment are available to vaccinate all eligible beneficiaries in the identified areas at a given time.
- DIO will be responsible for ensuring availability of required stock of vaccine and logistics for the Indradhanush sessions. Buffer stocks should be maintained as per recommendations.
- In case of any vaccine or logistic shortage at any session during the Indradhanush week, the ANM will contact the supervisor, who will arrange the required vaccine(s)/logistics from the nearby session or planning unit. Shortage at the block must promptly be replenished from the district level. In case of any shortage at district level, SIO will be informed for necessary action.
- The monitoring of vaccines and logistics can be done through eVIN in the states of Assam, Bihar, Chhattisgarh, Gujarat, Himachal Pradesh, Jharkhand, Madhya Pradesh, Manipur, Nagaland, Odisha, Rajasthan and Uttar Pradesh.

The reporting chain for vaccines/diluents is given in Figure 7.

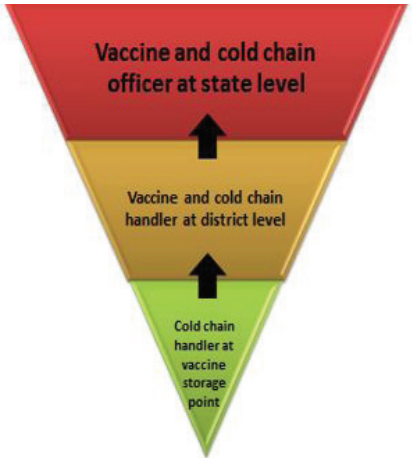


Figure 7. Vaccine/Diluent reporting for IMI

11.2 Vaccine wastage

- The existing Open Vial Policy (OVP) guidelines will be applicable to significantly reduce vaccine wastage. All efforts should be made to minimize vaccine wastage at all levels.
- The maximum acceptable wastage for vaccines eligible for reuse under the OVP (such as pentavalent vaccine, PCV, oral polio vaccine (OPV), IPV (inactivated poliovirus vaccine), hepatitis B, diphtheria-pertussis-tetanus [DPT], and tetanus toxoid (TT) vaccine) is 10% (Table 8).

11.3 Cold chain space and inventory

The cold chain infrastructure in India is a wide network of cold chain stores consisting of government medical supply depots (GMSD), state, regional/divisional vaccine stores, and district and PHC/CHC vaccine storage points. The cold chain network in the country has been the backbone to ensure that right quantity and right quality of vaccine reaches the target population.

The cold chain inventory should be regularly reviewed and status of the same should be updated in the National Cold Chain Management Information System (NCCMIS).

11.4 Cold chain monitoring

Proper storage of vaccines and maintenance of the cold chain during storage and distribution are essential to prevent the loss of potency. Once a vaccine loses its potency, this cannot be regained. Damaged vaccines should be discarded according to the guidelines. Measures should be taken to protect heat and freeze sensitive vaccines such as pentavalent and IPV because they lose their potency when exposed to temperatures outside the range recommended by the manufacturer. The heat impact on vaccines is cumulative.

11.5 Vaccine storage

To ensure efficacy of the vaccines, proper storage and packing are essential. The following are recommended for vaccine storage:

Figure 8. Vaccine stocked in ILR

- In top-opening refrigerators (ice-lined): store freeze-sensitive vaccines including DPT, TT, Hep B, Pentavalent vaccine and IPV and other on top.
- Freeze sensitive vaccines could be damaged if placed in direct contact with frozen ice packs that were inadequately conditioned. Therefore, ice packs should be conditioned before use.

Table 8. Wastage permissible for all vaccines In Routine immunization

Vaccine	Maximum acceptable wastage
BCG	50% and the wastage multiplication factor for calculation is 2.0.
RVV, Measles and JE	25% and the wastage multiplication factor for calculation is 1.33.
IPV, PCV, OPV, Pentavalent Hepatitis B, DPT, TT	10%. for all vaccines eligible for reuse under the open vial policy. The wastage multiplication factor for calculation is 1.11.

11.6 Conditioning of ice packs

In order to ensure correct storage of vaccines, the following procedures should be followed:

- Ensure that the insulated vaccine carriers are clean before use and at end of the day.
- Use a packing table, and remove ice packs from freezer and place on table to defrost. Packs are ready to use when there are physical signs of thawing; no ice but drops of water on surface, and sound of water is heard on shaking the ice pack.
- Dry the packs and line the walls of the insulated vaccine carrier with them.
- Place the vaccines inside and ensure that the container is properly closed.
- Allowing ice packs to thaw means that the initial freezing temperature is lost, so the temperature in the insulated carrier does not drop below 0°C.
- Properly conditioned water ice packs constitute the best method to maintain the temperature of the insulated carriers and cold boxes.

11.7 Recording and reporting

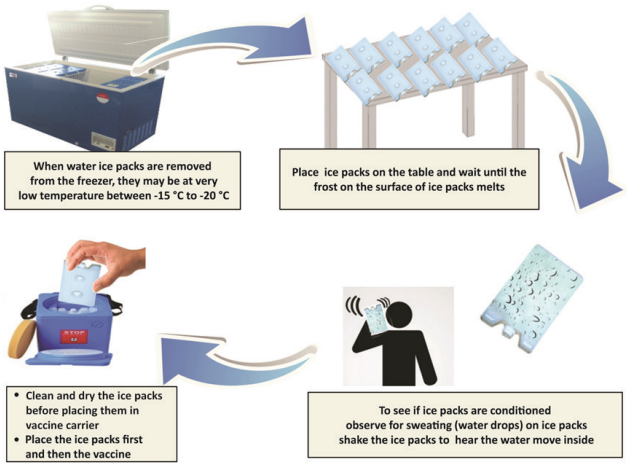


Figure 9. Conditioning of Ice Packs

- Recording and reporting of vaccination during Intensified Mission Indradhanush rounds will be done in the attached formats on a daily basis to the next higher level, i.e., ANM will report to the block PHC in the tally sheet for Intensified Mission Indradhanush (Annexure 12), block PHC will report to the district, and so on (Figure 4).
- Reporting for rural and urban areas will be done separately.
- Vaccination will also be reported through the existing HMIS and mother and child tracking system (MCTS)/ RCH portals. Blocks will compile ANM reports (Annexure 13) and districts will compile block reports (Annexure 14) and submit to the state (Annexure 15).

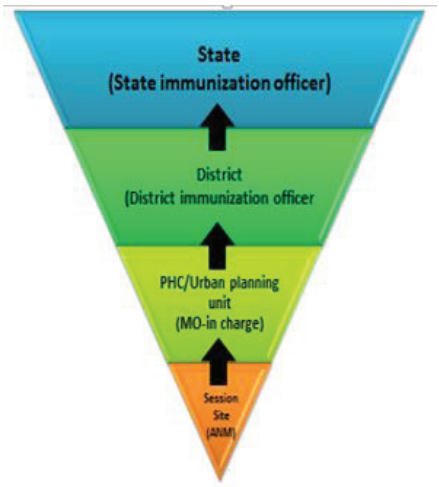


Figure 10. Vaccination reporting chain

Critical indicators that will be derived from these reports are:

- Target of IMI – rural and urban (based on head-count)
- Total beneficiaries immunized
- Total children fully immunized
- Total children completely immunized
- Total beneficiaries vaccinated antigen-wise
- Total children vaccinated for first time (0-11 m and 12-23 m)
- MCV 1 and MCV 2 coverage and drop-out rate

All the above indicators will be calculated separately for Urban and Rural Areas based on the reporting formats given in Annexures.

- **The routine immunization sessions will be held as planned but coverage data of these sessions will not be included in the Intensified Mission Indradhanush coverage report.** However, at the end of month, the Intensified Mission Indradhanush round coverage data and routine immunization data will be entered together in the HMIS.

11.8 Waste disposal

Keeping in harmony with the *"Swachh Bharat Abhiyan"* launched by the GoI, each session will ensure clean surroundings and proper segregation and containment of all immunization waste generated. The immunization waste will be sent to the PHC for disinfection and finally disposed of as per norms of the Central Pollution Control Board.

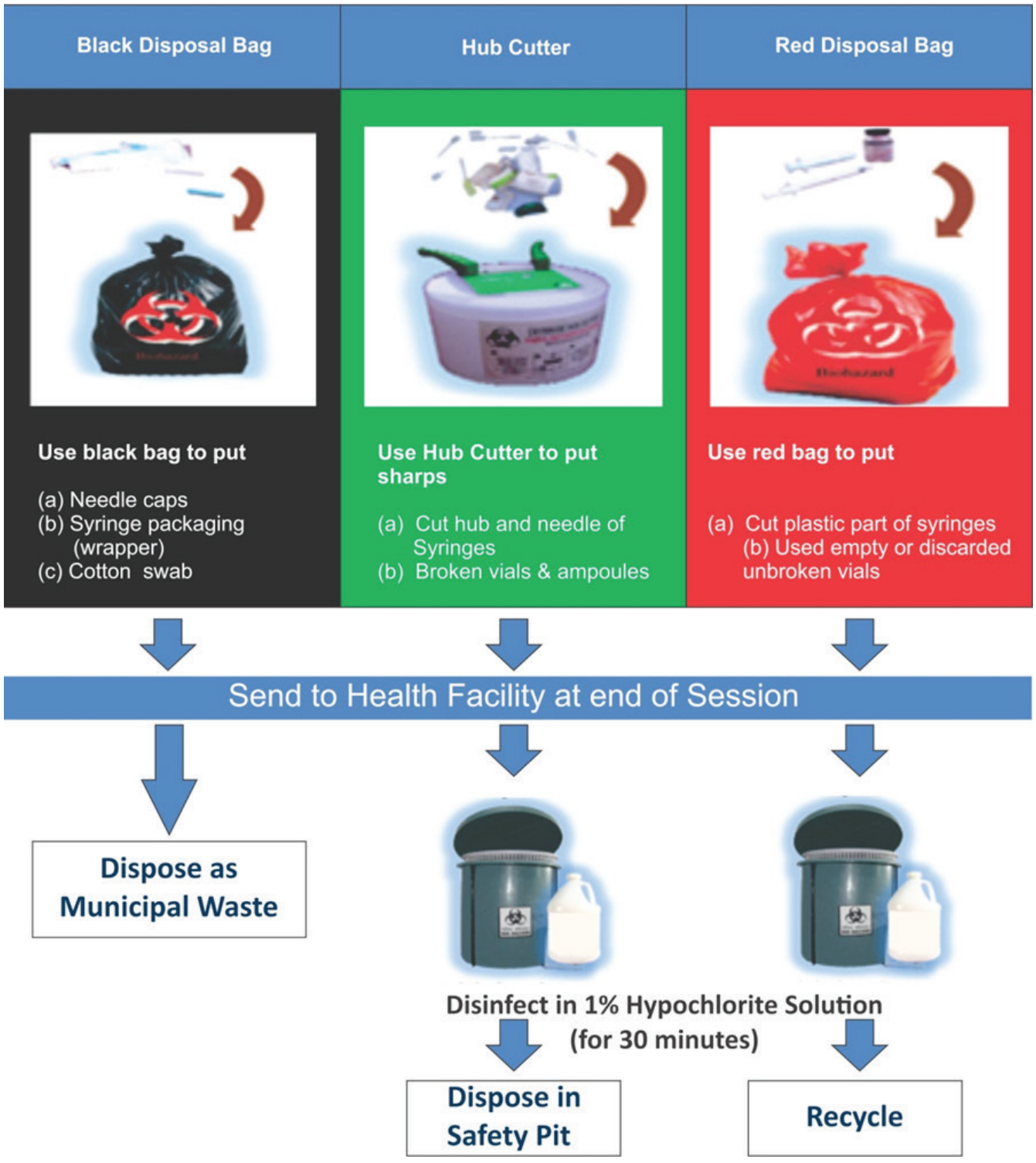


Figure 11. Waste disposal process

Chapter 12

Role of Partners

The technical and monitoring support of partner agencies such as WHO, UNICEF, Rotary International and other stakeholders continues to be of significance in strengthening of health systems and programmes in India. States must actively engage these partner agencies in their core areas of strength.

Partners mapping

Partners mapping activity (WHO, UNICEF, UNDP, CORE, Technical Support Units (TSU), Rotary international, lead partners supporting high priority districts, and others) will go a long way in supporting the districts and at the same time avoiding duplication of activities. Partners will extend support based on partner mapping.

WHO

WHO India will provide technical support to the Government by building sustainable institutional capacity for effective planning and implementation and undertake routine performance monitoring at district/ block level for timely delivery of routine immunization services. The following are the key thematic areas of support:

- Facilitate partners mapping in identified districts/ urban cities.
- Facilitate preparatory meetings for the development of microplans at district and block levels.
- Develop training materials and build capacity of district trainers for training of health personnel.
- Monitoring of head-count surveys in districts.
- Track the progress and implementation of the Indradhanush round through concurrent monitoring.
- Provide monitoring feedback during task force and other review meetings at district, state and national levels.
- Risk prioritization

UNICEF

- Support state, districts and blocks for social mobilization activities, dissemination of information and their monitoring through its social mobilization network.
- Provide supportive supervision for cold chain and vaccine management using standardized checklists and sharing feedback at the national, state and district levels.
- Participate as resource persons in training of health personnel at state and district levels.
- Monitoring of head-count surveys in districts.
- UNICEF will work collaboratively with Immunization Technical Support Unit (ITSU) to develop the dissemination plan for Intensified Mission Indradhanush at the national, state, district and block levels.
- UNICEF will take a lead on communication plan activities. UNICEF will formalise the communication plan with inputs and support from ITSU, Rotary, Global Health Strategies and other partners.

UNDP

- Support state, districts and blocks for microplanning, including cold chain and vaccine logistics planning.
- Review of IMI microplans in priority blocks/urban cities.
- Independent monitoring of IMI activities for identification of issues.
- Monitoring of head-count surveys in districts.
- Attend regular debriefing meetings at planning unit and district level.

JSI

- Support state, districts and blocks for microplanning, including cold chain and vaccine logistics planning.
- Monitoring of head-count surveys in districts.
- Independent monitoring of IMI activities for identification of issues.
- Attend regular debriefing meetings at planning unit and district level.

Rotary International

- Social mobilization of beneficiaries especially in urban slums and underserved areas having no mobilizers.

- Support to the members of NCC, NYK, NSS etc. in their efforts of community mobilization through incentives like refreshments/mementoes during the sessions.
- Advocacy and generating awareness through innovative approaches and involving private practitioners and local leaders for IMI.

Lead partners for call to action (RMNCH+A)

- The RMNCH+A state lead partners will assist with implementation of strategies to strengthen the Intensified Mission Indradhanush in selected high-focus districts. They will also support monitoring of immunization drives and share feedback at block, district and state levels.
- Any critical support required by the state may be forwarded to the lead partner agency through the STFI.

Professional bodies and CSOs

- Key state and local bodies such as IMA, IAP and CSOs should be actively involved. These organizations are expected to play a critical role in awareness generation and advocacy, particularly at the local level. They will participate in district and state level meetings.
- State and local bodies such as IMA, IAP and civil society bodies will be approached for seeking support in information dissemination and advocacy at various levels.
- IMA/IAP will be requested to support in creating awareness about full immunization and complete immunization. Support letters may be written by these organizational bodies along with promotion of "Intensified Mission Indradhanush Strategy" at various conferences conducted by them.

Involvement of Medical colleges and Nursing schools:

- The medical colleges should be engaged to conduct assessments, reviews, monitoring, and training. The staff may be identified from medical colleges and trained to create a pool of master trainers for conducting MO and Health worker trainings.
- The trained staff from Nursing colleges/ ANM training centers should be engaged to support immunization sessions where required.
- These identified officials from Medical Colleges should also be utilized to monitor the various activities related to IMI. Financial implications of these activities may be projected in supplementary PIP for approval by Government of India.

Involve NCC, Nehru Yuva Kendra, NSS and other groups to support mobilization efforts in identified districts. Support of Rotary, CSOs, NGOs and CSR may be explored to support the transport, refreshments etc. for above mentioned groups. Any funding support if required should be projected in the PIP.

Chapter 13

Monitoring & Evaluation

A massive framework has been put in place for rigorous monitoring of one of the largest immunization programmes of the world. The monitoring and evaluation activities can be broadly classified into the following:

13.1 Self-assessment of gaps by the districts

A self-assessment check list has been prepared by Government of India for the districts to assess status of key components including quality of task forces for immunization, deputation of senior officials to priority areas for monitoring, status of trainings at state, district and block levels and status of microplanning activities will be collated by medical officers and field monitors, and information generated will be shared with the Ministry of Health and Family Welfare, Government of India on a weekly basis.

13.2 Assessment of readiness for IMI

The districts will be objectively evaluated for their readiness to undertake the IMI activity by a senior national level team, led by officials from Immunization Division, Ministry of Health and Family Welfare during 10-20 September 2017. Districts will not be permitted to start the activity without proper preparations in place else it may affect the performance of activity as well as achievement of target. On the basis of assessment, a decision will be taken for IMI drive in the respective districts.

13.3 Monitoring of operations

The Intensified Mission Indradhanush rounds will be intensively monitored in the highest priority areas by officials from the national, state and district levels. Using the Intensified Mission Indradhanush monitoring formats for session site monitoring and house to house monitoring, all available monitors from national, state and district levels should be deployed to monitor activity in the highest priority blocks/urban areas. The monitoring formats should be compiled and summarized as per normal practices.

National-level monitors: Officials from MoHFW, GoI and partner agencies

State-level monitors: Senior state health officials will be deployed to the Intensified Mission Indradhanush districts by STFI

District-level monitors: Senior district health officials deployed to high priority blocks by DTFI

Key indicators derived from monitoring are given below:

Intensified Mission Indradhanush Session monitoring indicators

This captures information on vaccine supply and the availability of logistics, functioning of alternate vaccine delivery (AVD) system, injection practices of ANMs, injection safety and waste disposal, record keeping and inter-personal communication of service providers. The following indicators will be monitored:

- Sessions held as per plan
- Reasons for sessions not held
- Percentage of sessions found held among monitored HRAs (can be generated by type of HRAs)
- ANMs/ASHAs having due list
- IEC display status
- Availability of vaccines
- Reason analysis on non-availability of any vaccine
- Indicators on AEFI and implementation of OVP
- Availability of logistics as per microplan
- Indicators on safe injection practices
- Sessions visited by supervisors
- Caregiver responses regarding proactive mobilization efforts
- Reason analysis on non-availability of any vaccinator
- Dissemination of four key messages to caregivers.
- ANM days planned/ utilized
- Percentage of vacant sub centers with deployment of ANM
- Number of Intensified Mission Indradhanush sessions held outside the ANM sub-center area/ block

Intensified Mission Indradhanush House-to-house monitoring indicators

- Percentage of children due for any vaccine during Intensified Mission Indradhanush
- Percentage of children due in Indradhanush that got vaccinated with vaccine(s)
- Percentage of children who received vaccines for the first time in Intensified Mission Indradhanush
- Mobilization efforts: percentage awareness by ASHAs/AWWs/ANMs/others.

Information generated from concurrent monitoring will be utilized at local level during evening debriefing meetings at block and district level to ensure midcourse corrective actions. Data generated from the monitoring formats will be collated in a data tool to generate key indicators that will be shared at all levels with the government. A complete framework will be put in place to monitor the progress of immunization in these districts. Indicators will be developed to monitor key processes and outcome.

To strengthen monitoring in these districts the states may propose hiring of Immunization Field volunteers through NHM funding. Such a monitoring mechanism is already functional in States like Karnataka, Haryana, Gujarat, Himachal Pradesh, Jharkhand and West Bengal.

State /District Immunization Officer

- Conduct programme assessment to identify gaps
- Develop an action plan to address identified gaps
- Project (need-based funding) requirement in their PIPs with justification

Expected outcomes during monitoring:

- Full Immunization Coverage in the monitored areas: ~100%.
- No. of areas found with >2 out of 5 monitored children as partially immunized or unimmunized: Nil.
- Integration of IMI sessions into RI micro-plans: 100%.
- Availability of district level communication plans: 100%.
- Convergence with ICDS: at least 90% of the sessions.

State/District Immunization Officer

Prior to Intensified Mission Indradhanush

Critical Microplan Review:

- **Has the district assigned priority blocks to senior officers?**
- **Have all areas with vacant sub-centers been included?**
- **Have all areas where no routine immunization sessions planned due to staff on leave/ deputation been included?**
- **Are all Polio HRAs with no routine immunization service delivery included?**
- **Areas where VPD outbreaks reported;**
- **Have all hard-to reach areas/areas that are part of routine immunization sessions but with poor mobilization included?**
- **Have areas where routine immunization monitoring shows gaps included?**
- **How many ANMs have been planned to move to other sub center within the same block or to sub centers outside the block but in the same districts?**
- **Have they been informed about their TA/DA/ mobility support?**
- **In the areas where Intensified Mission Indradhanush sessions are planned, has head count survey been conducted?**
- **Following head count survey, have the due lists been made to track the beneficiaries?**
- **What is the status of IEC/communication materials for Intensified Mission Indradhanush?**
- **Has the district made a plan for timely funds transfer to mobilizers?**

13.4 Monitoring of communication interventions

For effective implementation of the communication plan, it is imperative to monitor all activities mentioned in the communication plan. Periodic monitoring (programme and finance) of communication interventions provides the policy/programme managers with:

- Status of all planned IEC/BCC activities mentioned

in the state/district communication plan

- Progress of various IEC/BCC activities at a particular time and at a particular implementation level
- Status of capacity-building activities as per the training plan
- Status of dissemination (achieved against planned) and stock position of IEC material at various levels – state, district, block
- Status of planned initiatives related to advocacy, coordination, convergence, etc.

The monitoring plan will comprise a list of measurable and quantitative activities from the final state/ district communication plan, previous community needs assessment, data from evaluations/surveys conducted and protocol/guidelines for monitoring plan implementation framework. Additionally, states with a robust management information system will be able to provide accurate, complete and timely data for effective monitoring of IEC/BCC activities based on HMIS. An integral part of the monitoring plan to provide timely feedback to data generating units on quality of data.

13.5 End line survey for evaluation

A district level, end line coverage evaluation will be planned to assess the impact of the Intensified Mission Indradhanush strategy through 30 cluster sampling technology in end January/February 2018. Further, a follow up survey will be conducted in December 2018 to assess the sustainability of the achievements of Intensified Mission Indradhanush.

Chapter 14

Key Points for Successful Implementation of Intensified Mission Indradhanush

The success of Intensified Mission Indradhanush strategy is based on inter-ministerial and inter-departmental coordination as well as action-based review mechanism to guide effective implementation of targeted rapid interventions to improve the routine immunization coverage and ensure reaching every child with available life-saving vaccines.

As mentioned above, Intensified Mission Indradhanush strategy includes two broad interventions: Intensified Mission Indradhanush drive and immunization system strengthening to sustain the gains. The immunization drive will be implemented in all identified districts and urban cities for ensuring >90% full immunization coverage.

14.1 Government ownership, partnerships and accountability framework

- Led by the government, a rigorous monitoring framework replicating the polio accountability system has been put in place for providing oversight to Intensified Mission Indradhanush implementation activities at the state, district and block levels through health experts, officials and various partners.
- Task forces for immunization at the state, district and block levels have been established using the polio model for regular planning and review of the routine immunization programme. Monitoring data from the field is fed back to the block, district and state task forces for immediate corrective action and to guide programmatic decision-making and actions following the campaigns.
- The core polio partners – WHO, UNICEF, Rotary, CORE, BMGF, and other partners continue to work closely together with the government on strengthening routine immunization.

14.2 Program assessment in selected districts and urban cities

Officials from Immunization Division, Ministry of Health and Family Welfare will conduct an assessment of preparedness of selected districts. Based on this objective evaluation, the districts will be recommended to undertake the IMI activity.

14.3 Microplanning for Intensified Mission Indradhanush

- Detailed district and block microplanning are critical to effective implementation if Intensified Mission Indradhanush immunization drive. Vaccinators used micro-plans to track vaccination activities in each community, and review by district task forces determined which children were missed and corrective actions taken as part of the accountability and supervisory system.
- Certain “high-risk” areas have been especially difficult to immunize – barriers due to geography, poverty, internal mobility/migration, lack of education, variety of languages cultural diversity and distrust of the government, as well as sheer population density have required creative and persistent efforts. Intensified Mission Indradhanush brought in communities that previously had only been reached for polio vaccination but with limited access to RI services. Microplanning for Intensified Mission Indradhanush should focus on improving coverage and addressing equity issues in access to immunization.
- Additional immunization sites planned under Intensified Mission Indradhanush will be included into the government system’s routine immunization microplans with support from the WHO & UNICEF polio network to ensure completeness of routine immunization service reach.

14.4 Head count survey and due list preparation

- Head count process to develop session specific due-list based on head count should be initiated well in advance, and pre-round validation of head count survey should be done for improving coverage. There is a need of regular orientation and supervision of frontline workers for doing head count survey, due list updation and mobilization of children. Visitors including females who are visiting their parents for delivery/after delivery and are present in the house during the head count survey should also be included in survey due list.

14.5 Capacity building of frontline workers

- Frontline workers should be trained prior to start of Intensified Mission Indradhanush immunization drive with brief orientation during subsequent campaign. These trainings will improve technical and communication skills of frontline workers.
- Reorientation of frontline workers on IPC skills should also be conducted on a regular basis.

14.6 Supervision of activities

- The STFI and DTFI are essential. Assign national and state level officials for monitoring Intensified Mission Indradhanush rounds. District and sub district supervision should also be strengthened.
- National and State level officials should be deployed for monitoring Intensified Mission Indradhanush activities. District and sub district supervision should be strengthened.
- Review by MD-NHM/Secretary/PS ensures strong ownership at the state/district/block.
- Feedback loop with utilization of technology (video conference/mobile-sms) found effective.

14.7 Vaccine and cold chain management

- Urgent attention is needed to improve vaccine upkeep to ensure conditioning of ice packs, maintenance of distribution register, implementation of open vials policy and its records, and adherence to AVD plan. Focus on cold chain management training.
- Use of NCCMIS and eVIN dashboards in review meetings at all levels should be made mandatory. Use available data for corrective action.

14.8 Social and behavior change communication (SBCC)

- State-specific and district-based communication action plans which comprise of activities related to mass media, IPC and social mobilization will have to be created for each of the districts. Since this is on aggressive mode with very tight timelines, the plans should be simple but effective to achieve results. The plans should clearly outline the what, how and who around messaging so that the diverse target audiences are extremely clear and also what and how we want to communicate with them. States (districts) to propose requests for additional resources required for implementation of demand generation activities (social mobilization and IPC) under need-based PIPs, with special focus on migrant and underserved communities.
- Provide standardized IEC materials/tools:
- Creation of key materials at the national level to support activation at the districts. This team will undertake the prescribed activities from the national level. These mainly include developing a package including audio visual material including short videos/audio-video clips of famous opinion leaders, etc. for community sensitization and awareness generation. Strengthen communication through personal communications, sharing pre-recorded WhatsApp videos, putting information on social media platforms, mass media (TV & press), displaying standardized IEC material (banners, posters) at health facilities.
- A quick assessment of existing communication material and tools will be made by the Core Communications Team before deciding to create any new material. This will save time and reduce mixed messaging.
- Nationally developed uniform communication branding (5 saal 7 baar) will be used across all the districts through all channels of communication including demand generation activities.

14. 9 Social mobilization

- Strengthen social mobilization.
- IEC is an important factor in creating awareness in community about the importance of immunization. Therefore, IEC activities should be improved.
- PRI members, ration dealers and local influencers involvement should be strengthened.
- Need of standardization of IEC material is required.
- Concept of mothers meeting, Nukkad Natak, videos in the community, etc., should be strengthened.

14.10 Timing

- IMI rounds should be planned in a way to ensure better coverage of migratory populations and HRG sites.
- The rounds shall begin from 7th of every month for four consecutive months, for 7 working days. The states will be requested to utilize 7 working days for each of the four rounds of Intensified Mission Indradhanush, keeping in view the local festivals, weather conditions and other local issues.

14.11 Financial issues

- Communication of financial guidelines for IEC activities should be shared well in advance. The financial guidelines have to be released well on time for replication.
- Ensure timely payments of incentives to motivate ASHAs/mobilizers.

14.12 Monitoring

- A complete framework will be put in place to monitor the progress of immunization in these districts. Indicators will be developed to monitor key processes and outcome
- Ensure completeness and quality of data for the Intensified Mission Indradhanush drive.
- A district level coverage evaluation survey (CES) will be planned to assess the impact of the IMI strategy. Funding support for CES will be required.
- Concurrent monitoring data will be used for review and monitoring of districts performance and CES data will be used as end line data.

14.13 Appreciation and awards

- An appreciation and awards mechanism to be established to recognize the districts reaching more than 90% coverage (monitored/ evaluated by external sources). Criteria could include best practices and media management during crisis.
- For partners/CSOs/others, appreciation certificates may be provided.

14.14 Strengthening Routine immunization after IMI

Strengthening of the above-mentioned activities will ensure successful implementation of Intensified Mission Indradhanush immunization drive. It is important to sustain the gains made through this drive through overall health system strengthening. Based on programme assessment, these selected districts and urban cities will clearly prepare an action plan for reaching beyond 90% immunization coverage by Dec 2018. The district should project the needs in supplementary PIPs that should clearly be spelt separately under urban and rural planning.

The districts will ensure integration of the IMI sessions into their RI microplans on completion of the four rounds of IMI.

Robust monitoring will be done by partners as well as national monitors to ensure that the integration of sessions have been done in a sustainable manner.The monitoring will continue after completion of IMI rounds to ensure seamless integration of IMI sessions into RI microplans and availability of vaccination services in all the areas included in revised RI microplans.

A second survey will be done through 30 cluster sampling technique in December 2018 to verify the sustainability of the achievement of full immunization coverage, by comparing the results from the endline survey which will be conducted in Jan/Feb 2018 through a similar methodology.

ANNEXURES

Annexure1. Intensified Mission Indradhanush Strategy, identified districts

1A. List of Districts identified in states other than NE states:

S.No.	State	No. of Districts	Name of Districts	
01	Andhra Pradesh	2	East Godavari	Nellore
02	Bihar	14	Champaran East	Darbhanga
			Champaran West	Madhubani
			Muzaffarpur	Sheohar
			Samastipur	Gaya
			Sitamarhi	Araria
			Saharsa	Nawada
			Lakhisarai	Katihar
03	Delhi	3	North	South-East
			Shahdara	-
04	Gujarat	3	Banaskantha	Bhavnagar
			Kutch	-
05	Haryana	3	Mewat	Palwal
			Faridabad	-
06	Jammu & Kashmir	1	Jammu	-
07	Jharkhand	2	Giridih	Pakur
08	Karnataka	1	Yadgir	-
09	Kerala	1	Malappuram	-
10	Madhya Pradesh	13	Tikamgarh	Jhabua
			Chhatarpur	Vidisha
			Sagar	Sidhi
			Rewa	Panna
			Raisen	Shadol
			Singrauli	Sheopur

S.No.	State	No. of Districts	Name of Districts	
10	Madhya Pradesh	13	Alirajpur	
11	Maharashtra	9	Nasik	Beed
			Ahmednagar	Solapur
			Nanded	Yavatmal
			Jalgaon	Gadchiroli
			Nandurbar	-
12	Odisha	1	Ganjam	-
13	Rajasthan	11	Alwar	Jalor
			Barmer	Karauli
			Partapgarh	Udaipur
			Jodhpur	Sawai Madhopur
			Bikaner	Dhaulpur
			Pali	-
14	Uttar Pradesh	52	Bahraich	Unnao
			Sitapur	Shahjahanpur
			Moradabad	Kaushambi
			Badaun	Banda
			Hardoi	Farrukhabad
			Gonda	Gorakhpur
			Barabanki	Mau
			Jaunpur	Kannauj
			Azamgarh	Sant Kabir Nagar
			Muzaffarnagar	Deoria
			Balrampur	Raebareli
			Kheri	Rampur
			Aligarh	Mirzapur
			Siddharthnagar	Srawasti

S.No.	State	No. of Districts	Name of Districts	
14	**Uttar Pradesh**	**52**	Mathura	Kasganj
			Ghazipur	Sonbhadra
			Kushinagar	Ferozabad
			Sultanpur	Etah
			Ballia	Mainpuri
			Pratapgarh	Ambedkar Nagar
			Maharajganj	Badohi
			Bulandshahar	Lalitpur
			Bijnor	Auraiya
			Fatehpur	Chitrakoot
			Basti	Sambhal
			Saharanpur	Hapur
15	**Uttarakhand**	**1**	Hardwar	-
16	**West Bengal**	**1**	24-Parganas North	-
Total		**118**		

1B. List of Urban Areas identified:

S.No.	State	No. of Districts	Name of Districts	
1	**Bihar**	1	Patna	-
2	**Haryana**	1	Gurugram	-
3	**Karnataka**	2	Belgaum	Bangalore (U)
4	**Madhya Pradesh**	1	Indore	-
5	**Maharashtra**	2	Thane	Gr. Mumbai
6	**Odisha**	1	Bhubaneshwar Urban (Khurda)	-
7	**Rajasthan**	1	Jaipur	-
8	**Uttar Pradesh**	8	Allahabad	Meerut
			Bareilly	Lucknow
			Ghaziabad	Kanpur(Nagar)
			Agra	Varanasi
Total		**17**		

1C. List of Districts in NE states:

S.No.	State	No. of Districts	Name of Districts	
1	Arunachal Pradesh	13	Anjaw	Papum Pare
			Changlang	Tirap
			East Kameng	Upper Siang
			East Siang	Upper Subansiri
			Lohit	Kurung Kumey
			Namsai	Kra Daadi
			Longding	-
2	Assam	7	Nagaon	Karbi Anglong
			Dhubri	Kokrajhar
			Goalpara	Chirang
			Darrang	-
3	Manipur	4	Chandel	Tamenglong
			Churachandpur	Ukhrul
4	Meghalaya	7	West Garo Hills	West Jaintia Hills
			South-west Garo Hills	South-west Khasi Hills
			East Khasi Hills	North Garo Hills
			East Jaintia Hills	-
5	Mizoram	3	Lawngtlai	Mamit
			Lunglei	-
6	Nagaland	11	Dimapur	Phek
			Kohima	Peren
			Kiphere	Tuensang
			Longleng	Wokha
			Mokokchung	Zunheboto
			Mon	-
7	Sikkim	2	East	West

S.No.	State	No. of Districts	Name of Districts	
8	**Tripura**	**5**	Dhalai	Unakoti
			North Tripura	West Tripura
			South Tripura	-
Total		**52**		

1D. List of cities under NUHM in the identified districts & urban areas:

S.No.	State	No. of Cities	Name of cities	
1	Andhra Pradesh	10	Amalapuram	Mandapet
			Peddapuram	Pithapuram
			Rajahmundry	Samalkot
			Tuni	Kavali
			Nellore	Venkatagiri
2	Assam	3	Dhubri	Goalpara
			Nagaon	
3	Bihar	7	Darbhanga DHQ	Gaya DHQ
			Katihar DHQ	Muzaffarpur DHQ
			Purnia DHQ	Chhapra
			Patna Urban	
4	Gujarat	10	Deesa	Palanpur
			Bhavnagar	Mahuva
			Palitana	Shihor
			Anjar	Bhuj
			Gandhidham	Mandvi
5	Haryana	4	Faridabad	Gurgaon
			Hodal	Palwal
6	Jammu & Kashmir	1	Jammu	
7	Jharkhand	2	Giridih	Pakur
8	Karnataka	5	Bangalore (U)	Belgaum
			Yadgir	Yadgir-Shahpur
			Yadgir-Shorapur	
9	Kerala	11	Kondotty	Kottakkal
			Malappuram(District Head Quarters)	Manjeri
			Nilamboor	Parappanagady

			Perinthalmanna	Ponnani
9	**Kerala**	**11**	Tanur	Thiroorangady
			Thirur	
			Chhatarpur	Indore
			Jhabua	Panna
			Raisen	Rewa
10	**Madhya Pradesh**	**13**	Sagar	Shadol
			Sheopur	Sidhi
			Singrauli	Tikamgarh
			Vidisha	
			Ahmadnagar Municipal Corporation	Kopargaon Municipal Council
			Sangamner Municipal Council	Shrirampur Municipal Council
			Ambejogai Municipal Council	Beed Municipal Council
			Parli Municipal Council	Gadchiroli Municipal Council
			Gr. Mumbai	Amlerner Municipal Council
			Bhusawal Municipal Council	Chalisgaon Municipal Council
			Chopda Municipal Council	Jalgaon Municipal Corporation
			Pachora Municipal Council	Latur Municipal Corporation
11	**Maharashtra**	**35**	Udgir Municipal Council	Nandurbar Municipal Council
			Shahade Municipal Council	Deolali Cantonment Board
			Malegaon Municipal Corporation	Manmad Municipal Council
			Nashik Municipal Corporation	Sinnar Municipal Council
			Barshi Municipal Council	Pandhrpur Municipal Council
			Solapur Municipal Corporation	Buldhana Municipal Council
			Chikhli Municipal Council	Khamgaon Municipal Council
			Pusad Municipal Council	Shegaon Municipal Council
			Wani Municipal Council	Yavatmal Municipal Council

S.No.	State	No. of Cities	Name of cities	
11	**Maharashtra**	35	Thane	
12	**Meghalaya**	4	Shillong	Nongstoin
			Jowai	Tura
13	**Mizoram**	1	Lunglei	
14	**Nagaland**	5	Dimapur	Kohima
			Mokokchung	Tuensang
			Wokha	
15	**Odisha**	2	Behrampur	Bhubaneshwar Urban (Khurda)
16	**Rajasthan**	18	Alwar	Balotra
			Bhiwadi	Barmer
			Bikaner	Bari
			Dhaulpur	Jaipur
			Jalor	Jodhpur
			Phalodi	Hindaun
			Karauli	Pali
			Pratapgarh	Gangapur
			Sawai Madhopur	Udaipur
17	**Sikkim**	1	Gangtok	
18	**Tripura**	3	Dharmanagar	Udaipur
			Agartala	
19	**Uttar Pradesh**	100	Agra	Aligarh
			Allahabad	Deoband (NPP)
			Saharanpur (M Corp.)	Auraiya
			Azam Mubarakpur	Azamgarh (NPP)
			Budaun (NPP)	Sahaswan (NPP)
			Ujhani (NPP)	Badohi

			Bahraich (NPP)	Ballia
			Balrampur	Banda
			Nawabganj (NPP + OG)	Aonla (NPP)
			Baheri (NPP)	Bareilly (M Corp. + OG)
			Faridpur (NPP)	Basti
			Bijnor	Bijnor (NPP)
			Chandpur (NPP)	Dhampur (NPP)
			Kiratpur (NPP + OG)	Najibabad (NPP)
			Seohara (NPP + OG)	Sherkot (NPP)
			Bulandshahr (NPP + OG)	Gulaothi (NPP)
			Jahangirabad (NPP)	Khurja (NPP + OG)
			Sikandrabad (NPP)	Chitrakoot Dham (Karwi) (NPP)
			Deoria	Etah
19	**Uttar Pradesh**	100	Farrukhabad-cum-Fatehgarh (NPP)	Fatehpur
			Ferozabad	Ghaziabad (M Corp.)
			Khora (CT)	Loni (NPP)
			Modinagar (NPP)	Muradnagar (NPP)
			Ghazipur	Gonda
			Gorakhpur	Hapur (NPP)
			Pilkhuwa (NPP)	Hardoi (NPP + OG)
			Sandila (NPP)	Shahabad (NPP)
			Jaunpur	Chhibramau (NPP)
			Kannauj (NPP)	Kanpur (Nagar)
			Kasganj	Manjhanpur
			Gola Gokaran Nath (NPP)	Lakhimpur (NPP)
			Padrauna	Lalitpur
			Lucknow	Maharajganj

19	**Utar Pradesh**	100	Mainpuri	Mathura
20	**Uttarakhand**	2	Hardwar	Roorke
21	**West Bengal**	13	Bangaon	Barasat
			Bhatpara	Garulia
			Habra	Halisahar
			Kanchrapara	Naihati
			New Barrackpore	North Dum Dum
			Panihati	South Dum Dum
			Titagarh	
Total		**250**		

Annexure 2A. House to House Survey Form

House to House Survey form

ASHA/AWW-Assessor Name/Ph No.: ________

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

Sub-Centre name:________

Name of ANM: ____________

Area Name: ________

Date of Visit : dd/mm/yy

First house visited today - House No. :_________

Name: Address with landmark:

Last house visited today - House No. :________

Name: Address with landmark:

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

Signature of ASHA/assessor:_____________________

Verified by ASHA Facilitator (Signature):___________________

Verified by ANM (Signature):_______________

SHEET NUMBER :________

Annexure 2B. Pregnant women survey listing

VILLAGE/ AREA - Pregnant Women Survey Listing

Name of ASHA/AWW/ assessor: _____ Area Name as in Annexure 2a: _____

Name of ANM:_____

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

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

Annexure 2C. Infant/children survey listing

Infants / children survey listing

Name of ASHA/AWW/ assessor: _________ Area Name as per Annexure 2a: Name of ANM: __________

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

Signature of ASHA/AWW/ Assessor________________

Verified by ASHA/AWW Facilitator (Signature):__________

Annexure 3A. Agenda for district workshop on Intensified Mission Indradhanush for medical officers

Training materials: Copy of operational guidelines including annexures for each participant

Duration: 1 day

Time	Session	Facilitator
	Registration	
45 minutes	Welcome and introduction	
	Introduction to Intensified Mission Indradhanush	DIO
	Remarks by partners	
	Remarks by District Magistrate	
30 minutes	Overview of immunization programme at national and state level	WHO India
TEA		
1 hour	Micro planning for Intensified Mission Indradhanush	WHO India
30 minutes	Conducting head count and preparing due lists	DIO/WHO India
30 minutes	Organizing trainings	WHO India
15 minutes	Monitoring and supervision	WHO India
15 minutes	Discussion	
Lunch		
30 minutes	Exercise on recording and reporting	WHO India & ITSU
30 minutes	IEC, social mobilization and media interaction	UNICEF & ITSU
30 minutes	Adverse events following immunization	WHO India & ITSU
30 minutes	Frequently asked questions	DIO/WHO India
15 minutes	Discussion	
TEA		
45 minutes	Financial guidelines for Intensified Mission Indradhanush	District Accounts Manager/ DIO
15 minutes	Way forward for Intensified Mission Indradhanush – Timeline of activities and support available	District Magistrate
Closing remarks		

Annexure 3B. Agenda for district orientation of district and block level programme/ accounts managers on financial guidelines for Intensified Mission Indradhanush

Participants: District Programme Manager, District Accounts Manager, Block Programme Manager, Block Accounts Manager and other related officials handling NHM funds

Training materials: Copy of operational guidelines including financial guidelines for each participant

Time: 1 hour

Time	Session	Facilitator
15 minutes	Introduction to Intensified Mission Indradhanush	DIO/Partners
30 minutes	Financial guidelines for Intensified Mission Indradhanush • Existing norms • Change in mode of payment from existing norms • Timeline for payments	District Programme Manager (NHM)/District Accounts Officer (NHM)
15 minutes	Way forward for Intensified Mission Indradhanush – Timeline of activities and support available	DIO

Annexure 3C. Agenda for district workshop on Intensified Mission Indradhanush for data handlers

Participants: District data handlers and one data handler from block and urban area responsible for routine immunization data entry at these levels

Training material: Reporting formats for Intensified Mission Indradhanush

Duration: Half day

Time	Session	Facilitator
15 minutes	Introduction to Intensified Mission Indradhanush	DIO
30 minutes	Planning process and forms	DIO/Nodal officer for urban area/ Partners
15 minutes	Data flow from ANM to district for Intensified Mission Indradhanush	DIO/Partners
45 minutes	Daily reporting process in Intensified Mission Indradhanush and forms	DIO
15 minutes	Day-wise key indicators generated through reported data to be submitted to DIO during Intensified Mission Indradhanush round	DIO/WHO India
30 minutes	Role of data handlers in Intensified Mission Indradhanush	DIO
15 minutes	Way forward for Intensified Mission Indradhanush – Timeline of activities and support available	DIO

Annexure 3D. Agenda for district workshop on Intensified Mission Indradhanush for vaccine and cold chain handlers

Participants: One cold chain handler from each cold chain point

Training material: Vaccine and cold chain reporting format and open vial policy

Duration: Half day

Time	Session	Facilitator
15 minutes	Introduction to Intensified Mission Indradhanush	DIO
15 minutes	Planning process	DIO/Nodal officer for urban area/ Partners
30 minutes	Availability of vaccine and logistics. Issue and receipt of vaccine and logistics for Intensified Mission Indradhanush	DIO/Partners
45 minutes	Planning for alternate vaccine delivery	DIO/Partners
15 minutes	Open vial policy	DIO/Partners
30 minutes	Role of cold chain handlers in Intensified Mission Indradhanush	DIO/Nodal officer for urban area
10 minutes	Day-wise vaccine and diluent utilization report to be submitted to DIO during Intensified Mission Indradhanush round	DIO/Partners
15 minutes	Way forward for Intensified Mission Indradhanush – Timeline of activities and support available	DIO
15 minutes	Way forward for Intensified Mission Indradhanush – Timeline of activities and support available	DIO

Annexure 4. Agenda for block/urban area training of health workers for Intensified Mission Indradhanush

Time	Session	Facilitator
15 minutes	Welcome and introduction	
	Introduction to Intensified Mission Indradhanush	Medical Officer-in charge
	TEA	
1 hour 30 minutes	Microplanning for Intensified Mission Indradhanush	Medical Officer (trained for Intensified Mission Indradhanush)
15 minutes	Importance of head count for preparing due list of beneficiaries	Medical Officer (trained for Intensified Mission Indradhanush)
15 minutes	Use of immunization tracking bag and revised counterfoil of MCP card	Medical Officer (trained for Intensified Mission Indradhanush)
10 minutes	Discussion	
	LUNCH	
15 minutes	Reporting and recording	Block Data Manager
15 minutes	IEC and social mobilization	
10 minutes	Open vial policy and implications for health workers	Medical Officer (trained for Intensified Mission Indradhanush)
15 minutes	Adverse events following immunization	Medical Officer (trained for Intensified Mission Indradhanush)
10 minutes	Discussion	
	TEA	
15 minutes	Financial guidelines for Intensified Mission Indradhanush	Block Accounts Manager
15 minutes	Frequently asked questions	
45 minutes	Preparing microplans – prioritizing areas for Intensified Mission Indradhanush sessions	Group work
1 hour	Preparing ANM rosters for working in the block	Medical Officer (trained for Intensified Mission Indradhanush)
10 minutes	What to do after this workshop: their role in sensitizing the social mobilizers: ASHAs and AWWs	Medical Officer (trained for Intensified Mission Indradhanush)
	WRAP UP	

Annexure 5. Agenda for block/urban area training of mobilizers(ASHAs/AWWs/link workers) for Intensified Mission Indradhanush

Time	Session	Facilitator
15 minutes	Welcome and introduction	
	Introduction to Intensified Mission Indradhanush	Medical Officer-in charge
15 minutes	Current immunization schedule	Medical Officer (trained for Intensified Mission Indradhanush)
15 minutes	Conducting head count for preparing due list of beneficiaries (exercise)	Medical Officer (trained for Intensified Mission Indradhanush)
15 minutes	Use of immunization tracking bag and revised counterfoil of MCP card	Medical Officer (trained for Intensified Mission Indradhanush)
10 minutes	Discussion	
15 minutes	Frequently asked questions	
45 minutes	IEC and social mobilization (role play)	Block Community Mobilizer/Any other official trained for Intensified Mission Indradhanush
10 minutes	Discussion	
10 minutes	What to do after this workshop	Medical Officer (trained for Intensified Mission Indradhanush)
TEA & WRAP UP		

Annexure 6. Financial norms under Intensified Mission Indradhanush

For operational activities of routine immunization, funds are available under Part C of Programme Implementation Plans (PIP) of the NHM. The same will be utilized to carry out operational activities for Intensified Mission Indradhanush.

However, for some of the activities approved under Part C of PIP of immunization, flexibility has been built in, so that we have greater participation of health workers for Intensified Mission Indradhanush.

The following norms remain the same as earlier:

Activity	Approved Norms under Part C routine immunization (ROP) NHM
To develop sub-centre and PHC microplans using bottom up planning with participation of ANMs, ASHAs, AWWs	@ Rs 100 per sub-centre (meeting at block level, logistics)
For consolidation of microplan at PHC/CHC level	@ Rs 1000 per block and at district level @ Rs 2000 per district
Focus on slum and underserved areas in urban areas	Hiring an ANM @ Rs 450 per session for 4 sessions/ month/slum of 10 000 population and Rs 300 per month as contingency per slum, i.e., total expense of Rs 2100 per month per slum of 10 000 population
ASHA incentive for full immunization per child (up to 1 year of age)	Rs 100 per child for full immunization in first year of age
ASHA incentive for full immunization per child up to 2 years of age (all vaccination received between first and second year of age after completing full immunization at 1 year of age)	Rs 50 per child for ensuring complete immunization up to second year of age of child
Supervisory visits by state and district level officers for monitoring and supervision of routine immunization	@ Rs 250 000 per district for district level officers (this includes POL and maintenance) per year. (Districts need to provide a minimum of Rs 20 000 to each block for supervision of immunization activity from block and PHC.)
	By state level officers @ Rs 150 000 per year
Printing and dissemination of immunization cards, tally sheets, monitoring forms, etc.	@ Rs 10 per beneficiary
Two-day district level orientation training for ANMs, multi-purpose health workers (male), LHVs, health assistants (male/female) as per reproductive and child health (RCH) norms	As per revised norms for trainings under RCH
One-day refresher training of district routine immunization computer assistants on routine immunization/HMIS and immunization formats under NHM	As per revised norms for trainings under RCH

Activity	Approved Norms under Part C routine immunization (ROP) NHM
Two days cold chain handlers' training for block level cold chain handlers by state and district cold chain officers and DIO for a batch of 15–20 trainees and three trainers	As per revised norms for trainings under RCH
One-day training of block-level data handlers by DIO and district cold chain officer to train about the reporting formats of immunization and NRHM	As per revised norms for trainings under RCH
Cold chain maintenance	@ Rs 750 per PHC/CHC per year per district (Rs 15 000 per year)
POL for vaccine delivery from state to district and from district to PHCs/CHCs	Rs 150 000 per district/year
Alternate vaccine delivery (AVD)	Hard-to-reach areas @ Rs 150 per routine immunization session
	For routine immunization session in other areas @ Rs 75 per session
Red/black plastic bags, etc.	@ Rs 3/bag/session
Bleach/hypochlorite solution and twin bucket	Rs 1200 per PHC/CHC per year
Safety pits	Rs 5250/pit
Support for quarterly state level review meetings of district officers	@ Rs 1250/participant/day for 3 persons (CMO/DIO/District Cold Chain Officer)
Quarterly review and feedback meeting exclusively for routine immunization at district level with one block MO, ICDS, CDPO and other stakeholders	@ Rs 100 per participant for meeting expenses (lunch, organizational expenses)
Quarterly review meeting exclusive for routine immunization at block level	@ Rs 50 per participant as honorarium for ASHAs (travel) and Rs 25 per person at the disposal of MO IC for meeting expenses(refreshments, stationery and miscellaneous expenses)

Reflecting change in mode of payment from the existing norms:

Activity	Existing Norms	For Intensified Mission Indradhanush
Vaccinators and mobilizers		
Line listing of households done twice a year at six-month interval	Rs 100 for ASHAs	For Intensified Mission Indradhanush, this amount may be paid to the ASHA. If no ASHA is identified or available, the same may be paid to the AWW, subject to a total ceiling of Rs 100.
Preparation of due list of children to be immunized to be updated on a monthly basis	Rs 100 for ASHAs	For Intensified Mission Indradhanush, this amount may be paid to the ASHA. If no ASHA is identified or available, the same may be paid to the AWW subject to a total ceiling of Rs 100.
Mobilization of beneficiaries to session sites	Rs 150 for ASHAs	For Intensified Mission Indradhanush, this amount may be paid to the ASHA. If no ASHA is identified or available, the same may be paid to the AWW/link worker). Each mobilizer may be paid Rs 75 with a maximum limit of Rs 150 per session site.
Mobility support to vaccinator for conducting sessions outside allocated sub-centre or place of posting		"Any additional requirement may be discussed or approved by DTFI. Some areas may require allocation of funds above the budgeted norms based on the geographical access. States to decide the financial norms for budgetary calculation & distribution to districts as per local need."
Mobility support for supervision of these activities		
Mobility support for mobile teams in far-flung/scarcely populated/scattered areas.		

Annexure 7. Intensified Mission Indradhanush sub-centre planning (Format 1)

For ANM

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

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

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

*Code: 1. Vacant sub-centre; 2. Areas where last three routine immunization sessions not held; 3. Polio high-risk areas; 4. Areas with low routine immunization coverage, identified through measles outbreaks or cases of diphtheria/neonatal tetanus in last 2 years; 5. Small villages, hamlets, etc. not having independent routine immunization sessions; 6. Others

Annexure 8. Intensified Mission Indradhanush: Block/urban area planning (Format 2) For Block/urban planning unit

(Compile information from Planning Format 1)

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

S. No	Name of sub-centre	Name of areas requiring additional Indradhanush session(s)	Head count done (Y/N)	Population based on head count (Write NA if head count not done)		No of immunization sessions required	Mention reason for additional session*(Write code) 1/2/3/4/5/6	If mobile session, write "mobile". For other sessions, mention location of session site(s).	Name, designation & mobile no of mobilizers (ASHA, AWW/ link worker)	Which ANM will conduct immunization session in this area			
				0–2 years	Pregnant women					ANM of same sub-centre	ANM of other sub-centre from same block	ANM from outside block	Hired ANM
									1. 2.				
									1. 2.				
									1. 2.				
									1. 2.				
									1. 2.				
									1. 2.				
									1. 2.				
									1. 2.				

* Code: 1. Vacant sub-centre; 2. Areas where last three routine immunization sessions not held; 3. Polio high-risk areas; 4. Areas with low routine immunization coverage, identified through measles outbreaks or cases of diphtheria/ neonatal tetanus in last 2 years; 5. Small villages, hamlets, etc. not having independent routine immunization sessions; 6. Others

.....

Signature of ANM .....Signature of Block MO IC.....

Annexure 9.ANM micro plan roster for Intensified Mission Indradhanush (Format 3) **Round I/II/III/IV For ANM**

(One format for each ANM in the district)

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

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

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

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

* Code: 1. Vacant sub-centre; 2. Areas where last three routine immunization sessions not held; 3. Polio high-risk areas; 4. Areas with low routine immunization coverage, identified through measles outbreaks or cases of diphtheria/ neonatal tetanus in last 2 years; 5. Small villages, hamlets, etc. not having independent routine immunization sessions; 6. Others

Signature of ANM ..... Signature of MOIC .....Signature of District Immunization Officer .....

Annexure 10. Mobile team planning for Intensified Mission Indradhanush

(Round I/II/III/IV) (One format for each mobile team) **For Block/ Urban area**

District: _____ Block/planning unit: _____

AEFI management centre name & Tel no: _____

Name and mobile no. of MOIC _____ Supervisor_____ ANM_____

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

Day	Vehicle details		Site 1	Site 2	Site 3	Site 4
5		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
6		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
7		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
Signature of ANM .....Signature of DIO ..... Signature of MOIC.....						

Annexure 11. Intensified Mission Indradhanush: District planning

For DIO

District:.....Name of DIO:.....

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

Annexure 12: Tally sheet for Intensified Mission Indradhanush session

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

Block/ planning unit: _____ Sub center: _____ Village: _____ Session site address: _____

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

S. No	Name of beneficiary	Father/ husband name	Age	Sex	Children vaccinated for the first time in life	Pregnant Women			CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY																	Full immunization achieved (Y/N)	CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY								Complete immunization achieved (Y/N)	DPT-B
						TT-1	TT-2	TT- B	BCG	OPV-1	Penta 1	RVV-1	fIPV-1	PCV-1	OPV -2	Penta 2	RVV-2	OPV-3	Penta-3	RVV-3	fIPV-2	PCV-2	Measles-1	JE-1	PCV-B	Vit A-1		*DPT-1	*DPT-2	*DPT-3	OPV-B	DPT- B	Measles2	JE-2	Vit A-2		
Total																																				

FULL IMUNIZATION ACHIEVED		
	Male	Female
9-11 months		
12-23 months		
Children vaccinated for the first time in life		
0-11 months		
12-23 months		

No. of target children for the session (as per due list prepared after head count)	
Total Children vaccinated	
AD Syringes 0.1ml used	
AD Syringes 0.5ml used	
5ml Reconstitution Syringes used	
Total no. of ORS distributed	
Total no. of Zinc Tablets distributed	

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

Signature of ANM

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

Annexure 13: Block daily reporting format for Intensified Mission Indradhanush

Date of activity: _____ **Setting:** Urban/Rural **For Block/ Urban Cities**

Block/ planning unit: _____ **Round:** I / II / III / IV

S. No	Name of ANM	Session site address	No. of children to be vaccinated as per the due lists based on head	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																	Full immunization achieved				Record number of vaccinations								Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
					0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	Measles-1	JE-1	PCV-B	Vit A-1	Male (9 - 11 months)	Female (9 - 11 months)	Male (12 - 23 months)	Female (12 - 23 months)	DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	Measles2	JE-2	Vit A-2				
Grand Total																																										

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

Annexure 14: District daily reporting format for Intensified Mission Indradhanush

Date of activity: _____ **For District**

District name: _____ **Round:** I / II / III / IV

S. No	Block/ Urban City name	Urban/Rural	No of sessions held	No. of target children for the day (as per the due lists based on head count)	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																Full immunization achieved				Record number of vaccinations									Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed
						0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV - 2	Measles-1	JE-1	PCV-B	Vit A-1	Male	Female	Male	Female	DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	Measles2	JE-2	Vit A-2			
																												9 - 11 months		12 - 23 months											
Grand Total																																									

Signature of Chief Medical Officer

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

Annexure 15: State daily reporting format for Intensified Mission Indradhanush

For State

Date of activity____________________

State name: ______________________________ **Round:** I / II / III / IV

S. No	District name	Urban/ Rural	No of sessions held	No. of target children for the day (as per the due lists based on head count)	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																		Full immunization achieved				Record number of vaccinations								Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
						0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	Measles-1	JE-1	PCV-B	Vit A-1	9 - 11 months		12 - 23 months		DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	Measles2	JE-2	Vit A-2				
																													Male	Female	Male	Female												
		U																																										
		R																																										
		U																																										
		R																																										
		U																																										
		R																																										
		U																																										
		R																																										
		U																																										
		R																																										
	Grand Total	U																																										
		R																																										

Signature od State Immunization Officer

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

Annexure 16. Daily vaccine and diluents utilization reporting format

For Vaccine and Cold Chain Handlers

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

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

Signature of MOIC

Name and signature of cold chain handler

Annexure 17-A: State level communication plan for IMI campaign

State level communication plan for IMI campaign (form no. 17A)										
Name of the state:		Name of District:						District IEC/ Media officer:		
Advocacy	**STFI meeting**	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….		
	Orientation of IMA/IAP members	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….		
	Orientation of education, WASH and WCD state officials on IMI	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….		
	Formation of Core Group for media management including cricis communcation	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….		
	Orientation of Religious leaders or key influencers	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….		
	Media Senstization workshop	Date…… Responsible person…….								
	State level Media round table	Date…… Responsible person…….								
	Any Other	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….		
Capacity Building	**State ToT including communcation training for district officials**	Date…… Responsible person…….								
	Training of Education department state officials	Date…… Responsible person…….								
Social Media	**Constitution of task force for social media**	Members…… Frequency……..								
	WhatsApp messaging	Members…… Frequency……..								
	Facebook messaging	Members…… Frequency……..								
IEC activities	**Hoadring**	No.		Responsible person…….				Date		
	Banners	No.		Responsible person…….				Date		
	Poster	No.		Responsible person…….				Date		
	Film Shows in Cenima hall	No.		Responsible person…….				Date		
	Any other									
		District 1	**District 2**	**District 3**	**District 4**	**District 5**	**District 6**	**District 7**	**District 8**	**District 9**	**Total**
Advocacy	DTFI meeting I										
	DTFI meeting II										
	Orientation of IMA/IAP members										
	Orientation of Religious leaders or key influencers										
	Media Advocacy workshop										
	Advocacey with school										
	Any Other										
Capacity Building	Training of district health functionaries i.e. ANM, ANM supervisour, CDPO etc.										
	TOT ANM supervisors , LHV, BEEs and ASHA supervisors										
	Training of media spokespersons for crisis management in case of										
Social Media	Constitution of task force for social media										
	Facebook messaging										
	WhatsApp messaging										

Note: I- This the responsibility of person responsible for IEC / communication/ SEPIO to collect information from district and compile the state sheet. II - He/ she needs to submit this template to director health services, mission director (NHM). III-This template need to be discuss in state ToT and will be basic tool for communication planning in state and district.

Annexure 17-B: District level communication plan for IMI campaign

	District level communication plan for IMI (Form No. 17B)										
	Name of the state:		**Name of District:**					**District IEC/ Media officer:**			
	Advocacy	**DTFI meeting**	Date…… Responsible person……			Date…… Responsible person……		Date…… Responsible person……			
Advocacy Meetings		**Orientation of IMA/IAP members**	Date…… Responsible person……			Date…… Responsible person……		Date…… Responsible person……			
		Orientation of CSO partners, including religious leaders and community influencer groups)	Date…… Responsible person……			Date…… Responsible person……		Date…… Responsible person……			
		Networking with school for supporting community mobilization	Date…… Responsible person……			Date…… Responsible person……		Date…… Responsible person……			
		District Media orientation workshop	Date…… Responsible person……								
		Any Other	Date…… Responsible person……			Date…… Responsible person……		Date…… Responsible person……			
Capacity building	Capacity Building	**Training of block level health officers**	Date…… Responsible person……								
Social Media	Social Media	**Constitution of social media committee**	Members…… Frequency……..								
		WhatsApp messaging	Members…… Frequency……..								
		Facebook messaging	Members…… Frequency……..								
		Any other	Members…… Frequency……..								
			District	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Total
Social mobilization activities	Advocacy	BTFI meeting for IMI										
		Meeting with Schools (Govt and Pvt.)										
		IMI microplanning meeting (For communication planning and operation)										
		Meeting with key CSO, religious leaders/influencers at block level										
		Sensitization meeting with govt. line department staff i.e. ICDS, Edu, Agri,										
		Any other										
	Capacity Building	Orientation of ANMs on BRIDGE and Microplanning review										
		Orientation of ASHAs/AWWs on BRIDGE										
		Orientation of ASHAs/AWWs on mobilization for IMI										
	Social Mobilization	Mother's meetings										
		Community/Influencer's meeting										
		Community meetings (VHSNC, SHGs, Mahila mandals for IMI campaign)										
		Govt. school teachers orientation/coordination meeting										
		Parent Teachers Meetings										
		Rallies	Date……									
		Mosque/Temple announcement										
		IPC sessions										
d-media activi	Mid media	Posters in community										
		Posters in Schools										
		Hoardings										
		Leaflets for community										
		Leaflets for Schools										
		Leaflets for ANM, ASHA and AWW										
		Leaflets for MOs										
		Miking/Local announcements										
		Any other activity										

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

Annexure 17-C: Health Facility/PHC level communication plan for IMI campaign

Health Facility/PHC level communication plan for IMI (form no. 17C)											
Name of the District:			Name of PHC/Planning unit:				Name of I/C MO:				
	Advocacy	BTF meeting for IMI campaign	Date…… Responsible person……				Date…… Responsible person……				
Advocacy Meetings		Meeting with Schools (Govt. and Pvt)	Date…… Responsible person……		Date…… Responsible person……				Date…… Responsible person……		
		IMI microplanning meeting (for communication and planning)	Date…… Responsible person……								
		Coordination meeting with CSO/NGOs, key religious leaders/influencers at block	Date…… Responsible person……		Date…… Responsible person……				Date…… Responsible person……		
		Sensitization meeting with block-level officers from government line departments	Date…… Responsible person……				Date…… Responsible person……				
		Any other	Date…… Responsible person……		Date…… Responsible person……				Date…… Responsible person……		
Capacity building	Capacity Building	Orientation of ANMs on BRIDGE (For IMI communication/planning)	Date…… Responsible person……				Date…… Responsible person……				
		Orientation of ASHAs/AWWs on BRIDGE (and IMI campaign communication)	Date…… Responsible person……				Date…… Responsible person……				
Social Media	Social Media	WhatsApp messaging (in coordination with District Social Media committee)	Members…… Frequency……				Members…… Frequency ……				
		Other									
			PHC/Planning unit ……	SC-1 ……	SC -2 ……	SC-3 ……	SC-4 ……	SC-5 ……	SC-6 ……	SC-7 ……	SC-8 ……	Total
Social mobilization activities	Social Mobilization	Mother's meetings										
		Community/ Influencer's meeting										
		VHSNC meeting for IMI										
		School meetings (Government)										
		School meetings (Private)										
		Rallies	Date……									
		Mosque/Temple announcement										
		IPC sessions										
		Miking	No……Areas……									
		Others (specify										
Med-media activities	Mid media	Posters in community										
		Posters in Schools										
		Leaflets for community										
		Leaflets for Schools										
		Leaflets for ANMs										
		Leaflets for ASHAs/AWWs										
		Leaflets for MOs										
		Any other activity										

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

Annexure 17-D: Sub-center level communication plan for IMI campaign

Sub-center level communication plan for IMI (form no. 17D)																
Name of the district		Name of the facility-CHC/ PHC		Name of sub-center /health center		Name of ANM:				Name of ASHAs and AWWs:						
S. No.	Name of Village/ Urban Area/ School	Social mobilization activities										Med-media activities				
		Mother's meeting	Community /Influencer's meeting	VHSNC meeting for IMI	School meetings (Govt)	Private school meetings	Parent Teachers Meeting	Rallies	Mosque/ Temple announcement	IPC sessions	Others (specify	Posters in community	Posters in Schools	Leaflets for community	Leaflets for Schools	Any other activity
1		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	
2		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....
3		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....
4		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....
5		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....
6		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....
7		Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Date & Time ..... Responsible person.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....	Numbers.....
Total No.																

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

Annexure 17E: Details of Process of Advocacy

Advocacy Objective	Advocacy tool/activity	Outcome Indicators
Policy-makers (parliamentarians and top government officials) The objective here is to gain consensus including the allocation of adequate resources through sound data and by creating a knowledgeable and supportive environment for decision-making		
• **Support with necessary resources (financial and HR).** • **Ensure high-level visibility as champions of IMI, with other policy-makers and decision-makers.** • **Strengthen collaboration with other related departments through visible advocacy.** **Key message:** "Your support can save lives of millions of children threatened by vaccine preventable diseases, and help meet the state/ district/constituency development goal (reduced IMR). The positioning of this message should be done in all communication material	• Factsheets/PPT/booklet/FAQ. • PPT presentation justifying support needed. • Sensitize at face-to-face meetings. • Invite for presentations and workshops.	• % of resources allocated • % of district immunization meetings chaired/ attended • % of events attended • # of new partners mobilized to support IMI efforts
Related government departments such as Education, Women and Child Development, Panchayati Raj Institutions This sector includes disparate groups, each with its own agenda, conflicting interests and concerns. Harmonizing the disparate units and building consensus are probably the greatest challenges, and will be necessary for sustained outcomes. Support must come from national level.		
Officials in the collaborating departments are able to recognize the benefits of convergence and support in achieving immunization goals. **Key message** **"Immunization success in partnership directly contributes also to the goals of other departments besides health"**	• IMI Factsheet/ brochure/ • PPT presentation on linkages between immunization, education, nutrition, and sanitation, justifying the kind of support needed and how it will help the IMI goal. • Sensitize with face-to-face meetings; Invite for presentations and workshops, especially when cross-sectoral linkages are being discussed; Invite to launch events of IMI. • Acknowledge support received in publications, public forums, social media, etc.	• % of districts with resources allocated for strengthening of state/district immunization cold chain • % of districts fully implementing commitments made • % of events supported by other departments, attended by policy-makers • # of new national partners mobilized to support RI efforts • % of district IMI meetings chaired/attended by representatives from other departments.
Advocacy with CSOs and local influencers CSOs (not only in Health but also those working in education, nutrition, children's issues, water and sanitation) with experience in participatory approaches can play strong roles in increasing awareness and collective action among local leaders, within health facilities, women's groups, and other networks.		

CSOs/Local NGOs support community mobilization activities, mobilize necessary resources such as transport during outreach camps, provide volunteers, conduct capacity building, and provide support during AEFI, help in monitoring, evaluation and documentation of activities **Key message:** Any support provided to the local immunization programme will be publicly acknowledged, and lead to institutionalizing partnership with government	• Identify and prepare list of CSOs in the state district • Prepare what support they and their network can offer. • Call for daily meetings and take feedback. • Prepare terms of agreement/memorandum of understanding (MOU) on the nature of cooperation. • Engage them in the planning of community mobilization activities. • Share monitoring formats. • Identify capacity development needs and prepare capacity development plans for identified NGOs. • Provide supportive supervision when necessary	• % of CSOs fully implementing commitments made in the MOU. • # of community mobilization activities conducted independently. • # of community mobilization activities conducted with others. • % of community members able to recall the name of the CSO/concerned person who lent support in any form. • % of households who have information available with them about the CSO who may contact during RI outreach programmes
Advocacy with IAP/IMA state/district chapters The Indian Medical Association (IMA) and the Indian Association of Paediatrics (IAP) can play a significant role in increasing vaccination coverage, since many privately practising paediatricians give vaccination in their own clinics. With effective communication, this group can be motivated to support IMI effectively		
• Promote and brand IMI by providing the necessary space in all their communication material sent to their members, on their websites, in their clinics • Advocate about IMI during their events/launches and other member programmes. • Promote the use of MCP card. • Offer HR support for vaccination and outreach if required. • Report and support during any AEFI. • Support in supportive supervision for IMI and capacity building **Key message:** "the most cost-effective child-survival strategy in which the medical fraternity can help." For medical students in institutions, the learning experience in the field can be rich and result in gaining institutional credit.	• Engage IAP/IMA nationally • Prepare proposal and PPTs on how IAP/ IMA members can support the immunization programme. Share it with local IAP/IMA chapters • Prepare a list of IAP/IMA members in the district and any networks. • Invite IAP/IMA members for workshops. • Offer IAP/IMA members incentives for providing support, such as recognition certificates and awards. • Induct selected senior IAP/IMA members to district immunization advisory committees. • For selected senior IAP/IMA members from district, create opportunities for interviews with media, talk shows on TV and radio/FM channels. • Use IEC showcasing participation from private health practitioners. • Seek support from district members for capacity building	• No. of caregivers/ parents who reported privately practising doctors advised completion of RI during IMI. • No. of IAP/IMA members from district who participated in IMI in different capacities. • No. of times IAP/IMA members from district attended any meetings. • No. of supportive supervision programmes in which IAP/IMA members/medical institution students or staff from district participated. • No. of capacity development programmes in which IAP/IMA members from district participated. • No. of times medical institutions from district offered support for AEFI.
Advocacy Objective	**Advocacy tool/activity**	**Outcome Indicators**
Advocacy with Media		

• **National media is able to profile RI as a national health priority.** • **Media is well oriented to the benefits of immunization and the stringent processes of cold chain, procurement, capacity building to make vaccines safe for use.** • **Media provides support during AEFI through positive, balanced reporting.** **Key message:** "the most misunderstood life-saving health intervention which needs their support in bringing its benefits to light." **(see more on media in the media section**	• **Prepare a database of journalists/ repo**rters in the district. • Hold media collaboration workshops; include state-level journalists. • Seek the help of development partners/ media and communication agencies to build capacity of media. • Produce and update standard media kit on IMI, vaccine preventable diseases and FAQ on RI. • Provide data on immunization-related disease burden of state/district. Provide national and global data. • Keep them regularly informed of all immunization related developments. • Prepare and provide list of media spokespersons from within Health system and IAP/IMA. • Build strategic partnerships with na¬tional/ state broadcast and print associations • Conduct media monitoring. • Prepare quarterly reports on national and h**igh-risk state media coverage.**	• **Number of quality reports published on IMI.** • **Number of reports on national and high-risk state media coverage and frequency.** • **Amount of complementary airtime gained for mass media broadcasts.** • **Number of positive reports during IMI, especially during an unfortunate AEFI.**

Advocacy with traditional healers (rural) and chemists (urban)

At least at the village level, traditional healers or rural medical practitioners (RMPs) are usually the first referrals during illness in the family since they live closer to communities and caregivers have quick access to them. Once these traditional healers are fully oriented with the benefits of immunization, they can be motivated to advise caregivers/parents to avail RI services as per schedule. Another habit of caregivers (families) is to seek advice about medicines directly from chemists (primarily because it saves money from visits to doctors, and because the perception of the gravity of the illness would be low). Chemists can mobilize communities successfully, especially male members who actually visit them for medicines and advice

• Traditional healers and chemists are able to understand and agree with the benefits of childhood immunization, know the childhood immunization schedule, and the four key messages. • Traditional healers and chemists agree to be available when required for community mobilization. • Communicate the key messages to caregivers/families on the benefits of immunization. • Chemists agree to and offer space for display of posters on IMI at their shops. **Key message:** As "a safe and free intervention that builds defence against life-threatening diseases in children, eradicated diseases like small-pox and polio from India, and saved lives of millions of children and adults around the world."	• Pictorial presentations/posters booklets on disease risk and benefits of immunization. • Provide examples of how vaccination has helped eradicate a dreaded disease like small pox. • ANMs/ASHAs invite them to group meetings and seek their counsel on health issues. • Provide chemists with IEC materials for display in shops. Engage and offer short incentives such as certificates of recognition. • Promote pictures of chemist shops displaying immunization posters in the district/block (contribute articles to ASHA newsletter produced by MOHFW). • Conduct capacity building for traditional healers and chemists in IPC.	• Number of caregivers visiting fixed sites/ outreach sessions who admit they were advised by traditional healers/ chemists to come for immunization. • Number of caregivers visiting fixed sites/outreach sessions who admit they saw IMI IEC material at chemists near their house. • Number of traditional healers seen extending mobilization support or available at outreach sessions

Annexure 17F: Roles and responsibilities in operationalizing communication at national, state and district level

National Level roles for communication

1. Call advocacy meeting with relevant sectors such as MoWCD, MoRD, MoUD, MoIB ministries and seek their support for communication at state level. Share details of contact persons at state/district level and provide advocacy and information material to the partner Ministries for further sharing with state departments
2. Call advocacy meeting with IMA/IAP chapters, national-level development partners, national-level CSO members, trade and industry bodies such as CII, and seek their support; share *5 saal 7 baar* communication material with them and information factsheet.
3. Seek support from IEC Division to prepare a special social media plan, and website/webpage on MOHFW site providing all relevant information regarding IMI, including links to download IEC material, templates, guidelines, etc
4. IEC Division to prepare a national broadcast plan for 5 saal 7 baar on various channels
5. Centre may decide to engage media on the government's aim to achieve 90% FIC in selected districts
6. Prepare messages for spokespersons, and a Spokesperson FAQ on IMI. It is recommended to have a Spokesperson orientation/training on the FAQ
7. The communication-in-charge at national level will make a preparedness/assessment/ monitoring schedule for the concerned states/districts, along with a partner-support schedule, review meetings; monitoring of communication activities through IMI App and preparation of report for presentation to Health Minister/ PMO

State-level roles for communication (Refer to Annexure 17A for planning template)

The activities in the planning template are broadly divided under the relevant heads of advocacy, capacity building, social media and IEC activities. The key roles are defined below:

1. Support the relevant districts in carrying out a resource mapping; fill any gaps strategically for communication; if necessary, do advocacy with Principal Secretary Health for achieving the resources
2. Ensure STFI and DTFI are in place and a review meeting schedule has been prepared on communications.
3. On advise of NTFI, follow-up with relevant departments from other sectors, primarily education, women and child development, rural, urban, tribal, directorate of field publicity, police (for conflict regions), agriculture, youth, state-level CSOs, State chapters of IMA-IAP and prepare a support plan. Have IMI concept note to share ready before hand.
4. Provide relevant information to NTFI for website/webpage proactively/on demand
5. Ensure all basic relevant advocacy and communication tools are available in open file formats/ready formats, with clear dissemination plan with guidelines on how to use them and translated/adapted as required to match the local context
6. Share details of coordination person at district/block level and provide advocacy and information material including *5 saal 7 baar* communication material to relevant partners and stakeholders
7. Designate a person at state/social media agency to plan, execute, monitor a social media plan. Have a message approval team in case any new messages are created/adapted, especially for social media.
8. Identify and support the necessary trainings of trainers for district-level communications team on development of communications plan and operationalization
9. Ensure BRIDGE (IPC Skills training of FLWs) has been budgeted with a clear training and monitoring plan.
10. Prepare a media orientation plan and media management plan.
11. Ensure that the State AEFI team is well oriented to the IMI strategy and goals, and aware of the FAQ developed for spokespersons. Hold spokespersons training; the training is recommended with national AEFI spokespersons training, especially in states where districts are less.
12. Prepare a broadcast plan for *5 saal 7 baar* on state channels after reviewing national dissemination plan for *5 saal 7 baar*, and district plans for the same.

13. As required, develop special communication products such as talk shows on television/radio with paediatricians, short videos of influencers appealing to communities, short videos of parents who have full confidence in vaccines and have completed immunization for their children. Budget for same.
14. Prepare a district monitoring plan (see Annexure on Monitoring); documentation plan, review meetings, and submission of consolidated documentation report to Health Secretary.
15. Create a Google email Group of selected communication coordinators at state and district level for inputting real-time information sharing. A whatsapp group may also be created with clear responsibility/coordination guidelines with selected people as administrators of the group.
16. Prepare a Gantt Chart for all activities keeping September 15 as deadline for completion of all activities, and working backwards.

District-level roles and responsibilities for operationalizing IMI communcations (Refer to Annexure 17B)

It will be the role of the DTFI to ensure that the IMI communication plans are in place, which is then implemented, monitored, and reviewed thoroughly.

1. Identify human resources for communication coordination at each level of district, block, and village; clearly indicate who is in charge and who is responsible for what and by when. Also include clearly defined partners's role as support to IMI.
2. Use geographical/community mapping to identify LODOR families (Leftouts-Dropouts-Resistant), with disaggregated demographic characteristics such as tribal areas, rural or urban; difficult terrain, hilly, riverine or desert regions; conflict regions. Block-wise mapping will help so that the channels of communication can be identified, planned, and costed accordingly
3. Hold training for District and Block-in charge of communication on the planning and monitoring tools. The Trainers have to be those who have undergone TOT at the state level
4. Ensure BRIDGE (IPC Skills training of FLWs) has been budgeted well with a clear training and monitoring plan. Use backward planning methodology.
5. Prepare the District Communication Plan:
    a. First get the Sub-centre/Village Plans ready (See Annexure 7D). Trainings for preparation of plans must have already happened
    b. At Block level, the communication person in-charge will compile all Subcentre plans (Annexure 7D), prepare the Block Plan (Annexure 7C), and submit to the District communication in-charge/DTFI for preparing the District Action Plan for IMI (Annexure 7B). This will help in budgeting for each activity.
6. Plan different communication activities in an intensified manner at least for 15 days before the special immunization sessions. (See mass media visibility plan below).
7. Remember to factor in all communication support activities by various partners such as by Directorate of Field Publicity or CSO partners like Lions Club and Rotary, or communications by influencers and influencing groups like religious leaders, etc
8. Ensure that a Supportive supervision plan for demand generation needs to be provided at subcentre level.
9. Start documenting and monitoring communication activities from Day One of planning.
10. Feed into the Gantt Chart being prepared at the state level, keeping September 15 as deadline for completion of all activities, and working backwards.

Annexure 18: Areas of Support from other Ministries

S. No.	Ministry/Department	Expected Areas of Support
1	**Ministry of Defence**	• Support in provision of immunization services in cantonment areas. • Support in border districts for delivery of vaccines in hard to reach areas. • Involvement of NCC for: ◊ Thematic focus on immunization in identified districts/urban areas. ◊ Generate awareness on immunization. ◊ Support in social mobilization. ◊ Mobilize families resistant/reluctant for vaccination
2	**Ministry of Home Affairs**	• Support and facilitation of Immunization sessions in the residential areas of the Central Police Organizations and Central Armed Police Force. • Support in border districts for delivery of vaccines in hard to reach areas
3	**Ministry of Housing & Urban Poverty Alleviation**	• Active involvement of Self Help groups under National Urban Livelihood Mission to increase awareness on importance of immunization in urban areas
4	**Ministry of Human Resources & Development**	• Convergence with health department to generate awareness about immunization through school curriculum/extra-curricular activities around the planned phase of Intensified Mission Indradhanush.
5	**Ministry of Information & Broadcasting**	• Involvement of MoI&B in the development of communication strategies • Support in wide dissemination of IEC material pertaining to immunization • Coordination with Indian Broadcasting Federation, Private Radio channels and explore areas of support including CSR for private FM channels
6	**Ministry of Labour & Employment**	• Support in identification of unvaccinated and partially vaccinated children among the registered beneficiaries of ESIC. • Provision of immunization services through ESIC hospitals and dispensaries. • Support in mapping of health facilities under Labour ministry in the identified districts/urban areas.
7	**Ministry of Minority Affairs**	• Generating awareness on immunization in minority communities and their mobilization to ensure full coverage of all children. • Inclusion of immunization details in the pre-matric scholarship forms

S. No.	Ministry/Department	Expected Areas of Support
8	**Ministry of Panchayati Raj**	• Conduct community meetings for awareness on importance of immunization • Proactive involvement in communication strategies for the area • Co-ordination and supporting health department in mobilization of beneficiaries and influencing the resistant families. • Review of RI activities in the area during meetings of Gram Sabha & Zila Parishads
9	**Ministry of Railways**	• Utilization of spots on trains & railway stations; railway stationary like tickets etc., for immunization branding. • Provision of immunization services through railway hospitals and dispensaries in areas of railway colonies and adjoining areas
10	**Ministry of Urban Development**	• Complete involvement of urban local bodies to support immunization. • Ownership by Municipal Commissioners of the Intensified Mission Indradhanush. • Specific directions to big municipal corporations for involvement in campaign. • Identification of nodal persons from urban local bodies for convergence with health department for immunization. • Involvement of Zila Preraks under Swachh Bharat Mission for generating awareness on immunization. • Identifying and encouraging involvement of local CSOs • Regular review by the District /City Task Force for Urban Immunization.
11	**Ministry of Women & Child Development**	• Sharing of data on beneficiaries with ANM/ASHA • AWW to support conducting head count surveys and assist in micro-plan development • Extra support needed from AWW in urban or other areas with no ASHAs • IPC with pregnant women for TT vaccination and infant vaccination • Monitoring of AWWs by CDPOs and DPOs.
12	**Ministry of Youth Affairs and Sports**	• Involvement of Nehru Yuva Kendra (NYK) and National Service Scheme (NSS) for generating awareness and mobilization of beneficiaries. • Support in social mobilization. • Mobilize families resistant/reluctant for vaccination

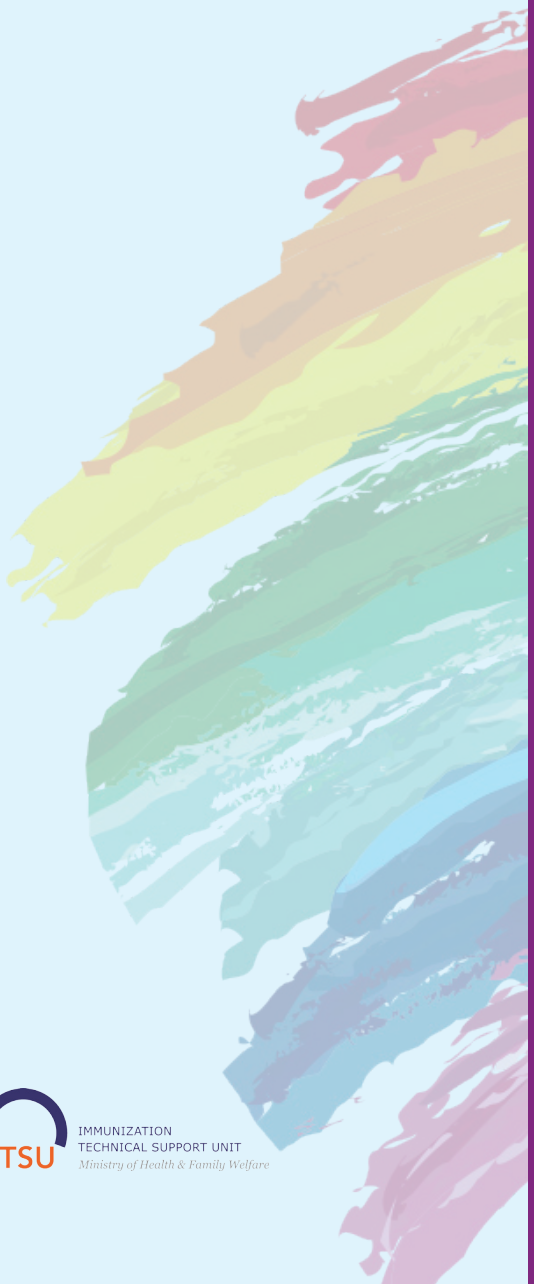
Annexure 19: National Immunization Schedule (NIS) for Infants, Children and Pregnant Women (Vaccine-wise)

Vaccine	When to give	Dose	Route	Site
For Pregnant Women				
TT-1	Early in pregnancy	0.5 ml	Intra-muscular	Upper Arm
TT-2	4 weeks after TT-1*	0.5 ml	Intra-muscular	Upper Arm
TT- Booster	If received 2 TT doses in a pregnancy within the last 3 yrs*	0.5 ml	Intra-muscular	Upper Arm
For Infants				
BCG	At birth or as early as possible till one year of age	0.1ml (0.05ml until 1 month age)	Intra-dermal	Left Upper Arm
Hepatitis B - Birth dose	At birth or as early as possible within 24 hours	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral
OPV 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks (OPV can be given till 5 years of age)	2 drops	Oral	Oral
Pentavalent 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks (can be given till one year of age)	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Pneumococcal Conjugate Vaccine (PCV) ^	Two primary doses at 6 weeks and 14 weeks. Booster dose at 9-12 months of age.	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Rotavirus#	At 6 weeks, 10 weeks & 14 weeks (can be given till one year of age)	3	Oral	Oral
IPV	Two fractional dose at 6 and 14 weeks of age	0.1 ml ID	Intra dermal two fractional dose	Intra-dermal: Right upper arm
Measles 1st dose	9 completed months-12 months. (Measles can be given till 5 years of age)	0.5 ml	Sub-cutaneous	Right upper Arm
JE - 1**	9 completed months-12 months.	0.5 ml	Sub-cutaneous	Left upper Arm
Vitamin A (1st dose)	At 9 completed months with measles-Rubella	1 ml (1 lakh IU)	Oral	Oral

Vaccine	When to give	Dose	Route	Site
For Children				
DPT booster-1	16-24 months	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Measles2nd dose	16-24 months	0.5 ml	Sub-cutaneous	Right upper Arm
OPV Booster	16-24 months	2 drops	Oral	Oral
JE-2	16-24 months	0.5 ml	Sub-cutaneous	Left Upper Arm
Vitamin A* (2nd to 9th dose)**	16-18 months. Then one dose every 6 months up to the age of 5 years.	2 ml (2 lakh IU)	Oral	Oral
DPT Booster-2	5-6 years	0.5 ml.	Intra-muscular	Upper Arm
TT	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

- *Give TT-2 or Booster doses before 36 weeks of pregnancy. However, give these even if more than 36 weeks havepassed. Give TT to a woman in labour, if she has not previously received TT.
- **JE Vaccine is introduced in 216 endemic districts after the campaign.
- *** The 2nd to 9th doses of Vitamin A can be administered to children 1-5 years old during biannual rounds, in collaboration with ICDS.
- #Phased introduction, at present in Andhra Pradesh, Haryana, Himachal Pradesh, Orissa, Madhya Pradesh, Assam, Rajasthan, Tripura and Tamil Nadu.
- ^PCV vaccine is currently being scaled up in Himachal Pradesh and select districts of UP and Bihar.

Intensified Mission Indradhanush Operational Guidelines



NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन
World Health Organization
unicef
UNDP
JSI INDIA
ITSU
IMMUNIZATION
TECHNICAL SUPPORT UNIT
Ministry of Health & Family Welfare