सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Operational Guidelines

STRENGTHENING IMMUNIZATION SYSTEMS TO REACH EVERY CHILD

Operational Guidelines

STRENGTHENING IMMUNIZATION SYSTEMS TO REACH EVERY CHILD

सबका साथ, सबका विकास, सबका विश्वास
Sabka Saath, Sabka Vikas, Sabka Vishwas

सत्यमेव जयते

डॉ हर्ष वर्धन
Dr Harsh Vardhan

स्वास्थ्य एवं परिवार कल्याण, विज्ञान और प्रौद्योगिकी व पृथ्वी विज्ञान मंत्री, भारत सरकार
Union Minister for Health & Family Welfare, Science & Technology and Earth Sciences Government of India

Message

India's success against Polio represents one of the most significant achievements in public health. The Polio campaign has enabled India to eliminate the disease from the country and steer the other public health interventions, especially the Immunisation Program, for designing strategies to reach every child. Placing central focus on the health of pregnant women and children continues to be our top-most priority. The Government of India is committed to saving lives by ensuring the delivery of life-saving vaccines adequately and effectively, especially to the marginalised and hard to reach population.

2. The visionary leadership of the Hon'ble Prime Minister, Shri Narendra Modi, is a guiding force that has motivated us to accord top priority to achieving 90% Full Immunisation Coverage. The efforts made under Mission Indradhanush and its intensified drive under Intensified Mission Indradhanush, have sharpened focus on addressing inequity issues and coverage gaps in immunisation. It is now time to garner the gains made under the mission mode and integrate them to strengthen the immunisation program.

3. Let us look back at the key determinants that led to the success of achieving polio elimination, these included effective and far reaching immunisation sessions, working in close coordination with other departments and organisations, intensive monitoring and an action-based review mechanism with an accountability framework and a vibrant communication strategy. Efforts should now be made to use this experience to reach every new-born, drop out and missed child through a strategic approach involving partnerships and a greater convergence of other departments to achieve improved health outcomes.

4. I offer my best wishes on the launch of the Operational Guidelines on Strengthening Immunisation Systems to Reach Every Child aimed at improving immunisation coverage by building trust and confidence of the general public in vaccines and immunisation services provided free of cost by the government.

5. I am hopeful that these guidelines will provide an impetus for steering, strengthening and sustaining the immunisation interventions in the country. Through collective efforts, we will ensure that immunisation is a success story in India, much like the Polio campaign, and that each child is protected against vaccine-preventable diseases.

Harsh

(Dr. Harsh Vardhan)

New Delhi, October , 2019.

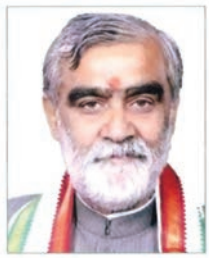
कार्यालय: 348, ए–स्कंध, निर्माण भवन, नई दिल्ली–110011 • **Office:** 348, A-Wing, Nirman Bhawan, New Delhi - 110011
Tele: (O) : +91-11-23061661, 23063513 • **Telefax:** 23062358 • **E-mail:** hfwminister@gov.in
निवास: 8, तीस जनवरी मार्ग, नई दिल्ली–110011 • **Residence:** 8, Tees January Marg, New Delhi - 110011
Tele: (R) : +91-11-23794649 • **Telefax:** 23794640

अश्विनी कुमार चौबे
Ashwini Kumar Choubey

सत्यमेव जयते
सर्वेसन्तु निरामया

स्वच्छ भारत
एक कदम स्वच्छता की ओर

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



संदेश

भारत सरकार, गर्भवती महिलाओं और बच्चों के स्वास्थ्य में सुधार के लिए प्रतिबद्ध है। आज हमारा देश पोलियो तथा मातृ और नवजात टेटनस जैसी बिमारियों से मुक्त हो चुका है। बिहार में काम करने के अपने अनुभवों के आधार पर मैं यह कह सकता हूँ कि ऐसी जटिल चुनौतियों को सफलतापूर्वक पार करने के लिए सभी हितधारकों एवं भागीदारों का एकजुट होकर समान लक्ष्य की ओर कार्य करना अनिवार्य है। विगत वर्षों में राज्य सरकारों के पूर्ण सहयोग के साथ, मिशन इन्द्रधनुष ने उत्साहजनक परिणाम प्राप्त किए है। इसके अलावा, यूनिवर्सल टीकाकरण कार्यक्रम के तहत टीकों का विस्तार भारत सरकार की प्रतिबद्धता के उच्चतम स्तर का प्रमाण है। यद्यपि प्रगति सराहनीय है, फिर भी कुछ क्षेत्रों में टीकाकरण कवरेज वांछित लक्ष्य से कम है। अब भारत को पूर्ण टीकाकरण लक्ष्य प्राप्त करने हेतु यह आवश्यक है कि टीकाकरण कार्यक्रम को और सुदृढ़ता से स्थापित किया जाए ताकि कोई भी शिशु टीकाकरण से वंचित ना रहे। टीकाकरण सेवाएं प्रत्येक बच्चे तक उपलब्ध कराने के लिए समुदायों के साथ मिलकर काम करना और उन्हें सही निर्णय लेने के लिए सशक्त बनाना, व्यवहार परिवर्तन के लिए महत्वपूर्ण होगा। सही दिशा निर्देश, राज्यों और जिलों को पूर्ण टीकाकरण के लक्ष्य तक पहुंचने में बाधाओं को पहचानने, उनके निराकरण और लोगों के बीच टीकों के प्रति विश्वास जगाने के लिए मार्गदर्शक के रूप में काम करेगा। मैं इस दिशा निर्देश का अनुसरण, राज्यों, जिलों और साझेदारों के द्वारा करने की अपेक्षा करता हूँ। जीवन रक्षक टीकों को हर बच्चे तक पहुंचाने और टीकाकरण के वांछित लक्ष्यों को प्राप्त करने के लिए अपने सामूहिक प्रयासों को गति देने के लिए अपने सामूहिक प्रयासों को गति देने का आग्रह करता हूँ।

(अश्विनी कुमार चौबे)

नई दिल्ली
दिनांकः

Office : 250, 'A' Wing,
Nirman Bhavan, New Delhi-110 011
Tel. : 011-23061016, 011-23061551
Telefax : 011-23062828
E-mail : moshealth.akc@gov.in

Residence :
30, Dr. APJ Abdul Kalam Road,
New Delhi - 110003
Tel. : 011-23794971, 23017049

प्रीति सूदन
सचिव
PREETI SUDAN
Secretary

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

Dated : 23rd October, 2019

Preface

Immunization programme is a critical component of our commitment towards Universal Health Coverage. It is integral to India's efforts of reducing the burden of vaccine preventable diseases and achieving universal care for children. The Ministry of Health and Family Welfare is continuously striving towards providing access to safe and effective immunization services, including reaching out to left-outs and drop-outs, thereby improving coverage to reach every child.

The introduction of Mission Indradhanush has catapulted the increase in immunization coverage by targeting underserved, vulnerable, resistant and inaccessible populations and aligned to the Sustainable Development Goals, throughout on leaving no one behind". These drives have demonstrated that strategic planning, intensive monitoring and a well-coordinated effort will help in boosting the immunization coverage. Efforts to reach unimmunized and partially immunized children through inter-sectoral convergence and partnerships as well as good governance and management have increased the overall immunization coverage in the country. Furthermore, the introduction of new vaccines into the Universal Immunization Program ensures that our children are protected from more life-threatening childhood illness.

We need to think of better approaches to improve the reach of Routine Immunization for ensuring a sustainable achievement of >90% full immunization coverage in all States/UTs. The Intensified Mission Indradhanush drives are directed towards sustaining the gains and amplifying the innovations to strengthen the immunization coverage.

This guideline has been prepared to help the state and district program managers in improving and sustaining high immunization coverage. I commend the sincere efforts of the officers at the Ministry of Health and Family Welfare and the partners who have contributed to the development of this guideline.

(Preeti Sudan)

Room No. 156, A-Wing, Nirman Bhawan, New Delhi-110 011
Tele : (O) 011-23061863, 23063221, Fax : 011-23061252, E-mail : secyhfw@nic.in

मनोज झालानी
Manoj Jhalani
विशेष सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
Special Secretary & Mission Director (NHM)

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
Dated 23rd October, 2019

FOREWORD

The Government of India has envisioned an integrated approach towards preventive and promotive healthcare. One of the key focus area has been the protection of children and pregnant women from vaccine-preventable diseases.

Mission Indradhanush was launched in December 2014, to improve the immunization coverage by reaching out to the partially immunized and unimmunized children and pregnant women. Further intensification of Mission Indradhanush has led to an accelerated increase in the full immunization coverage by 18.5 percent points; however, prevailing disparities and inequities have limited the scope of the country's progress towards goals of 90% full immunization coverage. Sustaining the gains from the previous rounds, it is crucial to strengthen the immunization system and integrate the learnings in the upcoming phases. Such an approach will help in reaching out to the left-out and drop-out population, thereby improving the coverage and ensuring no one is left behind.

The strengthening of health systems under NHM and incentivising the states for improving Full immunization coverage clearly establishes the priority of Government of India's focus towards ensuring that each and every child is protected against the preventable diseases.

It gives me immense pleasure to present this operation guideline to strengthen the immunization program in India. The guideline has been developed to aid the state- and district- officials in planning and implementing the mission with a greater focus on inter-sectoral convergence and intensified social mobilization efforts for the beneficiaries. I am confident that the identified states, districts and blocks will utilize this platform for strengthening the immunization system and achieving the target of 90% full immunization coverage.

(Manoj Jhalani)

Telefax : 23063687, 23063693 E-mail : manoj.jhalani@nic.in

वन्दना गुरनानी, भा.प्र.से.
संयुक्त सचिव
VANDANA GURNANI, I.A.S.
JOINT SECRETARY
Tel. : 011-23061706
Telefax : 011-23061398
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 Bhawan, New Delhi - 110011

23rd October, 2019

Message

Immunization is, undeniably, one of the most successful and cost-effective health interventions, with far-reaching economic and social benefits. The Ministry of Health and Family Welfare has been making continuous efforts to achieve the goals of 90% full immunization coverage and to sustain it thereafter. Improved coverage has contributed to significant reductions in child deaths and protected millions more from vaccine-preventable diseases.

The Government of India, has been accelerating actions to immunize every child, with an unstinted commitment. The Mission Indradhanush strategy is a testament to the national and state government's commitment and the efforts of the diligent community health workforce thathas led to a remarkable increase in coverage. The Intensified Mission Indradhanush was yet another effort to shift routine immunization to a people-centered approach, which was aimed at mobilizing communities and simultaneously dealing with barriers to vaccine use. Inter-sectoral participation is integral to the overall success of these drives.

It is imperative that the gains achieved from these drives are sustained, which would require an integrated approach of strengthening immunization processes, regular review at the state/ district level and planning special drives in areas that need focussed approach to bring our energy and resources together. Collaborating with other departments, local SHGs and Gram Panchayats for such drives can ensure a sustained high coverage of immunization.

This operational guideline will provide broad guiding principles on which the states and districts will drive the program and generate awareness on immunization through advocacy at all levels. It will serve as a guidance document to ensure proper implementation of the intensified drive in identified states, districts and blocks for marked improvements in overall immunization coverage in the country. I am confident that the states will utilize this document as they embark upon the road to covering every child with life-saving vaccines.

(Vandana Gurnani)

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Dr. PRADEEP HALDAR
Deputy Commissioner (IMM)
Telefax : 23062728, 23062126
e-mail : 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 Program Manager

Immunization has been one of the major tools for reduction of child mortality and morbidity against life-threatening diseases. India's immunization program is the largest in the world and targets to cover annually around 2.6 crore children and 2.9 crore pregnant women. Intensive efforts were undertaken in the past to improve immunization coverage, the major being the launch of the Mission Indradhanush and the Intensified Mission Indradhanush. With these critical interventions in place, the pace of full immunization coverage has shown a significant improvement. As per the recent coverage surveys conducted in 190 districts and urban areas, the coverage has shown an increase in the full immunization coverage by 18.5 percent points in the 190 districts. This progress has been the result of diligent efforts of our dedicated workforce, right from the state managers to the community health workforce.

It is now important for us to follow a strategic direction and work towards sustaining the gains achieved to date. The Government of India has decided to launch the Intensified Mission Indradhanush 2.0 to accelerate the progress towards goals of 90% full immunization coverage in the country. For proper planning and implementation of this intensified drive, this guideline has been developed to provide guidance to the states. I hope that this document will support states and districts in fast-pacing their efforts towards achieving coverage goals and sustaining them. The document outlines key strategies and activities for strengthening the immunization system and sustaining the gains to date.

We are committed to reducing the inequities in coverage and gearing up for the next steps to achieve 90% full immunization coverage.

Dr Pradeep Haldar

ABBREVIATION

A

ADR	Adverse Drug Reactions
AEFI	Adverse Event Following Immunization
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMOL	ANM online
ANMTC	Auxiliary Nurse Midwife Training Center
ASHA	Accredited Social Health Activist
AVD	Alternate Vaccine Delivery
AVDS	Alternate Vaccine Delivery System
AWW	*Anganwadi* Worker
AYUSH	*Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy*

B

BCC	Behavioral Change Communication
BRIDGE	Boosting Routine Immunization Demand Generation
BTFI	Block Task Force for Immunization

C

C4D	Communication For Development
CBHI	Central Bureau of Health Intelligence
CBO	Community Based Organization
CCE	Cold Chain Equipment
CCH	Cold Chain Handler
CCP	Cold Chain Point
CCT	Cold Chain Technician
CCVLM	Cold Chain Vaccine & Logistics Management
CMO	Chief Medical Officer
CS	Civil Surgeon
CSO	Civil Society Organization
CTFUI	City Task Force for Urban Immunization
cMYP	Comprehensive Multi Year Plan

D

DEO	Data Entry Operator
DF	Deep Freezer
DIO	District Immunization Officer
DM	District Magistrate
DQA	Data Quality Assessment
DTF	District Task Force
DTFI	District Task Force for Immunization
DTFUI	District Task Force for Urban Immunization
DVSM	District Vaccine Store Manager

E

EEFO	Early Expiry First Out
eGSA	extended *Gram Swaraj Abhiyan*
ESIC	Employees State Insurance Corporation
eVIN	electronic Vaccine Intelligence Network
EVMA	Effective Vaccine Management Assessment

F

FAQ	Frequently Asked Question
FBO	Faith Based Organization
FIC	Full Immunization Coverage
FIFO	First In First Out
FLW	Front Line Worker

G

GMSD	Government Medical Store Depot
GoI	Government of India
GSA	*Gram Swaraj Abhiyan*

H

HMIS	Health Management Information System
HR	Human Resource
HRA	High Risk Area
HSP	Health Service Provider

I

I & B	Information and Broadcasting
IAP	Indian Academy of Paediatrics
IAPSM	Indian Association of Preventive and Social Medicine
ICDS	Integrated Child Development Scheme
iCIP	Immunization Coverage Improvement Plan
IDSP	Integrated Disease Surveliance Program
IEC	Information, Education and Communication
ILR	Ice Lined Refrigerator
IMA	Indian Medical Association
IMI	Intensified Mission Indradhanush
IMI-CES	Intensified Mission Indradhanush- Coverage Evaluation Survey
INCHIS	Integrated Child Health and Immunization Survey
IPC	Inter-Personal Communication
iSC	Immunization Supply Chain
IT	Information Technology
ITDP	Integrated Tribal Development Projects
ITSU	Immunization Technical Support Unit

J

JE	Japanese Encephalitis
JRF	Joint Reporting Form

L

LODOR	Left Out Drop Out Refusal

M

MAS	*Mahila Arogya Samitis*
MCP	Mother and Child Protection
MCV	Measles Containing Vaccine
MI	Mission Indradhanush
MLA	Member of Legislative Assembly
MO	Medical Officer
MO I/C	Medical Officer in Charge
MoHFW	Ministry of Health and Family Welfare
MP	Member of Parliament
MR	Measles & Rubella

N

NCC	National Cadet Corps
NCCMIS	National Cold Chain Management Information System
NCCVMRC	National Cold Chain and Vaccine Management Resource Center
NCD	Non-Communicable Diseases
NEVMA	National Effective Vaccine Management Assessment
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHSRC	National Health System Resource Center
NIHFW	National Institute of Health and Family Welfare
NPSP	National Polio Surveillance Project
NQAS	National Quality Assurance standards
NUHM	National Urban Health Mission
NYK	*Nehru Yuva Kendra*

P

PCV	Pneumococcal Conjugate Vaccine
PHC	Primary Health Center
PIP	Program Implementation Plan
PPP	Public Private Partnership
PRI	*Panchayati Raj* Institution
PSU	Public Sector Undertaking
PTA	Parents Teacher Association

Q

QMS	Quality Management Systems

R

RBSK	*Rashtriya Bal Swasthya Karyakram*
RCH	Reproductive & Child Health
RI	Routine Immunization
RMNCH+A	Reproductive, Maternal, Newborn, Child & Adolescent Health
RTM	Remote Temperature Monitoring
RVS	Regional Vaccine Store
RVV	Rotavirus Vaccine
RWA	Resident Welfare Association

S

S4i	Supportive Supervision for Immunization
SBCC	Social and Behavior Change Communication
SC	Sub-centre
SEPIO	State EPI Officer
SHSRC	State Health Systems Resource Center
SIHFW	State Institute of Health & Family Welfare
SMNet	Social Mobilization Network
SOP	Standard Operating Procedure
SRS	Sample Registration System
STFI	State Task Force for Immunization
SVS	State Vaccine Store

T

ToT	Training of Trainers
Td	Tetanus and adult diphtheria

U

UIP	Universal Immunization Program
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UPHC	Urban Primary Health Center

V

VCCH	Vaccine and Cold Chain Handler
VHSNC	Village Health Sanitation and Nutrition Committee
VPD	Vaccine Preventable Disease
VVM	Vaccine Vial Monitor

W

WCD	Women and Child Development
WHO	World Health Organization
WIF	Walk-In Freezer

ACKNOWLEDGEMENT

Compiled & edited by:

Dr. Veena Dhawan, MoHFW

Dr. Prem Singh, ITSU

Dr. G.K. Soni, ITSU

Dr Ansuman Das, ITSU

Advisors:

Ms. Vandana Gurnani (IAS), MoHFW

Dr. Pradeep Haldar, MoHFW

Dr. M.K. Aggarwal, MoHFW

Dr. Pritu Dhalaria, ITSU

Technical Group:

Dr Bhrigu Kapuria, Dr Danish Ahmad, Dr Prem Singh, Dr G.K. Soni, Dr Deepak Polpakara, Dr Shachi Adyanthaya, Mr Raju Tamang, Ms Gauri Rishi, Ms Joshila Pallapati and Ms Noveena Swapnabh

We are thankful for special insight and contribution:

MoHFW:	Dr Disha Aggarwal and Dr Mayank Shersiya
UNICEF:	Dr Rija Andriamihantanirina and Mr Elnur Aliyev
UNDP:	Dr. Manish Pant and Mr. Abhimanyu Saxena
WHO:	Dr Pauline Harvey, Dr Pankaj Bhatnagar, Dr P.K. Roy and Dr Nitasha Kaur
ITSU:	Dr Urvin P. Shah, Dr Vikas Madaan, Dr Kamlesh Kumar, Dr Sourabh Saxena, Dr Amrita Kumari, Dr Mrinal Kar Mohapatra, Dr Shreeparna Ghosh, Ms Satabdi Kashyap, Ms Apurva Rastogi, Mr Jasmeet Singh Gujral, Mr Vishal Agarwal and Mr Chetan Mehrotra

Table of CONTENTS

Objective 3

INTRODUCTION AND RATIONALE

The Universal Immunization Program (UIP) was launched in 1985 to protect children from vaccine-preventable diseases. Currently, the program caters to a birth cohort of around 2.6 crore infants and 2.9 crore pregnant women every year. The program provides protection against 12 life-threatening diseases including diphtheria, pertussis, tetanus, polio, tuberculosis, measles, rubella, hepatitis B, meningitis, rotavirus diarrhea at the national-level; japanese encephalitis and pneumococcal pneumonia at the sub-national level.

A steady fall in the Infant Mortality Rate from 80 to 33 per 1000 live births between 1991 to 2017[1] and in the under 5 mortality rate from 119 to 37 per 1000 live births reflects Government of India's dedicated efforts under UIP to reduce child mortality and morbidity. Nevertheless, challenges of inequity remain in spite of UIP being operational for over 30 years, as full immunization coverage in the age group of 12-23 months children are only 62% as per NFHS-4 (2015-16).

In line with the commitment to improve immunization coverage and address equity issues, the flagship program Mission Indradhanush (MI) was launched in December 2014, followed by the Intensified Mission Indradhanush (IMI) in October 2017 for reaching the drop-out and left-out children for immunization. The first two phases of MI contributed to an average increase of 6.7 percent points per year in FIC[2]. In April 2018, MI was launched as one of the seven flagship schemes of the GoI under the *Gram Swaraj Abhiyan* (GSA), an intensified multi-sectoral outreach program to deliver social welfare schemes in selected villages. The GSA campaign was further extended to villages of the aspirational districts under eGSA.

Post MI and IMI Campaigns, the estimates showed a remarkable improvement in FIC, reflecting these as key drivers in boosting immunization coverage in the country. During these drives, around 3.39 crore children and 87 lakh pregnant women were vaccinated. Moreover, an average increase of 18.5% points in FIC was noted as compared to NFHS-4 in the 190 districts and urban areas covered under IMI.

Initiatives to achieve 90% Full Immunization Coverage

To rapidly increase immunization coverage and maintain the gains through routine immunization, the government has undertaken several initiatives, such as conducting gap-analysis and formulation of immunization coverage improvement plans, pilot interventions to create replicable models for increasing urban coverage, addressing vaccine hesitancy, improving data quality etc. In order to be eligible for NHM incentives state should ensure minimum Full immunization coverage (FIC) benchmark. Minimum coverage benchmark for the year 2018-19 was 75% FIC for EAG state and 80%

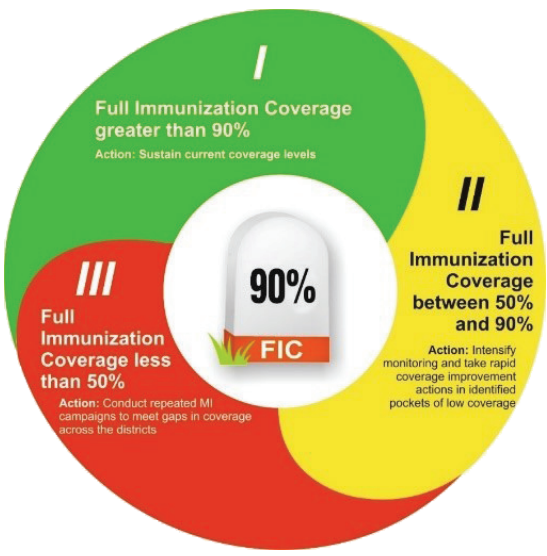


Figure 1: Classification criteria of states and districts under Roadmap

[1]Sample Registration System Bulletin, 1997-2017
[2]Integrated Child Health and Immunization Survey (INCHIS).

for North Easterns and hilly states, and 85% for all other states.

Health systems are being strengthened to achieve the 90% FIC goal and sustain the progress. GoI also released the "*Road Map to achieve 90% FIC and sustaining thereafter*" – A guidance document for the states. The document suggests the categorization of states and districts into three categories based on their immunization coverage status and suggests different approaches to improve performance in identified areas (Figure 1). It provides technical and operational guidance to the state and district program managers to identify gaps, develop an actionable plan with realistic timelines, undertake immunization intensification activities, track activities and guide on sustaining the gains achieved.

The Government has also scaled up innovative technological interventions to strengthen the health systems. A few major ones include the electronic Vaccine Intelligence Network (eVIN) for real-time tracking of vaccine stocks and tracking of vaccine storage temperature; ANM Online (ANMOL) to improve the health data recording and reporting system and generation of real-time beneficiaries' records; Surveillance and Action for Events Following Vaccination (SAFE-VAC) to speed-up the processes of recording, reporting and investigation of Adverse Event Following Immunization (AEFI) cases from districts; and *Kilkari*- an audio-based mobile service for messages to pregnant women and mothers about child-birth and care.

Current Challenges in Routine Immunization (RI)

The success achieved so far is the result of remarkable commitment at all levels; from the highest echelons of the national and the state governments, to the heroic millions of front-line workers. However, trends from the concurrent monitoring data and state UIP reviews revealed a stagnation in the immunization coverage. This can be attributed to several programmatic challenges, including gaps in health systems, issues of inequities, awareness-gap among parents regarding immunization services, and the fear of side-effects of immunization. Several service delivery issues such as lack of micro-planning, shortage of human resource and their capacity building are worrisome. There is still a need for continued efforts for strengthening systems and conducting special immunization drives to gather resources and gear up systems for reaching the left-outs and drop-outs and vaccinating them.

Devising future strategies based on the lessons learnt

It is imperative to sustain the gains of past immunization drives and incorporate the lessons learnt in the future programs. Learnings from the polio eradication program need to be integrated into the future approaches by steering inter-ministerial coordination, focusing on improving accessibility through meticulous microplanning, an action-based review mechanism, robust monitoring, a well-defined accountability framework and implementing a vibrant communication strategy. Highest levels of political commitment and governance, being the core of the successful MI and polio campaigns, play a crucial role.

Based on these learnings, all the future programs should focus on strengthening the immunization systems, supplemented by intensified drives to reach the left-outs and drop-outs and a well-elaborated communication strategy. To accomplish the vision of 90% FIC and sustain thereafter, the **Operational Guidelines on Strengthening Immunization Systems to Reach Every Child** have been developed to support program managers in identifying gaps, developing an actionable plan, undertaking intensification activities and sustaining the gains achieved.


માતા તંદુરસ્ત-
દીકરો-દીકરી એક સમાન
છેલ્લા માસિકની તારીખ : 09/09/18
છેલ્લી સુવાવડનું સ્થળ : સંસ્થા
ઘર
જનની સુરક્ષા યોજના :
તારીખ :
આંગણવાડી : ગ્રીડન
પેટા કેન્દ્ર : ગ્રીડન
પ્રાથમિક આરોગ્ય કેન્દ્ર : ગ્રીડન
હૉસ્પિટલ/એફ.આર.યુ. :
આંગણવાડી રજી. નં. :
રેફરલ
તારીખ

GOAL AND OBJECTIVES

Goal

Steering the country's vision into action, this strategic document has been developed to achieve 90% FIC in all districts of the country and sustain the coverage through immunization system strengthening.

Objectives

These guidelines aim to provide technical and operational guidance to the program managers:

- To strengthen the existing Universal Immunization Program for improving quality and sustaining the gains achieved through MI/IMI
- To implement intensified campaigns for boosting coverage in low performing areas and among vulnerable population
- To increase demand and build vaccine confidence for RI through communication strategy

KEY STRATEGIES

The Government of India has envisaged multiple integrated interventions that are strategic and targeted at instant tangible results to capitalize on and preserve the achieved objectives. The specific strategies for each of these objectives, aimed at bringing swift and sustainabe progress in immunization coverage, are briefly discussed below.

OBJECTIVE 1 - STRENGTHENING THE UNIVERSAL IMMUNIZATION PROGRAM (UIP)

Achieving full immunization coverage is one of the most important objectives of the country's Universal Immunization Program. It is one of the services which reaches out to every child and every community including vulnerable groups such as vaccine-hesitant populations, urban slum dwellers, tribal populations that are difficult to access, and frequent migrants. Therefore, strengthening of UIP becomes a priority for providing immunization services to every child.

The specific interventions to assess the strengths and weaknesses and improve upon the same are as follows:

1.1 Advocacy for integrated involvement of line ministries and key stake holders

Fifteen ministries can work and contribute to strengthen RI, coordinated by the Ministry of Health & Family Welfare.

1.2 Situational analysis and immunization coverage improvement plan

The state has to undertake self-assessment in districts and based on the identified gaps, prepare an immunization coverage improvement plan.

1.3 Quality head count survey and microplanning for UIP

All beneficiaries will be identified through a comprehensive head count survey along with regular updation of due-list with proper utilization of counter-foils through tickler bags for follow-up. Strengthening of the RCH portal will ensure the enlistment of every child. Enhancing the quality of RI microplanning, will ultimately lead to improved RI service delivery and hence improved immunization coverage .

1.4 Addressing inequities in immunization among high risk populations

Clear strategies and coordinated efforts to target the high-risk populations (urban slum, migrants and tribal populations) and other service gaps, with the support of states, partners and respective ministries should be implemented.

1.5 Vaccine Logistics and Cold Chain improvement and governance using e-VIN

Expanding eVIN to all states from the current 12 states with implementation ongoing in 9 states, will bring a paradigm shift in vaccine stock management by providing the program managers with real time status of vaccine stock.

1.6 Capacity building

Training of staff at various levels involved in immunization on various administrative, technical and practice-related components, is one of the most important components.

Newer vaccines, initiatives (MI/IMI), tools e-VIN, techniques and methodology for improving performance requires a clear understanding of relevant service providers through appropriate & timely capacity building.

1.7 Strengthening AEFI Surveillance

Steps need to be taken to improve the capacity of states to manage, report, investigate and conduct causality assessment of AEFIs.

1.8 Improving data quality and use of data for program monitoring

A three-pronged strategy which includes periodic data quality assessment including

development of data improvement plan in the districts, building capacity of the health staff/program officers for data management and analysis and ensuring systematic data analysis and feedback mechanism including preparation of immunization dashboard for strengthening program needs to be implemented. This will help to improve quality of data which should be used for evidence based action to improve coverage.

OBJECTIVE 2 - IMPLEMENTATION OF INTENSIFIED MISSION INDRADHANUSH 2.0 (IMI 2.0)

In the backdrop of low coverage in some high-risk pockets, the Government of India launched IMI in 2017 to improve immunization coverage. Mission Indradhanush has helped in boosting immunization coverage in areas where RI systems are falling short. It has been listed as one of the 12 best practices around the world and has been featured in a special issue (December 2018) of the British Medical Journal.

Drawing on the learnings from the first iteration of IMI, IMI 2.0 is planned for 271 districts spread over 27 states in the country, and 652 blocks in 109 districts of Uttar Pradesh and Bihar, from December 2019-March 2020. The objective is to reach the unreachable in the identified critical areas with all available vaccines under UIP. Few salient features of the IMI-2.0 are:-

1. Rapidly build up full immunization coverage to more than 90% in identified districts and urban cities by March 2020
2. Enhancing political, administrative and financial commitment, through advocacy and collaboration with key ministries/ departments and stakeholders, towards full immunization
3. Campaigning in four rounds with 7 IMI days excluding RI days, Sundays and holidays
4. Immunization sessions may be held with flexible timings, expanding reach through mobile sessions and mobilization by other departments and using the IMI portal for timely reporting and supervision
5. Intensive monitoring by national and state level monitors along with partners
6. States to take sustainable measures, after completion of the proposed 4 rounds, to sustain the gains from IMI 2.0
7. Linkage of IMI 2.0 coverage with due list of RI through the RCH portal
8. Performance incentives/ awards for achievement in immunization coverage at panchayat, block, district and state level.

OBJECTIVE 3 - COMMUNICATION STRATEGY FOR UNIVERSAL IMMUNIZATION PROGRAM

India is a diverse country with varied health seeking behaviours. The slow progress of complete immunization can be attributed to the varied behavior of communities and their levels of acceptance of vaccines. Field visits have recognized fear of AEFI, lack of knowledge of immunization, its benefits and information regarding accessibility of vaccination as barriers to immunization. Further, success of the polio vaccine coverage in India has also underscored the strategic importance of communication, to tackle the issue of misinformation and hesitancy towards vaccination. It is important to increase public awareness to ensure that the general public understands how immunization saves lives. A 360° communication strategy to include:

3.1 Advocacy through collaborations

Continuation and strengthening of collaboration with key ministries, professional bodies and educational entities will be taken up to transform the public perceptions and attitudes and to mobilize human and available platforms for immunization

3.2 Social mobilization for routine immunization

Engagement with public figures for mass

empowerment; engaging and empowering the children, youth and adolescents through schools, colleges and youth-based institutions and partnership with the CSO/ CBO will be emphasized to bring long term improvements in vaccine uptake.

3.3 Community engagement and empowerment

Community participatory interventions to encourage them to take informed decision, will be taken up to build trust and ownership for immunization. This will target the vaccine hesitant families, the local leaders and religious leaders in the community.

3.4 Interpersonal communication at the family level

Investment has been done to create and capacitate cadres of FLWs on the use of IPC skills to deliver key messages to every child and every family. ASHA driven mechanisms such as the mothers meetings need to be utilised to promote immunization messages, discuss how children become vulnerable to VDPs, various risks involved and educate them on importance of Routine immunization.

Engaging men:Recognizing the critical role men play in immunization decision making and uptake, states need to utilize the existing and create new platforms (such as community/ father's 'meetings) to sensitize and orient men on the importance of immunization and its linkages to a family's prosperity. Community and religious male influencers need to be identified to support frontline workers in reaching out to hesitant / resistant male members. States must also engage young male advocates from the community and members from youth-based organizations in community level IPC interventions.

3.5 Media engagement

Media outreach activities will be done before, during and after the IMI 2.0 for Program launch, IEC/BCC and outreach activities using print media, television media and social media.

3.6 Institutionalization of capacity building for routine immunization communication

Training modules such as the BRIDGE (Boosting Routine Immunization Demand Generation) have been developed and are being implemented to improve the knowledge and IPC skills of health service providers and strengthen the demand generation for RI. All front-line workers should be benefited by this training.

3.7 Improvement of routine immunization communication to address the vaccine hesitancy

Communication interventions focused on building vaccine confidence, building health care providers' skill of advocacy, rumour and misinformation management will be taken up to address the vaccine hesitance.

3.8 Improvement in management of the adverse events following immunization (AEFI) during crisis

To eliminate any flare-up of rumours and mis-information, the states need to ensure the development and availability of a comprehensive crisis communication plan, which will encompass roles and responsibilities, key messages, monitoring mechanism and strong media management plans for a crisis situation.

The following sections have elaborated upon the aforementioned strategies in detail to guide the states and districts in implementing them and achieve the goal of 90% full immunization coverage and sustaining thereafter.

OBJECTIVE 1

STRENGTHENING UNIVERSAL IMMUNIZATION PROGRAM

1.1 Advocacy for integrated involvement of Line ministries and key stake holders

1.2 Situation analysis and coverage improvement plan

1.3 Microplanning

1.4 Equity for RI strengthening

1.5 Strengthening cold chain and vaccine logistics management

1.6 Capacity Building

1.7 Strengthening AEFI surveillance

1.8 Improving data quality and its use for program monitoring

STRENGTHENING UNIVERSAL IMMUNIZATION PROGRAM

A comprehensive health system strengthening approach will help to successfully move towards achieving the goal of 90% FIC and sustain the achievements. The districts will conduct the following activities to strengthen the immunization system in their districts.

1.1 ADVOCACY FOR INTEGRATED INVOLVEMENT OF LINE MINISTRIES AND KEY STAKE HOLDERS:

The collaboration and partnership between various government structures with the engagement of development partners and media contributed to the successful implementation of previous MI/IMI rounds. In line with the commitment to improve immunization coverage and address equity issues, it is imperative to have a similar collaboration for strengthening RI and reaching the drop-out and left-out children for immunization. Continuing collaboration is critical to transform public perceptions and attitudes and to mobilize human and available platforms for immunization. The different ministries/departments will oversee the implementation, the problems encountered, and accordingly propose solutions and new action points. These important stakeholders will provide support in increasing awareness on important aspects of immunization, coordinate and support the health department in the mobilization of beneficiaries & influencing families, pro-actively involve in communication strategies and review of the RI activities. Extending support in the form of human resource and infrastructure will strengthen the health department in reaching every child and improving the immunization coverage. Involvement of the identified fifteen-line ministries and their proposed contribution has been described under Objective 2 (Chapter 2.8). Sensitization of private medical practitioners and the medical fraternity from the Indian Medical Association/Indian Academy of Pediatrics for community mobilization and providing immunization services will also help achieve our goal of improving immunization coverage. Engagement with partners for advocacy with influencers/celebrities and using their networks to mobilize communities, conduct rallies, and events are crucial for successful implementation and achievement of high immunization coverage. Engagement of partners in monitoring the immunization activities supporting states/districts in conducting gap assessment and preparation of immunization coverage improvement plan is crucial.

1.2 SITUATIONAL ANALYSIS (GAP-ASSESSMENT AND IMMUNIZATION COVERAGE IMPROVEMENT PLAN)

A comprehensive review of the existing health system for routine immunization is required to identify program strengths and weaknesses. Gap-assessment, in a methodical way, will not only enable the districts to identify the bottlenecks but also help them to explore possible solutions to strengthen the immunization program by developing immunization Coverage Improvement Plans (iCIP) that will help districts/ states to prioritize and undertake focused activities.

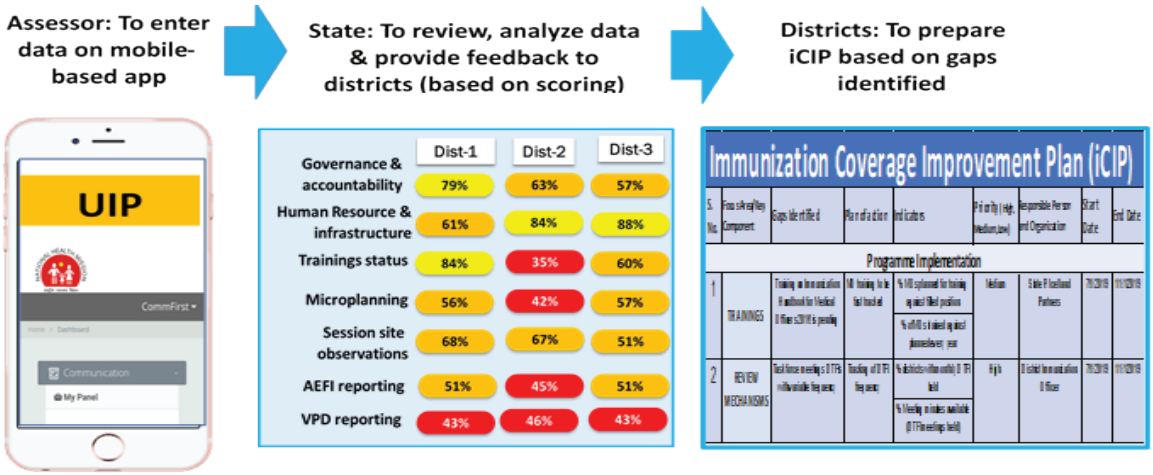
1.2.1 Methodology:

The process will be initiated by identifying a pool of assessors by state to support the

In each district assessment will be done for:

- district HQ,
- two blocks (one good and one poor performing)
- one urban area (one additional block, if no urban area)

Additionally, one district vaccine store and one vaccine store in each block/urban area will be assessed.



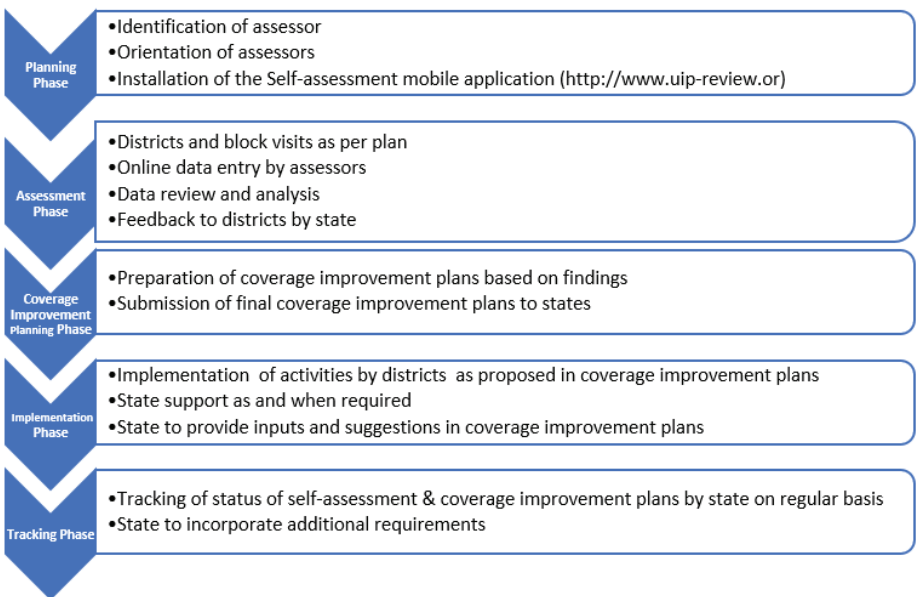
data collection and monitoring activities. The Deputy/Joint Directors (at the state/divisional level), faculty/post graduate students from medical college, development partners and DIO/BMO of adjoining districts can be considered as assessors for this activity. Data collection will be done using an online mobile application. The automated tool will help the generation of automatic scores for each thematic area as well as for the overall district/block performance.

MoHFW, through ITSU, will track states' progress on key indicators. The development partners will provide technical support in undertaking the gap-assessment and developing improvement plans.

The process may highlight the following special areas to be taken up on priority

- Improving the vacancy situation through recruitment drives and capacity building
- Need based inclusion of activities in the PIP
- Improving the vaccine and service delivery
- Better convergence with WCD dept.; covergence of ANMs, ASHAs & *Anganwadi* Workers
- Coordination of the different government departments and the NCC, NYK, NSS, SHGs, GPs etc
- Strengthening supervision and concurrent monitoring by increasing quantum, improving quality and enhancing government participation
- Strengthening name-based tracking of beneficiaries

Steps for roll-out of self-assessment by state



- Involvement of private sector providers and NGOs for giving immunization services
- Identifying, tracking, reaching and immunizing migrant populations like slum population and construction workers

1.3 MICROPLANNING

RI microplanning is the basis for the delivery of RI services to a community. A comprehensive microplan is essential to ensure the smooth delivery of immunization services. Microplanning is a dynamic process and needs to be updated regularly. There are various challenges in microplanning:

- Lack of mapping and area demarcation among health workers and health facilities. Well defined boundaries of urban and peri urban areas are not available
- Incomplete microplans: at most of the places, only ANM rosters are available
- House to house survey and due listing of beneficiaries are incomplete or not done
- Poor enlisting of high risk areas leading to their poor tagging in available microplans
- Poor planning for vacant areas

Key activities to improve RI microplans

RI microplans should include the following essential components:-

Enlisting and mapping of all villages/wards/ *tolas*/HRAs: The map should clearly show all areas including small habitations under each ANM, along with that of vacant positions. The area demarcation in the map should be contiguous so that the entire geographical area is covered including inhabited areas as well as vacant plots.

Identification of all beneficiaries through surveys: The survey should include entire population residing or visiting the area as well as families which have temporarily gone out for livelihood etc. including temporarily migrated populations, laborers who work in brick kilns, farms etc. All visitors including females who are visiting their parents for delivery/ after delivery and are present in the house on the day of the survey as well as members of tenants are to be included in survey list. All children missed out due to home deliveries should also be looked for. Identified ASHA or AWW or link worker should do Head Count Survey (HCS) in their designated area and supervised by respective ANMs.

Estimation of vaccines and logistics and their delivery mechanism: This would be based on the estimated beneficiaries through a head count survey. The Alternate Vaccine Delivery (AVD) plan should clearly mention the time and exact location with the person responsible, who would deliver the vaccine carrier and logistics for the session as well as collecting back after the session.

Supervisory plan: A good RI microplan should have a supervisory plan included with clear roles and responsibilities of all identified supervisors at districts and block levels.

Communication plan: A communication plan should be prepared as part of microplan in prescribed standard formats as per GoI.

Planning sessions: Based on the number of beneficiaries and the injection load, the session should be planned at an accessible location and all sessions should be mapped to ensure that they cover all geographical areas. Mapping of areas can be done using Google Earth and GIS tool. The sessions which were earlier a part of the MI/ IMI campaigns should be included in regular RI sessions. Planning for HRAs and hard to reach areas is mentioned in separate section.

Alternate Vaccinator: Need based hiring of vaccinators in both rural and urban areas is permissible for IMI 2.0. Vaccinators can be hired for IMI 2.0 where there is shortage of vaccinators especially in urban areas or in areas with chronic ANM vaccancies, strictly keeping in view the standards of programmatic requirements and immunization to the beneficaries. These hired vaccinators can be retired ANMs/ LHVs, retired Staff Nurses, pharmacists, Lab technicians or Third year or final year Nursing students from Nursing Schools or retired Nursing Assistants of defense or paramilitary forces. But these vaccinators should be trained for immunization of children and they must work with the ANMs at PHC/CHCs for at least one

week to get themselves well oriented with Immunization schedule and other details related to UIP under the supervision of Medical Officer.

Please note: Under NHM norms, there is provision to hire vaccinators for urban slums/ marginalized areas/other high-risk areas in district. Vaccinators can be hired @ 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.

Tracking of beneficiaries: Children who are left out/ drop out should be tracked by social mobilizers (ASHA/AWW) for successive sessions. The list of due beneficiaries along with the vaccine hesitant families/communities should be shared with the Village Health Sanitation and Nutition Committee (VHSNC), the *Gram Sabha*, *Gram Panchayat* and the Self-Help Groups for mobilization of such children. The list of such children should be displayed at prominent places in the villages.

RI microplan tools available in the Immunization Handbook for Medical Officers should be used for effective implementation and to maintain uniformity with easy compilation ensuring completeness of microplan after incorporation of all the components.

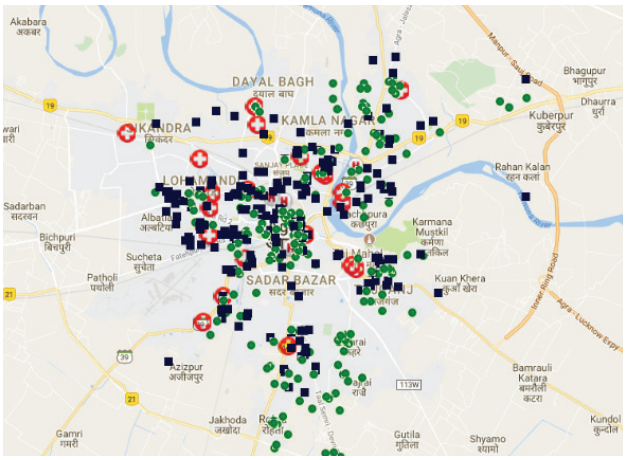


Figure 2: GIS Mapping of Urban Slums

Steps for developing RI microplans

Block/Urban PHC Meeting	○ To sensitize and review existing microplan ○ Confirm area demarcation of subcentres and mapping among ANMs, especially in subcentres where more than one ANMs posted ○ Generate a master list of villages/areas including high risk areas
Planning for head count survey	○ Training of ANM for head count survey ○ Prepare subcentre wise plan for head count survey ○ Sensitization of ASHA/AWW/Link worker/ surveyor on process of head count survey ○ Plan for validation of the head count survey for improving quality
Head count survey	○ Conduct head count survey by identified surveyor through house to house visits ○ On Non-RI day ○ Generating area wise line listing of beneficiaries ○ Validation of survey for maintaining and improving quality of survey
Generate line list of beneficiaries	○ Identify and generate the village/area wise line list of beneficiaries: • Pregnant Women • 0-2 Year beneficiaries Conduct head count survey by identified surveyor through house to house visits • Beneficiaries for DPT second booster and Td10/Td16 ○ Verify the line list generatedby surveyor
Review of process of microplanning activities	○ Review meeting with all surveyors/ANM/supervisors under oversight of MO ○ Review completeness of formats of the area ○ Review of master list of areas of subcentres and area demarcation ○ Review of HRA list and identifies beneficiaries
Consolidated ANM area plan	○ Based on injection load of the area plan for VHND/UHND sessions in the area ○ Develop consolidated microplan for the ANM area ○ Development of ANM roster with identification of mobilizer for the session sites ○ Ensure due list of the outreach session
Review and finalization of subcentre level microplan	○ Conduct review meeting at Block/Urban PHC ○ Review of all SC formats and approval of microplan ○ Verify due list of the outreach session
Finalize block/PHC microplan	○ Compile all ANM area wise plan in the PHC formats ○ Subcentre wise maps for all ANM areas of the block/PHC ○ Development of PHC RI microplan

1.4 EQUITY FOR RI STRENGTHENING

India is taking a leap forward to be closer to achieve the 90% Full Immunization coverage, so that it becomes extremely important to bridge the inequity which exists particularly due to the marginalized population residing in urban slums or distantly located tribal communities. **As per the NFHS 4 trends, an increase in full immunization is only 6.3 % in urban areas whereas the same is 28 % in rural areas as compared to the NFHS-3. The NFHS-4 data also reveals that FIC is the lowest among the scheduled tribe population (56%) in comparison to national average (62%)**.

Lack of manpower and infrastructure, poor microplanning with an inadequate mapping of underserved areas, improper area demarcation, multiple governance agencies, weak review mechanism are some key inadequacies affecting quality, reach and uptake of urban immunization. On the other hand, low coverage in tribal population is due to various other reasons like geographical inaccessibility, awareness gap, difficulty in delivery of services, myths and beliefs of the community etc.

1.4.1 Strengthening Urban Immunization

India has witnessed fast paced urbanization in the last few decades. It is projected that by 2030, 46% of our population will be living in cities. Thus, the focus on urban health planning is needed to keep further expansion of urban areas in mind.

Under the NUHM, 1067 cities have been identified, including 8 metro cities and 75 million plus cities. While there is an existing system of service delivery, issues of shortage of manpower and infrastructure combined with the rapid expansion of urban areas are having a detrimental effect on the quality and reach of services. Urban immunization faces challenges in various aspects of area mapping, micro-planning, shortage of human resource like the ANMs/vaccinators and lack of coordination between various agencies governing the urban areas. It has been observed that though the NUHM has been launched, the recruitment process is not yet complete in all the areas. Clear demarcation of urban areas is also not completed yet. Migratory populations are one of the major issues faced by any urban area. Involvement of the private sector, NGOs and medical colleges need to be streamlined.

To achieve the goal of full immunization coverage of more than 90% across all states, urban areas require separate and focused attention.

Major areas to be focused on for Urban Immunization:

- **Human Resource and its capacity building:** Human resource status in urban areas needs to be reviewed regularly in DTFI/CTFUI DTFUI/STFI and other review meetings. The vacancy situation of HWs needs to be improved through timebound recruitment drives. Quality training of health workers should be done and the status of training of various health staff cadres need to be tracked. It is important to rationalize the infrastructure and manpower required as many ANMs cater to the population much more than set norms.
- **Area Mapping and demarcation of urban areas:** This needs to be done for health facilities and health workers with a focus on peri-urban areas. Ward wise mapping and clear area demarcation among ANMs should be done.
- **RI Microplanning:** After proper area demarcation among ANMs, house to house survey should be done for enlisting beneficiaries (0-2 years and pregnant women). Based on the number of beneficiaries, session and logistics planning needs to be done considering the need to reach every child for immunization.
- **Enlisting of all HRAs:** Enlisting of HRAs including slums/ nomadic population/ construction sites and migratory populations needs to be done. Migratory populations may include seasonal workers and tenants.
- **Infrastructure:** All urban PHCs to be utilized as fixed vaccination sites.
- **Supervision:** This is a major concern

in urban areas. In RI microplanning, a supervision plan is to be prepared as per the available supervisory HR. Other options like the Department of Community Medicine of Medical Colleges can be explored to seek support for supervision.

- **Regular review of data:** For a regular review of progress in urban immunization, a DTFUI (District Task Force for Urban Immunization) should be constituted and regular meetings should be conducted. Similarly, Quarterly RI reviews should be done at the Urban Planning Unit level and District level. Data validation committees may be constituted for urban areas at Urban Planning Unit and District.
- **Inter sectoral Coordination:** Various departments like education, ICDS, Urban Local Bodies, Community Based Organization (CBO) to be actively involved in RI in Urban areas. Participation of all stake holders in immunization is to be ensured in DTFUI/DTFI/Quarterly RI reviews. Also, there should be coordination between all stakeholders at all levels like the National Urban Livelihood Mission for mobilization of beneficiaries.
- **Overlapping of the different administrative structures:** This may happen in large urban areas. Urban Coordination Committee with representatives from all administrative structures like Municipal Corporations, Railways, Cantonments & PSUs needs to be constituted in these large urban areas for coordinating the efforts for immunization. Each agency should have clear roles and responsibilities with nominated nodal officer for Immunization and should participate regularly in review meetings. A mechanism for getting Immunization coverage reports regularly (if providing immunization services) from these different agencies/organizations at the district should be developed.
- **Medical College:** The community medicine department of medical colleges can be involved in planning, implementing and monitoring of the program. The department can adopt UPHCs depending upon the HR in the Community Medicine Department.
- **Involve private sector providers and NGOs:** They should be involved for providing immunization services and submitting coverage reports, with clear segregation of such areas.
- **Urban Communication Plan for RI:** Such a plan should be developed and a review of the same should be done in DTFUI and Quarterly RI Reviews.
- **IEC Material and Community Awareness Activities:** Customized IEC material for urban areas should be developed to increase community awareness including social mobilization activities and proper utilization of print/electronic media. Social media can be used to increase awareness and acceptability in the society.

1.4.2 Strengthening tribal immunization

The reach of the immunization program to the tribal population has been lower as compared to all other population groups i.e. general, OBC and SC population. The CES 2009, as well as RSOC 2014, indicate that there is a ~10% gap in full immunization in STs compared to the national average. This has been consistent for the past few years even with all the efforts initiated by MoHFW to increase full immunization coverage. As per the NFHS-4, the gap is now reduced to 6% but the FIC of ST population still remains the lowest as compared to the other social groups in the country.

Major areas to be focused on for Tribal Immunization:

- **Mapping of areas with high tribal population:** Enlisting and mapping of areas with tribal population should be conducted either by a survey or by the data available through census or other sources.
- **Identification of the root cause of low immunization coverage in such areas:**
  - **Supply side challenges**- Less number of Cold Chain Points (CCPs) and trained HR, poor transportation services, long distance etc.

  - **Demand side challenges**- Low awareness, poor health-seeking behaviour, myths and beliefs etc.
  - **Social or indirect factors**- Poverty with wage loss for immunization visits, seasonal migration, language barrier etc.
- **Addressing the identified challenges using different focused approach.**
  - **Human Resource strengthening**:
    - **Recruitment** of human resource or allocation of existing staff for tribal areas. States could recommend special allowances for retention of staff in these areas.
    - **Continuous capacity building of FLWs:** Organizing repeated trainings including refresher training for imparting skills for immunization and communication to the HWs.
    - **Award/Reward mechanism:** provision of special incentives for improving coverage in tribal areas/ Special recognition of the HR in special forums.
- **Strengthening existing RI system:** Filling up of vacant SCs in Tribal areas on priority, updating the microplan to include all areas, improving mobilization of community, hand holding through supportive supervision, regular monitoring and training.
- **Special RI Sessions/Mobile vaccinatio**n
  - In the identified hard to reach pockets/ hamlets/villages using mobile team. Use of special vehicles like boats, two wheelers to reach difficult areas where needed.
  - Conduction of sessions at popular places like *Haat Bazar*, Church, temple or mosque etc.
- **Integrated approaches:** Organizing health camps for the delivery of packages of health services- Immunization, RCH, NCD, RBSK etc.
- **Formulation of special strategy for migrant population**: On key events/ tribal festivals
- **Adopting local methods to overcome demand side challenges**: Use and promotion of Folk media, *Nukkad Natak*, audio visual and a more pictorial IEC specially meant for low literacy level population, dissemination of messages in tribal festivals and making use of local cultural practices to generate awareness about immunization and overcoming vaccine hesitancy.
- **Need based expansion of Cold Chain Points**: To bring the cold chain closer to the community and ensure the availability of vaccines.
- **Leveraging funds**: Preparing a budgeted action plan and utilizing the different sources available with– Ministry of Tribal Affairs (MoTA), State and district welfare department, Mineral funds, CSR and through PIP.
- **Leveraging partnership**: PRI, ITDP, WCD, NGOs, CBOs, CSOs, Tribal leaders, Ward members/ *Pradhans* etc.

1.4.3 High risk area approach

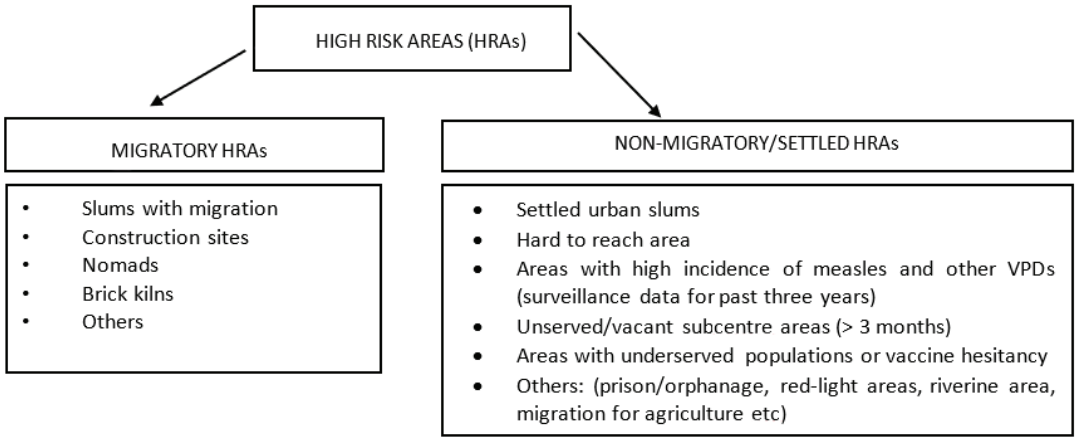
Despite the achievements of the Mission Indradhanush (MI) & the Intensified Mission Indradhanush (IMI) rounds, significant coverage gaps exist between the highest and lowest socioeconomic quintiles, and coverage varies considerably across and within districts. Even in well performing states, there are pockets of unreached or hard-to-reach populations for whom special efforts are needed.

IMI 2.0 is focused on bringing equity in identified high-risk populations in traditionally low-coverage areas. Due to geographic, demographic, ethnic and other operational variations, a tailored, evidence-driven and people-centric service delivery strategy should be designed for reaching the children in the identified HRAs.

The growing phenomenon of urbanization in India has contributed to an increased settlement of urban slums. In addition, migration has created pockets of unprotected individuals at risk for VPDs. Therefore, the HRA classification has been revised currently and time-bound reprioritization activity has been undertaken across the country. The current HRA reprioritization has been drafted

Nearly 25%-50% of migrants live with their families and return to their native states at least once or twice during the year for socio-cultural reasons. Some of these areas are unauthorized and/ or are not recognized by urban development authorities.

with an overarching goal of closing immunity gaps and reducing mortality and morbidity due to VPDs, particularly measles and rubella.



Classification of HRAs:

HRAs are special sites that have been classified as below:

Migratory HRAs are categorized as follows:

Slums with migration:

India has had a sharp rise in migration over the past decade and acknowledges 37% of migration of the total population. Almost 15% of migration is due to work. (Source: GoI Migration Data (last available) Census 2011). Most of these migrants work in small and large scale industrial units situated in urban and peri-urban areas and live around them. There are settlements in urban/peri-urban areas such as slums situated close to industrial areas with sugarcane factories or agriculture fields, rag pickers and settlements at railway tracks. Colonies of migrant workers are situated within these industrial areas or in nearby areas.

Construction sites:

Some migrant families live on sites with ongoing construction (building/road/railway etc.). Generally, they live in *jhuggies* or brick sheds in and around the under-construction buildings.

Brick kilns:

The migrant labor camping in brick kilns, stone crushers and the "*pather*" fields where

raw bricks are prepared. The number of families and children present in these sites vary according to the size of the brick kiln unit. They live in *jhuggies* or brick sheds in and around *pathers*.

Nomads:

Nomads are the populations such as *Mangtey, Kanjar, Fakirs, Natts, Banjara, Shah, Shahbali, Albi, Gadhia Lohar, Ghumantu*, and traditional healers etc. who often move from place to

place for livelihood, usually setting up "*dera*" wherever they stop. They are normally found in between or at the end of big colonies, railway stations, along the rail tracks, open fields, market places and in urban/peri urban slums.

Others:

There are migratory fisherman's communities

based in large coastal areas (e.g. *Char* areas in river delta).

Settled HRAs

Following are the categories under settled HRAs. These categories may overlap each other and hence coding of these categories is avoided.

Urban slums (settled populations):

These are compact, densely populated areas, poorly built or substandard congested tenements (*Pucca or Kaccha jhuggies*), invariably unhygienic environments lacking proper sanitary and drinking water facilities. These are mainly situated within the urban or expanding peri-urban areas. All the recognized and non-recognized slums should be included in this category.

Hard to reach areas:

Hard to reach areas include hilly regions with vertical terrains, desert areas with low and sparse population density, areas that are cut off during heavy rains and forest areas. In addition, northern Indian areas with a Himalayan border are to be considered as

hard to reach areas.

Areas with a high incidence of measles/other VPDs:

Areas with any vaccine preventable disease outbreak include measles or rubella outbreaks or cases of diphtheria, pertussis, and neonatal tetanus during the last three years. The outbreak signifies compromised RI coverage in that area.

Unserved areas with a shortage of health workers (sub centers vacant for more than three months):

All the villages/*tola*/hamlets etc. within a vacant sub center should be considered HRAs. These areas should be validated and reclassified every 3 months based on posting of new ANM or vacancy of ANMs or ANMs returning from long leave, maternity leave etc. Vacant sub-center status should be assessed biannually.

Areas with underserved populations or vaccine hesitancy:

Areas with resistance in communities identified during the MR campaign to be listed and considered as HRA. One or two families with refusal should not be considered as an area. When any community or mass population is having a refusal, then it should be considered as an area. e.g. *Banjara basti* or any other community. Refusals may be identified in settled as well as migratory population.

Strengthening immunization in high risk areas:

- Plan sessions for all the above areas which are identified as HRAs (migratory and settled HRAs) where the reach of the

immunization program is inadequate.

- Flexible timings of sessions at certain places will ensure that all beneficiaries are immunized.
- Reach and immunize migrant populations like slum population and construction workers on their monthly holiday (eg. *Amavasya* in parts of northern India).
- Ensure availability of all vaccines and sufficient vaccinators during immunization sessions with a high number of beneficiaries.
- Mobile sessions should be planned at places where a small number of beneficiaries does not warrant an independent session.

1.5 STRENGTHENING COLD CHAIN AND VACCINE LOGISTICS MANAGEMENT

1.5.1 Immunization Supply Chain

An effective and efficient Immunization Supply Chain is critical in ensuring the availability of adequate and safe vaccines for the beneficiaries and its optimum management is critical in strengthening routine immunization. India has a vast immunization supply chain network of more than 28,000 cold chain points and 1,00,000 cold chain equipment catering to more than 10 million sessions every year. The immunization supply chain is organized in 4 levels comprising of the primary level (GMSDs and State Vaccine Stores), the sub national level (Regional Vaccine Stores), the lowest distribution level (District Vaccine Stores) and the service delivery points (Last Cold Chain Points). Each CCP is managed by a Vaccine and Cold Chain Handler who is responsible for the day to day management of the vaccine and cold chain system at the PHC/CHC level.

The Government of India, in the course of implementing the Universal Immunization Program in the country, has come up with various interventions designed to improve the coverage and quality of immunization services. Of notable mention is the introduction of the electronic Vaccine Intelligence Network (eVIN) aimed at monitoring the real time temperature of the cold chain equipment and the real time stock position of vaccines across the country.

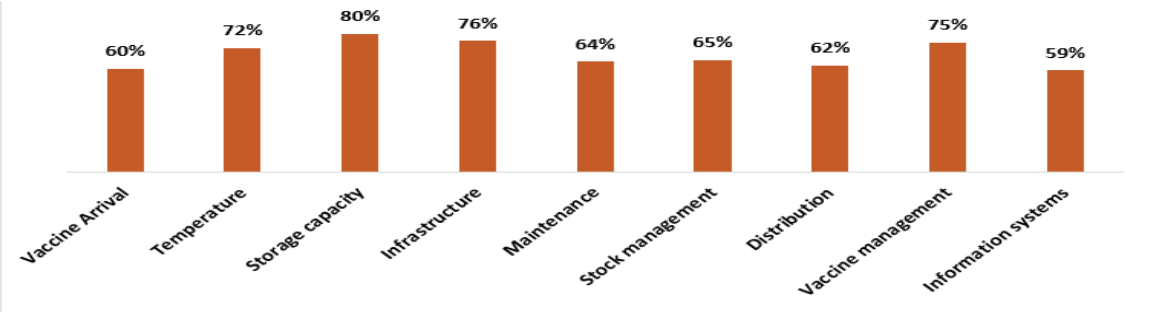
The country recently undertook a National Effective Vaccine Management Assessment (NEVMA) in 2018 which has highlighted the major areas for improvement of the Immunization Supply Chain. EVM assesses 9 global criteria for an agreeable vaccine supply chain over a defined period of past 12 months at all levels. EVM sets minimum standards for the entire vaccine supply chain management.

The identified issues from findings of the NEVMA 2018 to be addressed by States, Districts and CCPs are given below:

National Effective Vaccine Management Assessment (NEVMA) Issues

- Absence of standard temperature log books and non-compliance to standard practices
- Temperature log books and alarm events were not being reviewed
- Ice pack freezers did not have sufficient storage capacity in most of the SVS
- Emergency contingency plan & Vaccine distribution plan were not available in most of the stores
- Planned Preventive Maintenance (PPM) checklist for equipment not universally followed
- Deficient stock management practices including updating of vaccine registers, monitoring of vaccine transactions, standard formats for vaccine transactions, Pre-Delivery and Pre-collection notification system, recording of vaccine wastage, vaccine demand forecasting and physical count of vaccine stocks
- Lack of adequate knowledge/ practice of shake test, open vial policy, vaccine requirement and wastage calculations, immunization waste management
- Inadequate number of supportive supervision visits by supervisors and lack of documentation of these visits

The findings of the NEVMA 2018 from an assessment of 9 global criteria for an agreeable vaccine supply chain over a defined period of past 12 months, showed we are still below the minimum benchmark of 80% (Total EVM score 68%) in 8 out of 9 EVM criteria.



EVM: 2018

Effective Vaccine Management Improvement Plan

STATE (SEPIO/ CCO to ensure)	DISTRICT (DIO/ VCCM/ CCT to ensure)	COLD CHAIN POINT (MO I/C & VCCH to ensure)
• Issue letter for 100% VCCH training for all vaccine stores based on training load • Ensure proper documentation of shipment and arrival procedures from the SVS to DVS • Demand estimation of temp log books and initiate printing and distribution to all districts • Development of an appropriate vaccine distribution plan based on available vehicles and IPs and raise indent for any further requirement • Document IP and passive container requirement at SVS based on vaccine delivery plan • Monitor implementation of the vaccine delivery plan • Redistribution of cold boxes within the state to meet the requirements of SVS/RVS • Use of the supplied DFs to ensure adequate ice pack freezing capacity at SVS/RVS • Undertake a facility assessment of SVS/RVS buildings as per standard checklists in a time bound period and prepare a costed estimate for repair work • Issue guidelines for CFC equipment phase out • All WIC/ WIF at SVS and RVS functional with standby generator and adequate fuel • Functional vaccine vans available at SVS, RVS with adequate number of cold boxes for transport • Issue guidelines for CFC equipment phase out • All WIC/ WIF at SVS and RVS functional with standby generator and adequate fuel	• Temperature log book demand and communicate to CCO and ensure adequate distribution to CCPs after receiving printed copies • Ensure proper documentation of shipment and arrival procedures from the DVS to CCP • Printing of monthly eVIN temp monitoring outputs at all CCPs and keep the records for 3 years • Generate weekly reports on temp excursions • Vaccine & logistics estimates to be calculated as per standard formats. Cold Chain handlers should have knowledge regarding this calculation • Resolution of temp excursion due to CCE failure • Develop vaccine delivery plans based on available vehicle and IPs • Monitor vaccine delivery plan monthly and provide feedback • All CFC equipment under major repair to be replaced with non-CFC equipment • Develop monthly PPM visit plan for approval and implement • Monitor physical and financial activity for PPM visits monthly • Monitor vaccine stock position weekly and take appropriate action • Availability of registers at all CCPs • Review vaccine transactions monthly and provide official feedback to CCPs	• Primary and alternate VCCH are trained on VCCH module • Monitor temp recordings at least weekly and review any deviations • VCCMs to supervise and sign temperature log book • Twice daily temp monitoring and recording in log book with alternate arrangements for holidays • Monitor temp recording daily and identify excursions immediately for resolution • Supervision of PPM activities weekly at all CCPs • Maintain the PPM records as per standard format • Vaccine & logistics estimates to be calculated as per standard formats. Cold Chain handlers should have knowledge regarding this calculation • VCCH to monitor stock position after every session day and take appropriate action • Review of vaccine stock registers weekly for completeness and accuracy • Update of the relevant stock registers within 1 day of every vaccine transaction • Record any opened or unopened vaccine wastage at all levels in the standard stock register • Monitor and review vaccine wastage monthly • Monthly reconciliation of stock, preferably after vaccine supply by district

Effective Vaccine Management Improvement Plan		
STATE (SEPIO/ CCO to ensure)	DISTRICT (DIO/ VCCM/ CCT to ensure)	COLD CHAIN POINT (MO I/C & VCCH to ensure)
• Functional vaccine vans available at SVS, RVS with adequate number of cold boxes for transport • Hooter alarm systems for all WIC/ WIFs • Time bound installation of eVIN data loggers at all WIC/WIFs • Review and ensure presence of CCE PPM plan at all districts • Printing and distribution of PPM recording formats to all CCPs • Review eVIN implementation and stock position monthly and communicate feedback to districts • Printing, distribution and availability of standard GoI vaccine registers across all districts • Conduct supportive supervision of vaccine stock management and recording • Review vaccine wastage monthly with feedback to all districts • Supportive supervision of SVS/RVS and monitor physical stock counts • Supportive supervision and monitoring of vaccine distribution plan implementation at SVS/RVS and districts • All state supervisors to be trained on supportive supervision with the mobile app installed • Monitor availability and update of transport contingency plan regularly • Prepare a quarterly supervision plan for state level supervisors, including RI partners, and ensure monitoring • Minor repairs, if required, to be completed and minor items (racks, shelves) procured • Ensure contingency plans available at all SVS and RVS	• Generate monthly vaccine transaction reports for all CCPs and review performance • Organize training batches for VCCH and ensure nomination and participation • Training of CCP staff on microplanning and ensure development of SC level and CCP level microplans • Functional vaccine vans available at DVS with adequate number of cold boxes for transport • Monitor physical stock counts against stock records • Development of vaccine distribution plans for the district • Monitor vaccine distribution plan implementation monthly and follow up on corrective measures • Timely indent of vaccines to ensure supply to CCPs as per distribution plan • Development of a quarterly supervision plan for district level supervisors and monitor its implementation during RI reviews/ DTFI • Increase the use of the standard GoI RI monitoring formats and cold chain monitoring formats available on the SS app of NCCMIS to document supervisory visits and follow up on findings on repeat visits • Minor repairs, if required, to be completed and minor items (racks, shelves) procured • Ensure contingency plans available at all DVS • All district supervisors to be trained on supportive supervision with the mobile app installed	• Monitor physical counts of vaccines at the store • Availability of VCCH module at CCP for ready reference • Development of a quarterly supervision plan for block and sector level supervisors and monitor its implementation during block/ sector review meetings • Increase the use of the standard GoI RI monitoring formats and cold chain monitoring formats available on the SS app of NCCMIS to document supervisory visits and follow up on findings on repeat visits • Minor repairs, if required, to be completed and minor items (racks, shelves) procured • Ensure logistics for immunization waste management available at CCP • Ensure contingency plans available at all CCPs • All block supervisors to be trained on supportive supervision with the mobile app installed

To ensure the quality improvement of immunization supply chain and track progress of EVM improvement plan, which leads to the overall strengthening of the routine immunization program, strong **supportive supervision and a mentoring plan** is required for states. States should assign supervisors to visit District Vaccine Stores and Service Delivery Points and ensure that supportive supervision tools are filled by these assessors and feedback are shared for immediate corrective actions.

1.5.2 Vaccine Logistics Management through eVIN

eVIN (Electronic Vaccine Intelligence Network) is a technology system that digitizes vaccine stocks and monitors the temperature of the cold chain through a smart phone application. It has been developed by Ministry of Health & Family Welfare, India which aims to support the Government of India's Universal Immunization Program by

providing real-time information on vaccine stocks and flows, and storage temperatures across all cold chain points. States and districts Program managers should regularly track vaccine stock and monitor vaccine temperature through eVIN system and review eVIN data with District Immunization Officers and Medical Officers on a regular basis to improve the immunization supply chain in their respective vaccine stores.

Effective use of eVIN for efficient Immunization Supply Chain management

Monitoring consumption:

Closely monitored consumption to ensure optimum pipelines and proper and timely utilization of vaccine supply. In order to evaluate wastage, consumption data to be triangulated with coverage data.

Ensuring adequate stock:

Vaccine availability can be tracked on a real time basis using eVIN Bulletin Board, MY eVIN Application, eVIN Web and eVIN Mobile Application. eVIN also provide alerts on nearby expiry, stock-outs etc.

Temperature Monitoring:

It is important to ensure that Vaccines are stored under the recommended temperature of +2 to +8°C Range. eVIN temperature to be monitored remotely and action to be taken for instant alerts when there is a temperature breach. As per the temperature monitoring SOP, immediate action to be taken at the time of temperature breach and cold chain technician to take corrective action.

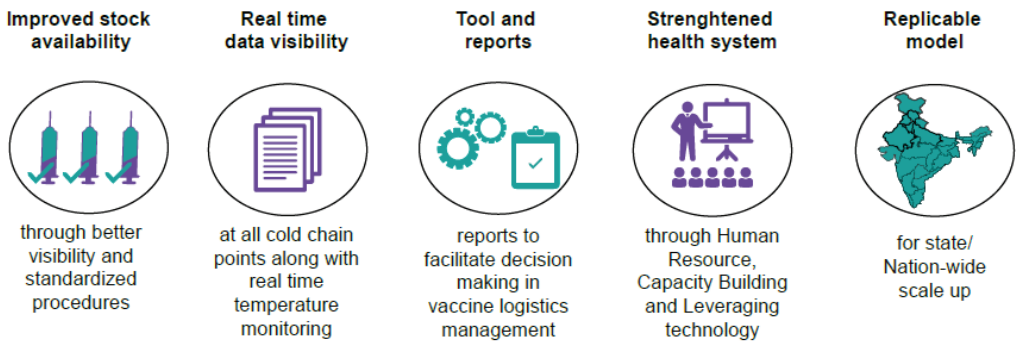


Figure 3: Expected benefits of eVIN

Access to eVIN:

The specific features of eVIN can be broadly categorized according to the role the users play in the system. The following table depicts the same:

Responsibility	State-level/ Regional	District Level	CCP	eVIN access through
Real time updation of vaccines on eVIN	SVS in-charge/ manager	DVS in-charge/ manager	Cold Chain Handlers(CCH)	"Stores" app
Micro-level monitoring of supply chain system	State Vaccine store Managers and Regional/Divisional Store Managers	District Vaccine Store Managers(DVS)	Cold Chain Handlers(CCH) and Medical Officer	eVIN web application and "Stores" app
Responsible overall supervision of supply chain system	MD, NHM at State level , State cold Chain Officer, Joint Director , Health etc.	District Vaccine Store Managers(DVS)	Cold Chain Handlers (CCH) and Block Medical Officer	eVIN web application
Responsible for taking corrective measures /follow up based on the alerts received from eVIN system	MD, NHM at State level, State cold Chain Officer, Joint Director, Health etc.	District Medical Officers (MOs) and District Cold Chain technicians	Cold Chain Handlers (CCH) and Block Medical Officer	eVIN login not shared)

eVIN has set up a strong example of how technology can be leveraged to enhance the efficiency and effectiveness of public health measures. States are benefiting with the implementation of the eVIN and have been able to improve planning, temperature monitoring, management of stocks and distribution of vaccines to the last mile.

1.6 CAPACITY BUILDING

Capacity Building is an important instrument in tackling health inequities by enhancing the capacity of organisations at national, regional and local levels, thereby improving overall outcomes. The Global Vaccine Action Plan identifies workforce capacity building as a key strategy to achieve strong immunization programs.

Health workers providing RI services play a crucial role in influencing vaccine uptake, a key determinant of improved immunization coverage. They are increasingly expected to have general and specialized technical competencies to meet the growing complexity of RI service delivery and integration with other health interventions in activities such as introduction and expansion of new vaccines, roll-out of intensive immunization drives (MI/IMI), implementation of technological innovations (e-VIN), etc.

India has a huge healthcare workforce with more than 900,000 ASHAs, 200,000 ANMs and large number of medical officers and Cold Chain Handlers across nearly 30000 cold chain points. Despite these huge numbers, the health workforce is inundated with challenges including inefficient deployment, poor distribution of health worker, poorly organized trainings with limited budgetary allocation for capacity strengthening efforts, etc.

There are several potential barriers to the implementation of proper training of health workers. Some of the barriers includes

- Multiple responsibilities and heavy workload resulting in lesser attention to training over other program components
- Difficulties in coordinating among different programs and stakeholders
- Inadequate monitoring and review mechanism
- Limited infrastructure at district/sub district level and logistics
- High attrition rate of trained HR
- Lack of refresher trainings
- Poor planning and tracking of the trainings
- Inadequate utilization of funds for immunization-related trainings
- Sub-optimal quality of the trainings
- Shortage of master trainers
- Translation of training materials in local language

India has a well-defined capacity building program under UIP to ensure that service providers at all levels are trained appropriately. The UIP has recommended trainings for health functionaries at several levels, the current system of capacity development of stakeholders follows a cascade-based training mechanism, which could be classified under three heads as below:

Routine Immunization/In-service trainings:

- **Training on immunization handbook for routine immunization:** A three days residential training of medical officers on routine immunization are organized at district/ regional/state training centers to train on 'Immunization handbook for MOs', facilitator's guide through training kit.
- **Training on immunization handbook for HW for routine immunization:** Two days training of health workers are conducted on 'Immunization handbook for HWs' and facilitators' guide at district training center/ ANMTC.
- **Field level workers training:** A half day training of frontline workers immunization is held on Info-kits for HWs and ASHAs/AWWs, facilitators' guide for intensified immunization training of frontline workers at block/

PHC level. In addition to this, BRIDGE (Boosting Routine Immunization Demand Generation) training is designed for ANMs, ASHAs and AWWs to improve their interpersonal communication (IPC) skills for boosting RI demand generation

- **VCCH-2016 (Vaccine & Cold Chain Handler module):** Two days training of cold chain handlers on 'Handbook for vaccine and cold chain handlers (2016)' is organized at district training centre/ANM training centre.

Subject specific/ thematic- vaccine or technology

- AEFI (Discussed at relevant section)
- e-VIN (Discussed at relevant section)
- T-VaCC: NCCVMRC has facilitated the capacity building of senior and mid-level managers, working at the state and district level in the country through the Training on Vaccine and Cold Chain (T-VaCC)/Effective Cold Chain Vaccine Management Course (ECCVMC).
- VPD Surveillance
- Data management (Discussed at relevant section)
- IMI/MI immunization drives (Discussed at relevant section)
- Pulse Polio campaign
- MR campaign
- New vaccine introduction- Rota, PCV, IPV
- Communication

Need based and refresher trainings

- **Regular FLW trainings:** Different mechanisms to train the health functionaries include half day training of front-line workers at PHC/block level once every 6 months, review meeting at the block/PHC held every fortnight/month/quarter; supervisory visits to the health centres, session sites and the community.
- **RI microplanning:** Two days training of Medical Officers on microplanning is to be conducted at state level TOT followed by cascade training at district and sub-district level.

Key recommendations posed to stakeholders and policy makers involved in training health workers providing routine immunization include but are not limited to the following;

1. Develop training calendars based on the load and ensure its timely implementation at national/state/ districts and block level
2. Ensure tracking and monitoring of quality & frequency of all trainings and regular sharing of training reports at all level for review and necessary action.
3. Strengthen existing training institutes and identify state and district master trainers
4. Monitor institution strengthening initiatives undertaken by state master trainers
5. Institutionalize trainings by preparing combined calendars with existing resource institutions (NHSRC/SHSRC/ NIHFW/SIHFW/ANMTCs) and plan for refresher trainings
6. Develop quality assessment checklist, action on feedback by participants, spot check of trainings to ensure the quality of training and to improve further.

1.7 STRENGTHENING AEFI SURVEILLANCE

Fear of AEFIs has been reported to be one of the key reasons for drop outs. While vaccines are safe, adverse events can occur sometimes following vaccination which has a negative impact on vaccine confidence and affects immunization coverage. Therefore, it is important to have a functional and effective AEFI surveillance system which can help in reporting, investigation and finding the cause of adverse events. This demonstrates

that there are proper mechanisms in place to ensure vaccine safety and contributes to confidence in vaccines and vaccinations leading to better immunization coverage.

One of the important components of the Universal Immunization Program (UIP) is surveillance of Adverse Event Following Immunization (AEFI). It is important to identify, record and report all minor, severe and serious AEFI cases.

While there has been an improvement in AEFI reporting, investigation and causality assessments, there exist some areas for improvement:

1. Provide immediate and quality treatment to all AEFI cases by providing referral transportation and access to specialist care to reduce preventable mortality and morbidity.
2. Effectively convey results of investigation and causality assessment of coincidental cases and expected vaccine reactions to the care-givers and the community.
3. Vaccinators and supervisors should monitor and respond to any refusals or dip in coverage after AEFIs. Frontline workers and supervisors should take support of key professionals, community leaders, opinion makers and use interpersonal communication skills to convince the community that vaccines are safe. Explain to the community that there may be long-term consequences of not vaccinating and not completing the immunization schedule. The support of partners, NGOs and local practitioners should be sought for this.
4. In case of program/immunization errors (due to improper storage, transportation, handling and administration of vaccines and diluents), the results should be shared with program managers, medical officers and health workers to ensure corrective action is taken.

Some gaps observed in AEFI surveillance are:

1. Two-thirds of districts do not report even a single AEFI case a year. Many districts report only deaths.
2. Lack of awareness regarding reporting of AEFIs amongst clinicians (specially paediatricians) working in government, PSU hospitals and private hospitals
3. Poor awareness levels of health workers and medical officers
4. AEFI registers are not available at all PHCs/ block PHCs. Minor, serious and severe AEFIs are not regularly recorded in AEFI registers
5. Investigations are not completed in time for most reported cases
6. District AEFI committee meetings are not held regularly
7. Poor utilization of existing state resources for support in AEFI surveillance (monitoring, investigations and causality assessments)

- All adverse events (minor, serious and severe) need to be recorded in the PHC AEFI register.
- All serious and severe AEFIs should be further reported and investigated as per the current National AEFI Surveillance and Response Operational Guidelines of Ministry of Health and Family Welfare, GoI, using the Case Reporting Form (CRF), Preliminary Case Investigation Form (PCIF), and Final Case Investigation Form (FCIF).
- In cases of hospitalization, all hospital records including case records, laboratory investigation reports, discharge summaries, etc., should be collected and submitted with the PCIF and FCIF.
- In cases of deaths, post mortems should be encouraged and reports to be sent with PCIF and FCIF.
- In case of deaths in which there is no hospitalization and post mortem has not been done, Verbal Autopsy Format for AEFI should be filled and sent with the PCIF/FCIF.

SAFE- VAC

To improve the efficiency of AEFI surveillance processes, a web-based application called SAFE-VAC (Surveillance and Action for Events following Vaccination) has been launched. This software will reduce loss of information and records and reports during transmission to state and national levels, empower district and state authorities to monitor and track on their own, provide easy and secure access to information to program managers and facilitate early causality assessments. The results of the causality assessment done at the state level will be available on SAFE-VAC, which can be conveyed to care-givers in case of coincidental cases and vaccine product related reactions and to program managers and vaccinators in cases of program errors.

Quality Management System (QMS) for AEFI surveillance

Setting up a QMS for AEFI surveillance in districts and state will result in incremental, rapid and sustainable improvement in AEFI surveillance processes, which in turn will result in improved vaccine confidence in the community. The processes and tools are explained in the National Quality Assurance Standards for AEFI Surveillance Processes. Capacity building meetings and trainings, demonstration of processes, handholding and support by states and district have been developed.

Recommended actions at the state level-

1. State AEFI committee experts should review status of AEFI surveillance in the state and recommend actions to overcome critical gaps using district AEFI committee tracking tool, state monthly presentations, etc.
2. Trained experts of the committee should conduct causality assessment of all eligible AEFI cases in a timely manner as per the national guidelines.

Recommended actions at the district level are -

1. The DIO should ensure that the district AEFI committee meets at least once a quarter to review surveillance status, identifies gaps and recommends actions to improve surveillance

2. The DIOs should coordinate with Adverse Drug Reaction Monitoring Centers located in select medical colleges and corporate hospitals; paediatricians of government and private institutions in the district for notifying AEFI cases
3. The DIO to ensure recording of all minor/ severe/serious AEFI cases in PHC/Block AEFI recording register by health workers and MOs on recording and reporting of AEFIs and use of anaphylaxis kits.

Recommended actions at the PHC/block level are-

1. Medical officer in charge of the PHC / block should ensure that all health workers, paramedical staff and medical officers as well as any private practitioner are aware of AEFI reporting.
2. Medical officer in charge should check AEFI registers every week to ensure that all ANMs are recording minor, serious or severe AEFIs; serious and severe AEFI cases are immediately reported in CRFs.
3. Medical officer in charge ensures availability of Anaphylaxis kits with all vaccinators and AEFI management kits in all PHCs; vaccinators and MOs are trained to use these.

1.8 IMPROVING DATA QUALITY AND ITS USE FOR PROGRAM MONITORING

Health information, which includes recording and reporting process is an important determinant of better health management. Systematic recording and reporting process is essential to assess the performance and aid decision making. There are several data sources which are being used in the immunization program like Routine reported data, Monitoring data, Impact data, Evaluated coverage data etc.

1.8.1 Routine Reported Data

The major sources of routine reported data in the immunization program are the Health Management Information System (HMIS) portal and the Reproductive & Child Health (RCH) portal.

Health Management Information System (HMIS):

Health management information system (HMIS) is a web-based reporting system to monitor the performance of programs and interventions under the National Health Mission (NHM). It helps in the monthly assessment of the immunization program and immediate corrections as it is available up to the facility level. Although, routine data has many advantages, it is not being used for the program monitoring due to weaknesses like timely updating, protocols for freezing the data and poor feedback mechanism. It is therefore imperative to ensure the improvement of data quality in HMIS and enhance the use of reported data to improve program performance.

Recommended actions

The following activities needs to be undertaken to ensure better data quality.

1. **Immunization Dashboard**

The reported data on Child Immunization (service delivery) is captured in Health Management Information System (HMIS) and the same needs to be analysed, developed into immunization dashboards on a monthly basis, program gaps needs to be identified and district specific feedback must be provided. Program Managers should use this dashboard to review data quality and program performance on various immunization component (timeliness, drop-outs rate, VPD cases, etc.) (Figure 4)

2. **Immunization Coverage Monitoring Tool (iCOMOT) to measure progress**

It is a useful tool which provides information on target figures and the immunization coverage, particularly in terms of left-outs and dropouts. The performance is presented in tabular and graphical form and the same platform needs to be used to provide feedback to the units. The supervisor should plot the immunization data on the chart upto the block level (as given in Figure 5). It should be updated every month.

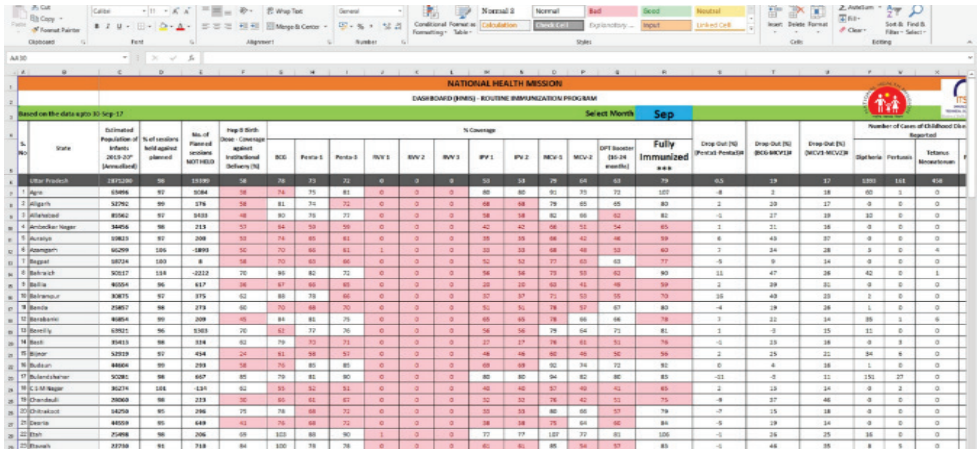


Figure 4: Immunization Dashboard

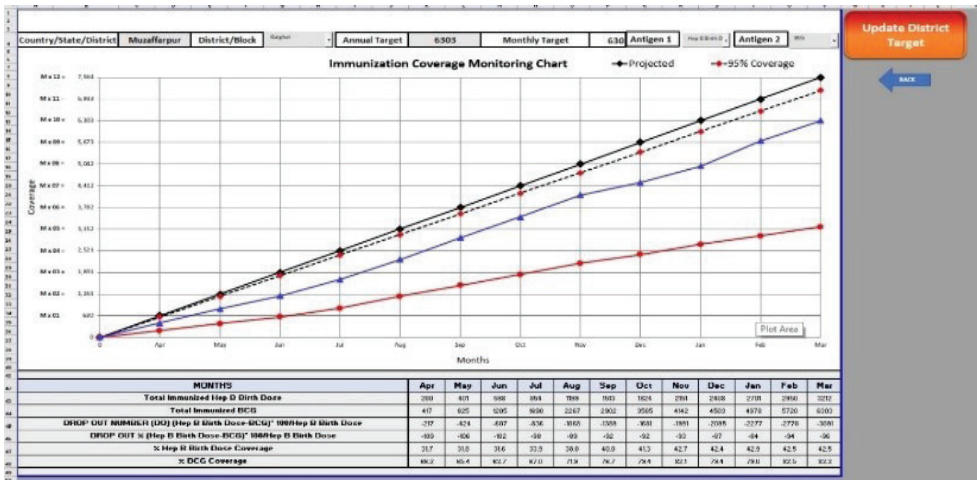


Figure 5: Immunization Coverage Monitoring Tool (iCOMOT)

1.8.2 DATA QUALITY ASSESSMENT

Quality data is an important requisite to facilitate evidence-based planning, hence it is essential to ensure better systems and processes of data collection, collation and analysis. To understand the status of data quality, Data Quality Assessment (DQA) needs to be conducted in the states and data quality improvement plan needs to be prepared and implemented.

The key objectives of this DQA exercise will be to assess the quality of data for four main measures- availability of records & reports, completeness of records and reports, agreement between two records or reports and consistency between various indicators and to understand the strengths and the weaknesses of the data management system. This is illustrated in table below:

The purpose of this verification is to determine if a sample of service delivery sites (e.g. Health sub-centers) have accurately recorded the immunization component of the data related to various data sources. These data sources are traced at each step of the data flow to

Indicator	Description
Availability	Availability measures whether the records and reports are physically available at the assessment site or at the electronic portals.
Completeness	Completeness measures if all the specified immunization-related data fields are filled.
Agreement	Agreement measures whether the two documents that are supposed to have the same data are actually identical or not.
Consistency	Consistency measures determine if information documented follows the logic that is expected from an immunization system.

verify if it has been correctly aggregated and reported through the intermediate levels (e.g., Primary Health Center, Block/CHC) to the higher levels (e.g., District).

Based on the findings of the assessment, a data quality improvement plan needs to be developed to achieve the goal of utilizing administrative data for evidence-based planning and management of the Universal Immunization Program (UIP).

1.8.3 Reproductive and Child Health (RCH) portal:

Delay in identification and service provision has been a major hurdle in achieving goals. In view of this, an innovative RCH portal, which is an online software application has been designed for early identification and tracking of the individual beneficiary throughout the reproductive lifecycle. This RCH portal acts as a vehicle to disseminate all relevant information pertaining to how, when and where to receive basic health services. The RCH Portal however does have some challenges like issues of timely registration and updation of beneficiary (children), inadequate feedback mechanisms and limited capacity of data entry staff.

Recommended actions

The following activities needs to be planned in the states to ensure improved registration and updation in the portal.

1. Proper availability of RCH registers to be ensured in all blocks / ANMs
2. Regular entry in the RCH portal to be ensured from planning unit
3. Capacity building of DEOs on the RCH portal
4. For states with issue of manpower for data entry, facilitating entry of the beneficiary details in the RCH portal, primarily through outsourcing of data entry and inclusion of budget for outsourcing the service in the PIP
5. Monthly Analysis of the status of data entry (district wise) in the RCH portal.
6. Provide feedback to the districts on the status of data entry in the RCH portal
7. Use of beneficiaries' contact number provided in the portal to send immunization schedule and awareness messages

ANMOL: ANMOL or ANM Online is a solution that aims to bring better healthcare services and better consultation to millions of pregnant women, mothers and newborns in India. ANMOL ends drudgery for ANMs by making their work paperless. The tablet allows them to enter and update the service records of beneficiaries on real time basis, which ensures prompt entry and updating of data. Since it is a completely digitalized process, the high quality of the data and accountability is maintained. The tablet complements the ANMs' tasks as well as that of the counselors, by providing them with readily available information about newborns, pregnant women and mothers in their area. Furthermore, the list of an ANM's pending tasks gets auto-generated.

Recommended actions

The following activities needs to be carried out to strengthen the ANMOL implementation in the states.

1. Ensure entry of the drop out/ left out beneficiary details in ANMOL on regular basis
2. Monthly Analysis of the data entry (district wise) in ANMOL
3. Provide feedback to the districts on the status of data entry in ANMOL

Retaining MCP Card and use of tickler bag

The state needs to ensure that the MCP card is maintained and updated regularly (Figure 6). The card has two parts: the main card and the counterfoil. While the main card is retained by the beneficiary, the counterfoil is retained by the health worker or the community link worker (ASHA) safely in the tickler bag.

Recommended actions

Retention of MCP cards needs to be ensured to facilitate scheduled and timely vaccination and to reduce the recall bias during the coverage evaluation survey. The counterfoils

Figure 6:
MCP card

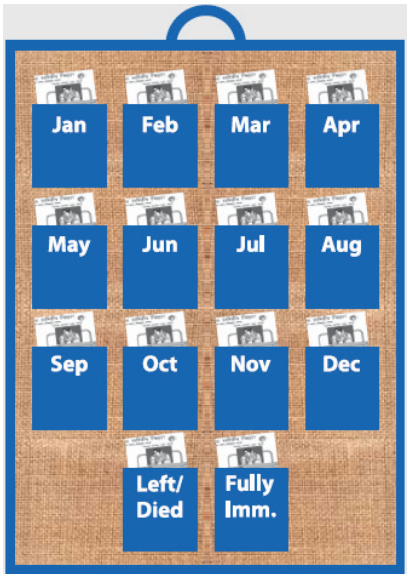


Figure 7:
Tickler Bag

need to be arranged month-wise in a tickler bag (Figure 7) and should be used by the health worker as a reminder for the beneficiaries who have doses due in the forthcoming month. At the end of each month, cards remaining in the pocket for that month represent dropouts who need to be followed up or moved into the next month's pocket.

1.8.4 Monitoring data

Monitoring data is generated by some external monitoring agencies including development partners, medical colleges and also by internal monitoring through supervisors, MOs, etc.

Recommendation

The monitoring data needs to be improved by increasing the sample size, improving the methodology using random sampling, increasing number of monitors by involving more government supervisors participation, using S4i tool, and by monitoring immunization data using government system.

Immunization program managers at state and district level should use S4i to monitor and review the immunization program using readily available monitoring findings

1.8.5 Role of Task forces in improving quality and governance:

An accountability framework is a structured platform that regularly reviews the planning, implementation and program performance. The state steering committee meeting under the chairpersonship of the Chief Secretary could guide the inter-ministerial coordination and providing oversight to the state immunization, while the state task force on immunization (STFI) to be held under the Principal Secretary/Mission Director – National Health Mission (MD-NHM).

The task forces have been constituted at the districts (DTFI) and an exclusive task force for the large urban areas under the chairpersonship of the District Magistrates (DM). In major metropolitan cities having corporation set up, task forces on immunization for a corporation CTFUI are in place and held under the chairpersonship of the Commissioner.

The task forces at all levels should review the progress, clear the obstacles/bottle-necks and provides solutions and empowers the program managers and other stake-holders for extending support to reach the common objective of enhancing the coverage levels.

The task forces should review and track the immunization program on all the broad components with the involvement of all stakeholders. The key areas include microplanning, manpower, inter sectoral coordination, urban immunization, vaccine and other logistics, cold chain, performance indicators on immunization and vaccine preventable disease outbreaks, communication and fund requirement and utilization, etc.

1.8.6 Program Review meetings:

Program Managers should review the immunization program in regular planned health review meetings at the state and

districts. The state should conduct the meeting of the Chief Medical Officers (CMO) and the District Immunization Officers (DIO). The CMO and the DIO should conduct the monthly meeting for all the medical officers in charge of the primary health centers at the block/urban planning unit. In addition, the districts and blocks should undertake quarterly review meetings that have been provisioned under state NHM PIP. The immunization performance and progress should be critically reviewed in terms of head count survey and due listing, proportion of planned sessions versus held including missed session with/without alternate planning, progress in full immunization coverage, drop out and left out, reason analysis for children not getting age appropriate vaccines, areas with high work load and vacant sub center/ urban health post, vaccine and logistics supply, vaccine utilization/wastage rates, timely submission of coverage report etc.

1.8.7Impact Data

Impact data is related to the morbidity and mortality due to VPDs and it gives the ultimate result of the immunization services provided. Areas having VPD cases shows that there is a gap in immunization services irrespective of the high coverage shown in HMIS. All VPD cases should be reviewed and immunization coverage should be assessed in that area. The main sources of impact data are CBHI, NPSP, IDSP, HMIS, SRS etc. This data is always under-utilized for most of the VPDs except Polio, mainly because of mismatch of data from different sources.

Use of VPD surveillance data to strengthen Immunization

In India, the availability of quality surveillance data for VPDs is limited. The WHO disease burden estimates are based on information available from a variety of sources such as demographic data, immunization coverage levels, vital registration data, mortality data and mathematical models using numerous assumptions. The degree of accuracy of these estimates depends upon the quality of surveillance data available in the country. Reducing burden of VPDs, will greatly contribute to achieving the Sustainable Development Goal (SDG) 3 target of reducing infant mortality rate (IMR) to 25 per 1000 live births by 2030. Therefore, a robust surveillance system to detect cases and deaths due to vaccine-preventable diseases is essential to generate country specific epidemiological evidence to be able to formulate vaccination strategies as well as to measure its impact on the disease after its introduction.

Laboratory supported VPD (Diphtheria, Pertussis and Neonatal tetanus) surveillance has been initiated in 12 states (Bihar, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Punjab, Uttar Pradesh and Uttarakhand) across India covering approximately 62 % of India population and Measles Rubella case-based surveillance has been initiated in 36 states/ UTs of India along with fever rash surveillance in 3 states (Karnataka, Madhya Pradesh and Odisha). Areas with any vaccine preventable disease outbreak include measles or rubella outbreaks or cases of diphtheria, pertussis, and neonatal tetanus during the last three years.

The outbreak signifies compromised RI coverage in that area. During outbreaks, it is important to identify additional cases using clinical diagnosis. However, laboratory investigation of suspected cases is strongly recommended. Active case searches or community assessment is recommended in the area with the suspected VPD cases.

Outbreak response

Using data from Immunization and Surveillance to guide programmatic decisions through District Weekly Review Meetings (DWR).

District weekly review meetings are one of the best platform for monitoring the progress of surveillance and routine immunization. The objectives of DWR are as below:

- Timely detection and early response to Measles, Rubella and VPD outbreaks
- Review key elements of routine immunization for data driven actions to intensify routine immunization

- Enhance the coordination between different surveillance systems across the country
- Formulate data driven strategies by triangulating the surveillance data to close the immunity gaps in pockets of low immunity

The minutes of the DWR meeting should be captured in a standardized format (Annexure 1). The DWR meeting will be chaired by the Chief Medical Officer (CMO) and facilitated by the District Immunization Officer (DIO) with all the partners and key stake holders on a weekly basis. The key observations/findings of this meeting should be discussed in regular DTFIs/STFIs.

The state should review the status of district weekly review meeting within the state and update the progress to MoHFW.

RI Intensification during an outbreak response

Epidemiological data captured through disease surveillance helps to monitor the progress and impact and effectiveness of vaccination programs. The outbreak indicates low population immunity of the community affected. It signifies compromised RI coverage in that area. With the accumulation of susceptible cohort of unimmunized children, the disease transmission is sustained in the community. It is important to break this transmission by increasing the population immunity by intensifying routine immunization in such pockets with low population immunity.

The vaccine preventable disease surveillance data sources at districts are:

- AFP/MR surveillance nationwide
- Lab supported VPD surveillance from 12 states covering the 62 % of the country population with nationwide expansion planned
- IDSP surveillance data for 33 diseases including vaccine preventable diseases

The available data from measles, rubella, diphtheria, pertussis and neonatal tetanus should be triangulated in the district weekly review meetings on regular basis to derive program decision on the intensification of routine immunization.

During an outbreak, routine immunization services should be intensified in the affected and surrounding PHC catchment areas depending on the spread of the outbreak. This opportunity should be used to strengthen routine immunization in an outbreak area. Plan an additional RI session as soon as possible. The following steps should be conducted once the active case searches in the community have been completed.

- The ANM will review records and MCP counterfoil of children below 2 years to identify and enlist dropout and left out children for vaccination.
- Unimmunized or partially immunized beneficiaries will be identified during the house to house case searches and included in duelist for vaccination.
- Vaccinate due beneficiaries through routine sessions, or additionally planned session (if needed) at the earliest.
- Additionally, during an outbreak, the ASHA/AWW/ANM will educate village leaders and parents to vaccinate any child between 0-59 months of age that has not received the scheduled age appropriate doses from a scheduled vaccination session.
- The importance of retention of MCP card would be emphasized along with four key messages.

The link between IDSP, HMIS VPD data & WHO data needs to be established.

Evaluated Data

Evaluated data is a large-scale, multi-round survey conducted in a representative sample of households and conducted by government and/or any independent agency. However, it does not provide the real time data to plan mid-course corrections as surveys are conducted at irregular frequency (approx. 2-5 years). Getting the coverage estimates below the district level is not possible for evaluated surveys.

Recommended actions

The evaluated coverage data can be improved by using a robust methodology. Retention of MCP card needs to be done to reduce recall bias. Program Managers should ensure that ANMs provide 4 key messages and inform caregivers regarding the vaccine given and the immunization schedule.

OBJECTIVE 2

IMPLEMENTATION OF INTENSIFIED MISSION INDRADHANUSH (IMI) 2.0

IMPLEMENTATION OF INTENSIFIED MISSION INDRADHANUSH 2.0

2.1 Rationale And Objectives For Intensified Mission Indradhanush 2.0

Rationale for IMI 2.0

To reach each and every child and pregnant woman, intensive efforts were undertaken through Mission Indradhanush to cover left out and drop out children especially in underserved and vulnerable communities. The efforts made under MI for the last four years are encouraging as evident through the IMI-CES conducted in 2018 across 190 districts, which has shown an increase in FIC by 18.5 percent points.

Based on Routine Immunization monitoring and the Mission Indradhanush data, it is estimated that annually more than 70 lakh children in the country still do not receive all vaccines that are available under the UIP. Covering these children will help in achieving the goal of 90% FIC and IMI 2.0 will play a major role for the same.

The gains achieved through Intensified Mission Indradhanush, need to be sustained through strengthening the immunization systems. Further key learnings from MI such as inter-ministerial and inter departmental coordination, action-based review mechanism, incorporation of IMI sessions into RI microplans, an intensified monitoring and accountability framework and a vibrant communication strategy will be the key to improve the immunization coverage and reach every child with lifesaving vaccines though IMI 2.0.

Criteria for selection of districts and urban cities:

IMI 2.0 is planned for selected 271 districts spread over 27 States/UTs in the country and 652 blocks in 109 districts of Uttar Pradesh and Bihar.

The districts and cities have been selected through triangulation of available datasets such as national surveys, HMIS data and WHO concurrent monitoring and VPD surveillance data.

Selection criteria for 271 districts

- State with FIC < 70% based on CES 2018 (unpublished data) - 14 States & UTs
  - All districts < 80% FIC based on survey data (IMI-CES & NFHS 4)
  - All districts < 95% FIC based on HMIS coverage
- Remaining 20 States & UTs with > 70% FIC based on CES 2018 (unpublished data)- except Uttar Pradesh & Bihar
  - NPSP VPD surveillance data i.e. measles incidence more than 10 per lakh population or diphtheria & pertussis incidence more than 1 per lakh
  - Aspirational districts FIC < 80% based on IMI CES & NFHS-4

States & UTs not included in IMI - Andaman & Nicobar, Chandigarh, Daman & Diu, Goa, Lakshadweep, Puducherry, and Sikkim.

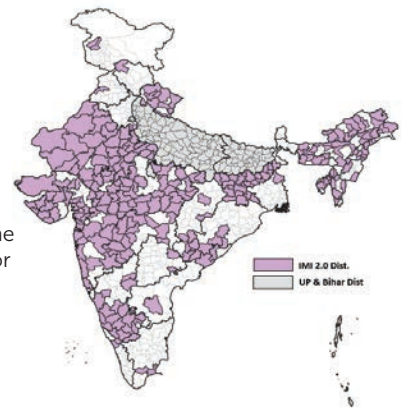


Figure 8: The map illustrates 271 Districts of 27 States/UTs as identified by the government for IMI 2.0

In Uttar Pradesh and Bihar, IMI strategy is based on the identification of poor performing blocks– a total of 425 blocks are selected for Uttar Pradesh and 227 for Bihar for IMI 2.0.

Criteria for block selection:

i. FIC < 80% based on concurrent monitoring data

ii. Block with high VPD cases i.e. measles incidence > 10 per lakh population or diphtheria/pertussis incidence > 1 per lakh population

The detailed list of selected districts and blocks has been provided in the Annexure 2.

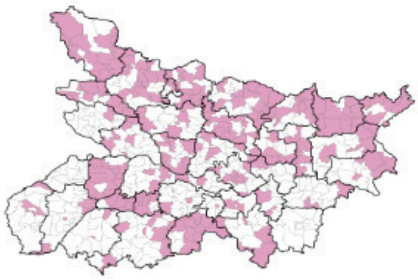


Figure 9: Blocks for IMI 2.0 in Bihar

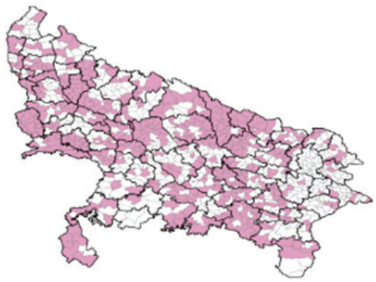


Figure 10: Blocks for IMI 2.0 in Uttar Pradesh

The urban areas (NUHM cities) under these identified districts and blocks should be part of IMI 2.0

(List attached in annexure 3)

Objective for IMI 2.0

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

With the launch of the Intensified Mission Indradhanush 2.0, the government aims to:

- Reach all children with all UIP vaccines due for the age as per the national immunization schedule in the geographical area with focus on children up to 2 years of age and pregnant women.
- Enhance the focus on missed vaccinations, especially for children belonging to Left outs, Dropouts, and Resistant families, hard to reach areas and resistant communities
- Rapidly buildup 90 % FIC 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.
- Sustain the gains made in Intensified Mission Indradhanush 2.0 through the Health System Strengthening (HSS) approach.

- The priority for conducting Intensified Mission Indradhanush 2.0 should be areas with weak routine immunization coverage in the district. This may require deployment of ANMs to areas outside their own sub-centre and block.
- Special attention should be provided to urban settlements and cities identified under the NUHM.
- Intensified Mission Indradhanush 2.0 should be taken as an opportunity to improve:
  - ◊ Full Immunization Coverage
  - ◊ Complete Immunization Coverage (Measles/ MR 2nd dose and other booster doses)

Schedule for IMI 2.0

The Intensified Mission Indradhanush 2.0 immunization drive will be conducted through 4 rounds in the selected districts.

Round 1 –December 2019

Round 2 –January 2020

Round 3 –February 2020

Round 4 –March 2020

IMI 2.0 immunization drive will be spread over seven working days, excluding public holidays, sundays and the routine immunization days planned in that week. The planned routine immunization session should be held as per the RI microplan.

After the completion of the proposed four rounds, the states will be expected to undertake measures to sustain the gains from IMI, through activities like the inclusion of IMI sessions in routine immunization plans, improving RI microplans (including communication plans), sustaining monitoring, strengthening review mechanism, etc. The sustainability of IMI 2.0 will be assessed through an evaluation survey after the 4th round of IMI 2.0 and intensive monitoring in last week of April during the World Immunization Week.

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 the Intensified Mission Indradhanush and the areas of support from these ministries are described in Objective 2 (2.8).

- **Ministries to be involved:** Women and Child Development, (WCD), *Panchayati Raj* , Minority Affairs, Human Resource Development (HRD), Information and Broadcasting, Urban Affairs, Housing and Urban Poverty Alleviation, Defense, Home Affairs, Youth Affairs and Sports,Railways, Labour and Employment, Tribal Affairs, Rural Development, Drinking water and Sanitation
- **Departments in the Ministry of Health& Family Welfare to be involved:** Urban Health division (NUHM), Maternal and Child Health division, *Rashtriya Bal Swasthya Karyakram* (RBSK), Information, Education & Communication (IEC) Division.
- **Mobilizers:** NGOs, Public Relations, SHGs, CSOs, Rotary International, NSS, National Cadet Corps (NCC), *Nehru Yuva Kendra*, MSW, along with relevant stakeholders to be involved as mobilizers.
- **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.

Focus areas

The 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 identified districts for ensuring >90% full immunization coverage.

Head Count Surveys will be conducted for the entire district; based on which, left-outs, drop-outs will be identified for each area and listed for coverage under IMI, the children due to routine vaccination need not be included in the list prepared for IMI. Areas with a high number of left-outs and drop-outs will be targeted along with a focus on the following areas:

- Areas with vacant subcentres– Auxiliary Nurse Midwife (ANM) not posted or absent for more than 3 months;
- Unserved/low coverage pockets in subcenter or urban areas, due to issues around vaccine hesitancy, hard to reach areas and subcenter/ANM catering to populations much higher than the norms.
- Villages/areas with three or more consecutive missed routine immunization sessions;

- High-risk areas (HRAs) identified by the polio eradication program that do not have independent routine immunization sessions and are clubbed with some other routine immunization sessions. These include populations living in areas such as:
  - ◊ Urban slums with migration
  - ◊ Nomadic sites
  - ◊ Brick kilns
  - ◊ Construction sites
  - ◊ Other migrant settlements (fishermen villages, riverine areas with shifting populations)
  - ◊ Underserved and hard-to-reach populations (forested and tribal populations, hilly areas, etc.).
  - ◊ Settled HRA population
- Peri urban areas or border areas between *mohallas*, villages, blocks/ urban areas and districts
- Areas with low routine immunization coverage identified through measles outbreaks, cases of diphtheria and neonatal tetanus in the last 2 years.

2.2 Strategy for Intensified Mission Indradhanush 2.0

IMI 2.0 is to be conducted in selected districts. All blocks and urban areas in the selected districts will need to be assessed for coverage and accordingly be included in IMI 2.0.

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 to 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.

Microplanning should be done in such a way that **all ANMs in each district are involved for 7 working days** (in addition to routine immunization days) to visit and conduct sessions for maximum immunization coverage. In case alternate vaccinators are deployed in areas with no ANMs, it should also be recorded in microplan.

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.

The IMI sessions should be included in routine immunization micro-plans by the end of the four rounds of IMI, the sustainability of which will be assessed through intensive monitoring during the World Immunization Week.

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

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

Focus on NUHM cities in IMI 2.0:

IMI 2.0 must focus on the NUHM cities in 271 identified districts across 27 States/UTs and selected blocks of Uttar Pradesh and Bihar with identified urban areas. Continuing the drive provides an opportunity to focus on the urban poor and vulnerable population in these identified districts/blocks.

Assigning lead development partners to support the IMI 2.0 in identified districts for providing technical support for capacity building, review of progress and monitoring and evaluation. Detailed role of partners in IMI 2.0 described in the annexure.

Strategic steps for implementation are described in the figure below:

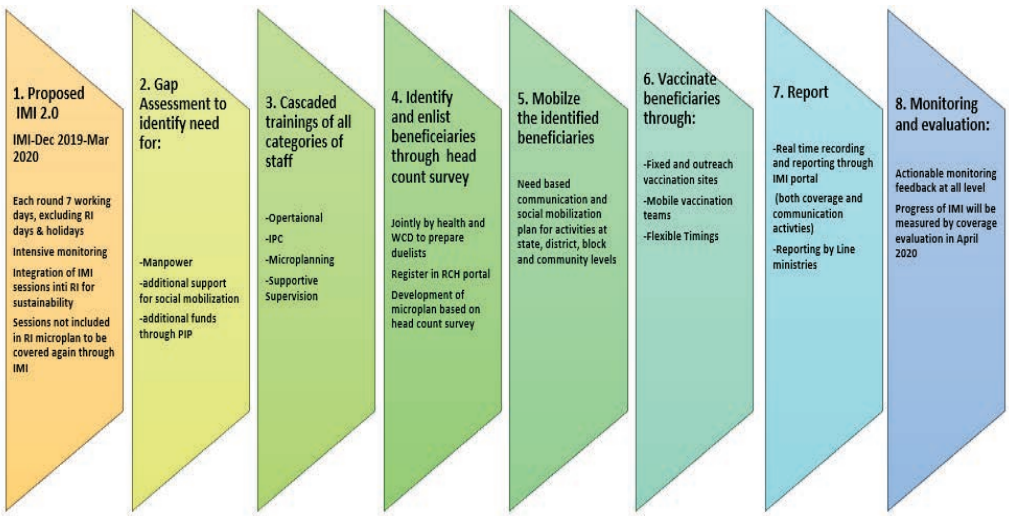


Figure 11: Strategic steps for IMI 2.0 Implementation

Strong accountability framework at state, district, urban city and block level will be the key to success. Regular reviews will be done from National level through video conferences with states and districts.

Activity	Timelines
State steering committee meeting	End October, Late November & Late December
STFI/DTFI meeting	Once a month
Gap analysis	October 2019
National Orientation Workshop for SEPIOs	October 2019
State ToT	October 2019
Supplementary PIP for additional requirement	End October 2019
District ToT	October 2019
Completion of HW and mobilizer trainings	November 2019
Completion of Microplan after head count survey	15 November 2019
Assessment of district readiness by national monitors	End November 2019
First round IMI 2.0	December 2019

Assessment of District Readiness by National Monitors:

From National level, a team of experts led by senior officials from MoHFW/ other ministries will visit the states/districts a month prior to the start of IMI, to assess and validate the target set and 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.

The National monitors will closely follow-up on the progress of IMI activities mainly the quality of STFI/DTFI meetings, 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. IMI portal has been set up to enable the MoHFW closely monitor all activities done under IMI and follow up of IMI.

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

2.3 Components of Intensified Mission Indradhanush 2.0

Based on the learning and the good practices observed during the earlier Mission Indradhanush Phases, the reach would be further enhanced through the following components of IMI 2.0:

1. Microplanning for IMI sessions based on a head count survey with
   - Flexible timings
   - Additional sessions including mobile sessions for hard to reach and migratory areas
   - Conduction of sessions by other departments (ESI, Railways, Defence)
   - Deployment of additional HR for vaccination
2. Immunization supply chain management for IMI 2.0
3. Trainings and orientation
4. IMI 2.0 intensive communication campaign
5. Real time recording and reporting through the portal (both coverage & communication activities)
6. Monitoring and evaluation
   - National, state & partners monitoring
   - Communication support & monitoring
   - Concurrent monitoring-based Post IMI coverage evaluation survey
7. System strengthening immunization week

2.3.1. Microplanning for IMI 2.0 sessions:

Head count survey in identified districts: The ASHA/ AWW/ Surveyor would conduct house to house survey in their designated areas covering 25-30 households in a day. This survey should not be planned on RI session days. The activity may be completed in 7-10 days. All beneficiaries including tenants, families who had temporarily migrated for work, nomadic sites etc. have to be inquired about and included with focus on home delivered new borns left out and drop out children. At the end of the survey, the village wise beneficiary list has to be generated by the respective ANM. Intensive monitoring of the head count survey should be done through supervisors and district lead partners and targets to be uploaded on the IMI portal.

All the activities under IMI will be funded by NHM as per the detailed financial guidelines attached (Annexure 7)

Microplans:

Microplans for IMI 2.0 are to be drawn 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.

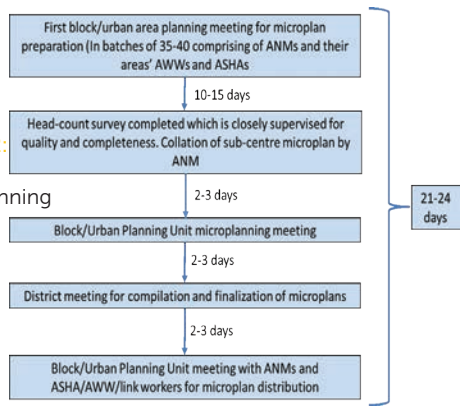


Figure 12: Steps of Microplanning

The following steps should be undertaken for preparing a complete microplan for Intensified Mission Indradhanush sessions. (Figure 12)

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

Activities to be conducted:

- A master list of all villages/hamlets/ wards/ 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 to be prepared.
- ANMs should be provided blank microplanning format 1 (Annexure 4) in A3 size paper to list all areas and subsequently identify areas requiring additional sessions under the Intensified Mission Indradhanush in their own subcenter areas.

During the following 2-3 days, ANMs should list all villages, hamlets and HRAs (slums, nomadic sites, brick kilns, construction sites, other high-risk settlements) on the ANM microplanning format 1 (Annexure 4). Once all the 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 involved in headcount survey should be trained for enlisting of beneficiaries. The ASHA coordinator will ensure that head-count is conducted for estimation of the 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 an oversight for this activity.

Step 2. Block/Urban Health unit microplanning preparation meeting

Activities to be conducted:

- ANMs will bring filled microplanning format 1 (Annexure 4) during the 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-centers. MO IC will enlist all such areas in microplanning format 2 (Annexure 5) 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 6) for additional sessions in her own subcenter area in consultation with the Block MOIC. For Intensified Mission Indradhanush days, she can be assigned areas outside her subcenter 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 subcenter 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 Mission 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.
- ASHAs/AWWs/link workers will be assigned to each session in consultation with the block ASHA coordinator.
- A reasonable sample of a due-list prepared on the basis of head-count survey will be verified by the supervisory staff for every planning unit

Activities specific for urban areas:

- Identify Nodal officer for immunization activities in urban areas for Intensified Mission Indradhanush

- Gap assessment to be done separately for urban cities with projection of needs in supplementary PIP for Urban Health
- Estimating urban city population and the number of beneficiaries for IMI for planning purposes
- Listing/ revision of lists of new areas/ high-risk areas (planning unit wise) in urban cities
- Mapping resources in urban areas (SHGs/ 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 4). 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. All such areas will be listed in microplanning format 2 (Annexure 5).
- Need based support will 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) for:
    - * 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 1067 cities identified under the NUHM– coverage reporting and monitoring should be done separately to get a better sense of progress and gaps which require further attention.

Step 3. District-level microplan finalization 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 Format 3 (ANM roster for Intensified Mission Indradhanush) for all ANMs in the block.
- The 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.
- These assigned sessions will be included in the ANM roster (microplanning Form 3) of ANMs by their MOICs concerned.
- Such ANMs working in other subcenter 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.

- The 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

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 6) will be filled. This includes areas in ANM's subcenter with weak routine immunization coverage, where she will conduct routine immunization sessions on the two routine immunization days designated by the state. Alternate vaccinators like retired ANMs, staff nurses, pharmacists, private practitioners can be used in urban areas, where ANMs are not posted. During these days, she will be supervised by the supervisor designated for that particular area.
- 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 to the MOIC of the block where the ANM is posted.

IMI 2.0 Sessions:

Fixed and outreach sessions: Medical officer in-charge (MOIC) for the block/urban planning unit would 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 centers (PHCs) and district hospitals on all days of Intensified Mission Indradhanush.

- **Sites for vaccination:** Schools, *Anganwadi* centers, private dispensaries, non-government organization (NGO) sites or any other locations that are easily accessible and acceptable to the community can be used as the immunization site. In addition, urban health posts; post-partum centers; family welfare centers and local influencer's premises may be utilized in urban areas.
- **Availability of human resources:** All ANMs in the district will conduct the 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 the availability of local mobilizers working for 15-20 days per month till the end of the fourth round of IMI 2.0, 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 the 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 ANMs can be deployed to another subcenter 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 with less than 7 days of involvement in Intensified Mission Indradhanush in their own sub-centre areas should be deployed to vacant sub centers or in identified urban areas, if

alternate vaccinators are not available in these 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. Involve the vaccinators from medical colleges etc.
- Need-based mobility support should be extended to ANMs deployed outside their subcenter areas.
- Need-based support should be provided for the mobile teams in far-flung/ scarcely populated/scattered areas.
- Other health staff trained for administering the injection available from the same or neighbouring community health center (CHC)/ block/PHC/NGOs (LIONS club, Rotary International, etc.), retired health workers and staff available from other government agencies such as Medical Colleges, ANM/Nursing Training School, Employee's State Insurance Corporation, Central Government Health Scheme, Armed Forces, Railways, District Urban Development Agency/State Urban Development Agency and Community Based Organizations (CBOs) should be utilized to reach the largest number of children.

Please note: Under Program 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 the district.

- **Timings:** The activity will be conducted from 09:00 Hrs to 16:00 Hrs. However, sessions should be planned based on the availability of the target population to maximize the benefits. In urban settings, DTFI or DTFUI/CTFUI may take the decision for **flexible timings** of sessions at certain places to ensure all beneficiaries are immunized. Remember to ensure functional AEFI management centers 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 and payments to both mobilizers should be made as per financial guidelines (Annexure 7). An additional vaccinator will be included in the team if the estimated injection load is more than 60–70 beneficiaries.

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 *dhanis*/*tolas* 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 8. BCG and MR vaccines that are opened at one site should not to be used at the next site. The Integrated Child Development Services (ICDS) department 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.

2.3.2 Immunization Supply Chain Management

An effective and efficient Immunization Supply Chain is critical in ensuring availability of adequate and safe vaccines for the beneficiaries and an optimum supply chain

management will be critical in ensuring success of the IMI campaign. Poorly managed supply chain systems can lead to high and/ or unnecessary vaccine wastage, stock outs, or improper management of waste, resulting in significant operational Program costs and leading to missed opportunities.

Vaccine & logistics estimation – Estimation of vaccine and logistics requirements should be done on the existing formats, based on the verified headcount of beneficiaries for the IMI period. In case of any vaccine or logistic shortage at any session during the IMI weeks, 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 be promptly replenished from the district level. In case of any shortage at district level, SIO should be informed for necessary action. Logistics including auto-disable (AD) syringes and MCP cards available under the UIP will be used for IMI 2.0.

Reducing Vaccine wastage –

The existing Open Vial Policy (OVP) guidelines will be applied to 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 [Pentavalent vaccine, PCV, oral polio vaccine (OPV), IPV (inactivated poliovirus vaccine), hepatitis B, diphtheria-pertussis-tetanus (DPT), and tetanus and diphtheria toxoid (Td) vaccine] is 10%.

Stock management –

Standard vaccine registers available and completely updated, including vaccine wastage information, at all cold chain points with data entry in eVIN within 24 hours of any transaction in eVIN states. Standard stock management protocols, including guideline-based storage in CCE, priority for issue based on expiry/ VVM, periodic physical verification of stock, to be followed.

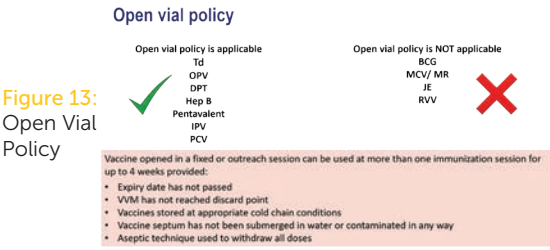


Figure 13: Open Vial Policy

Reorder levels to be documented and indent initiated accordingly in case of stock shortage. At no point should there be a stock out of any antigen during the IMI rounds at any Last Cold Chain Point (LCCP). In eVIN states, real time recording and monitoring should be done.

Vaccine distribution –

Documented vaccine delivery plans to be available and followed for all levels of vaccine stores. Vaccine transport between higher stores and from LCCP to the session site to be done in cold boxes and vaccine carriers respectively, with conditioned ice packs to prevent freezing of vaccines.

Alterante vaccine delivery plans for the proposed IMI & RI sessions to be prepared and finalized as per standard formats training.

VCCH training – A one-day refresher training for all VCCH should be organized prior to IMI based on the VCCH module on locally identified priority topics.

Immunization Waste Management: 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.

2.3.3 Trainings and orientation:

The roll-out of the IMI would require meticulous planning at all levels. This would require 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 who has been left unimmunized or partially immunized.

Intensive training of health officials and frontline workers on micro-planning, Immunization & supply chain, communication & media management, waste management, supportive supervision, AEFI management and other immunization activities need to be carried out before the first round of IMI 2.0 to ensure the highest quality of immunization service delivery to beneficiaries. Block and districts should prepare training calendars well in advance, so that all trainings must be completed as per the timeline.

Institutionalize BRIDGE training for FLWs in the existing resource institutions (NHSRC/ SHSRC/NIHFW/SIHFW/ANMTCs). Plan for refresher trainings and use regular platforms such as sector meetings, review, task force meetings for capacity building of all cadres.

2.3.4 IMI 2.0 Communication Campaign

A robust communication campaign has been designed to complement and steer operational interventions for IMI 2.0, driven to meet and sustain India's national coverage goals. These interventions are guided towards strengthening demand-side interventions and help communities, parents and key stakeholders understand the importance of Immunization in protecting children from life-threatening diseases, counter myths, address perceived misconceptions, and build vaccine trust to facilitate greater immunization service seeking behaviour.

Communication Objectives for IMI 2.0 Campaign

- Enhance awareness, knowledge and understanding among the families and communities on the need, value and benefits of immunization
- Strengthen public support and demand for immunization through focused community mobilization, engagement and empowerment interventions catering to parents, caregivers, and communities
- Create an enabling environment to support IMI 2.0 interventions through leveraged partnerships with key stakeholders within the government, partner, civil society canvass.

Communication Strategies for IMI 2.0

IMI 2.0 campaign will be guided by strategic communication pillars which are inter-linked

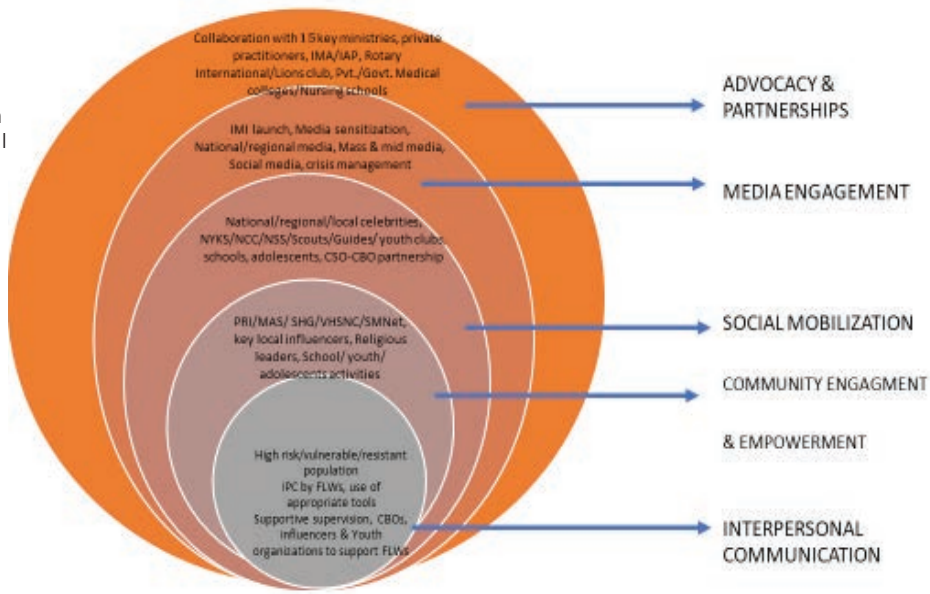


Figure 14: Communication Strategies for IMI 2.0

and mutually supportive.

IMI 2.0 Highlights:

- The campaign will position individuals and families at the heart of its interventions with an intensified focus on interpersonal communication steered by the ASHAs utilizing mothers meetings for provision of lifesaving messages and counselling, influencing attitudes and empowering caregivers to seek age appropriate immunization for their children. Building on male engagement strategies, efforts will be guided towards promoting a cohesive environment for women to take informed decisions related to immunization, with support from men in the community as proactive fathers and husbands.
- Enhanced engagement of critical stakeholders such as CSOs and CBOs, hard to reach, adolescents through school and outreach and youth-based organizations will be sought through tailored interventions, critical for making IMI a "people's movement".

Creating a buzz! - Amplifying pre-rollout interventions

IMI 2.0 is scheduled for launch in December 2019. States need to ensure there is full preparedness to implement the campaign. Below are key points for states to ensure as part of preparedness interventions:

Mark the date! - Make an internal announcement to all stakeholders for getting prepared for the launch date.

Map existing capacities! - Carry out a resource mapping of existing HR, skills and finance at district and block levels; fill any communication gaps strategically; if necessary, do necessary advocacy for acquiring resources

Fix accountability! - For communication - At all levels!

Amplify immunization-messaging visibility! – Through availability of the IEC Package

Details of communication interventions have been enlisted in sections below;

Advocacy

The collaboration and partnership between various government structures with the engagement of development partners, professional bodies and media have greatly contributed to improved coverage outcomes.

IMI has, in the past, collaborated with 12 ministries (such as Education, Women and Child Development, Tribal Affairs, Railways and Panchayati Raj etc) for using their networks to reach communities, and work closely with civil society and professional bodies. Continuing with the previous IMI's momentum, strengthening this collaboration further will be critical for the success of the IMI 2.0 campaign.

a. Leverage Inter- ministerial collaboration through 15-line ministries and their relevant departments:

The IMI 2.0 strategy will require support from key ministries and departments; namely Women and Child Development, (WCD), Panchayati Raj , Minority Affairs, Human Resource Development (HRD), Information and Broadcasting, Urban Affairs, Housing and Urban Poverty Alleviation, Defense, Home Affairs, Youth Affairs and Sports,Railways, Labour and Employment,Tribal Affairs, Rural Development, Drinking water and Sanitation.

IMI 2.0 Highlight

Fixing accountability through convergent reporting mechanism

To ensure the highest level of accountability and supervision 15 line ministries and key partners, CSOs, and other identified stakeholders will report on critical updates through a national dashboard developed in collaboration with the National Health Portal.

The identified ministries will support in awareness generation, publicity, influencer engagement, mobilization and monitoring interventions.

Note: Refer to Annexure 9 for advocacy for IMI 2.0: Inter-ministerial Collaboration

In addition to the line ministries, States need to advocate for support from other key stakeholders to support mobilization, awareness generation and service delivery interventions for the IMI 2.0 campaign as enlisted below

b. Advocacy with professional bodies and other stakeholders:

- States need to identify and sensitize private medical practitioners and the medical fraternity from the Indian Medical Association (IMA) /Indian Academy of Pediatrics (IAP) to support community mobilization
- Engage with Rotary International/ Lions club for advocacy with influencers and celebrities; and utilize their networks to mobilize communities and conduct rallies, and events. Rotary International and Lions club must also extend support for publicity of IMI 2.0, school activation events (detailed below) and procurement of the IMI 2.0 promotional collaterals

c. Involvement of Medical colleges and Nursing schools:

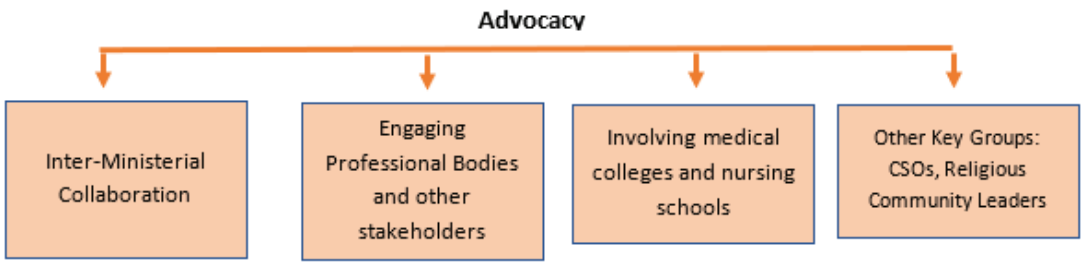
Due to their strategic positioning in urban areas, medical colleges and nursing schools will play a critical role in the roll-out of IMI 2.0 interventions, which will broadly include support for planning, advocacy, capacity building, supervision, documentation and exploring innovations in Immunization.

- States should identify and train the staff from medical colleges to create a pool of master trainers for conducting medical officer and health worker trainings.
- Support from medical colleges and nursing schools needs to be sought for organizing visits of medical students to high-risk areas and vaccine hesitant pockets, a week or two prior to IMI 2.0, to sensitize and mobilize the community.
- Utilize medical college faculty to serve as AEFI committee members and support in case of any AEFI
- The trained staff from Nursing colleges/ ANM training centers needs to be engaged to support immunization sessions where additional ANMs are required
- Private and Government medical colleges to support to counter the negative messages on immunization and participate as expert speakers for the school events prior to and during the campaign.

d. Advocacy with other key groups:

- Advocacy with CSOs such as youth networks (NSS, NYK), faith-based groups, other national / local NGOs, traders and occupational leaders will play a crucial role in reaching local influencers, leaders, women's groups and other local networks.
- Advocacy with religious and community leaders will play a critical role in amplifying positive information and message dissemination on immunization, and or influencing community interventions, especially in tribal and hard to reach areas.

Note: Refer to Annexures 10 on Advocacy with professional bodies, medical colleges



and other groups.

Social mobilization

Social mobilization will create an enabling environment to raise awareness and demand for immunization, assist in the delivery of services and cultivate sustainable individual and community involvement. While FLWs (ASHA, ANM and AWW) will continue to serve as primary community mobilizers for IMI 2.0, other key interventions to support this cause have been enlisted below.

a. Social Partnership for Change through celebrity engagement:

- Engage with regional/local celebrity ambassadors from the field of cinema, television, theatre, music, dance or sports to do AV spots and state-level launches

Common Advocacy Platforms	Advocacy Kit
Celebrity advocacy through events and social media handles i.e. web pages, Facebook and Twitter	IMI 2.0 Factsheets and speaker notes
One-to-one meetings	Detailed brochure (Printed Information material in English/Hindi/ Local language)
Multi-stakeholder meetings (Round-table discussion, workshop, event launch)	Power Point Presentations (PPTs)
Network meetings	Videos for group meetings
Influencer access	Customized messages
Media orientation workshop	Media reports

School Activation Plan

Activities for IMI 2.0 Buzz will be implemented from 14 – 24 November 2019.

Suggested activities for IMI 2.0 school activation plan:

- States along with partners (Lions Club, Rotary and private sector partners) need to facilitate road shows engaging radio jockeys and schools
- Press advertisements on IMI 2.0 and student's role in steering the mission to be put out in state / local news papers
- Immunization to be a theme in the model UN events in schools; government and partners to support and facilitate these events
- Flash mobs on immunization to be conducted with support of college/ schools' cultural teams at strategic sites
- Moderated Panel discussions on the TV channels on 'students' support to the Immunization program and contribution towards creating communities which are disease free'.
- Signature campaign in prominent sights: setting up photo-booths and showcasing the IMI 2.0 promotional collaterals (caps, badges, sashes, balloons)
- Selfie moment with the ''Teeko'' cut-out in prominent sights
- All schools to display the immunization IEC throughout the school activation phase.
- Advocate with local influencers and local celebrities (including sportsperson, artists etc.) to publicize and support the cause

- The audio and video spots/ bytes developed by states must effectively be used for School-based and community activities through social media channels, local cables network, cinema theatres, and regional TV/Radio channels
- Celebrated state-level musical groups, choirs, drum-beating teams to be involved to promote key messages on benefits of immunization

b. Children/Youth/Adolescents' Engagement and Empowerment:

Children, young people are the center of the school community relationship which defines the roles and responsibilities to the to-be-future-parents and leaders to adopt and maintain the positive practices on immunization. Today's children will be parents and leaders tomorrow to achieve and sustain FIC in India. Using November 14, Children's Day as an opportunity to create pre-launch buzz for IMI 2.0, the states need to implement interventions involving schools, educational and vocational institutions.

b.1. School-community based interventions:

- A School Engagement Package (SEP) for IMI 2.0 will be developed and shared with states for greater engagement of students' engagement within schools and outreach (with an adapted slum/ village/ area).

States will also receive prototypes of branded collaterals (badges, caps, sashes, posters and banners) for promotional activities through students

- Identify school nodal teachers/ staff to be oriented on the SEP. The identified nodal teachers need to coordinate, facilitate, and lead the SEP through the student council, class representatives, youth parliaments, existing MR champions, warriors and cultural committees, to educate, engage and empower their peers and family members.

Note: States need to ensure the SEP information package is provided to all identified nodal teachers)

- School outreach activities
  - Conduct house-to-house visits in identified neighborhoods to mobilize parents with 2 year-old children due for a vaccination
  - Distribute Immunization information & invitation card (to attend IMI 2.0 events and RI sessions) to parents of children below 2 years of age
  - Students to put up the drama/ skits on immunization at the local slum/ villages/identified areas
  - Support mobilization for IMI sessions
  - Conduct rallies in communities
  - Organize Quiz on immunization
  - Support mobilization for IMI sessions

b.2. Youth engagement:

IMI 2.0 will optimize engagement with a youth-based institution like NYKS/NCC/NSS/ Scouts/Guides/ youth clubs to facilitate in making IMI 2.0 as a "people's movement". These youth institutions are part of a nation-wide network of youth volunteers, present in every state /district, and are driven by the spirit of contributing to people's welfare and national development.

Youth engagement for IMI 2.0 needs to be leveraged through the following interventions:

- Orientation on IMI 2.0 and their role to be undertaken for members of the youth groups
- The representatives of youth groups to participate in the state/ district task force meetings (DTFI).
- Youth groups to support the DIO/ MOs in facilitating the head count survey.
- Undertake community cultural interventions like drum beating, miking, rallies, skits, *nukkad-nataks*, etc.
- Undertake mobilization activities with the support of local influencers

- Support local Influencers and FLWs in motivating families of drop-outs, left-outs and other resistant families; and mobilize them for Immunization at the session site.
- Coordinate with RWAs/local business houses/clubs/NGOs/ corporates to seek their support for immunization activities in urban areas.
- Support in dissemination and display of IEC materials and provide information on the importance of full immunization to the caregivers at the IMI 2.0 session.

b.3 Social Partnership for change with CSO-CBO:

States need to identify key CSOs to work with and support the government in strengthening and improving community engagement platforms during IMI 2.0. The key role of CSOs will include:

- Orient and build capacities of identified CBOs (SHG/MAS/PRI/ VHSNC) across all levels to engage and empower communities including left-out/drop-out/ resistant) with knowledge and skills on immunization.
- Support government and partners in all communication efforts during IMI 2.0
- Organize public talks, gatherings, community events to strengthen information on immunization and address rumors, myths and misinformation before, during and post sessions organized under IMI 2.0
- Set up IMI 2.0 immunization information booths/kiosks in village weekly markets (haats)/ fairs/melas/ and in identified hard to reach areas
- Promote visibility of IMI 2.0 through the strategic use of IEC materials
- Support in identifying left-out, drop-out and resistant families and conduct guided discussions to address barriers and myths related to immunization
- Organize "*Bulawa Tolis*" with the support of students/ children from the communities as advocates for immunization to mobilize families for IMI 2.0 sessions.

Note: Refer to Annexures 11 on detailed roles of mobilization partners

Community Engagement and Empowerment

Enhanced engagement of communities in planning, implementation and evaluation of healthcare services that cater to them will facilitate in developing stronger trust and ownership towards the system that offers them these services. Community engagement and empowerment will form a key pillar for making IMI 2.0 a "People's Movement" and needs to be steered through the following activities-

a. Mapping and identification of high risk, vulnerable population, and vaccine hesitant pockets

- Engage with key stakeholders to undertake preliminary assessment of socio-cultural and political contexts of affected communities to build locally acceptable interventions to decode fear and resistance
- Identify the number, role and reach of influencers to serve these

vulnerable populations

- Involve community leaders in information dissemination and in responding to rumours.

b. *Community mobilization with a focus on pregnant women and mothers in HRAs*

- Map/ update information on pregnant women and mothers of children aged 0-2 years to provide information on immunization services and building vaccine confidence.

- Undertake household visits (5-10 households to be covered by each ASHA/AWW per day) in families having children 0-2 years of age to disseminate information on immunization and address beneficiary queries

c. *Engagement and empowerment of PRI/MAS/ SHG/VHSNC*

Engagement in promotion, adoption and maintenance of positive practices in strengthening routine immunization through monthly mothers' meetings and weekly meetings with resistant mothers facilitated by FLWs with support of identified influential women.

d. *Engagement of SMNet in Uttar Pradeh and Bihar*

SMNet present in approximately 100 districts focusing to support the 458 identified high-risk blocks in both states, to facilitate communication and social mobilization interventions during IMI 2.0. as enlisted below:

- Identify left-out, dropped-out and resistant families and conduct guided discussions
- Support FLWs in conducting community mobilization/ special community meetings and create awareness to avail services at immunization sessions during IMI 2.0
- Support in organizing *Bulawa Tolis* with children in their communities to mobilize families for IMI 2.0 sessions.

Reaching out to hesitant / resistant communities during IMI 2.0

Suggested communication interventions for vaccine hesitant areas have been enlisted below for states to adopt and adapt:

- Building Vaccine Confidence by highlighting real-life experiences through parents whose children have fallen ill or suffered fatal repercussions to a vaccine-preventable disease
- Orient resistant mothers and pregnant women through mothers' meetings, house-to-house visits during immunization sessions in schools / anganwadi centers and during ANC sessions.
- Develop and disseminate WhatsApp videos with FLWs and influential community members, stimulating discussions on perceptions and risks associated with VPDs.
- Orient fathers with support of *Gram Panchayat*/ ward members on AEFI as they prohibit mothers to return to the health facility for consecutive immunization doses.
- *Gram Panchayats*/ *Gram Sabhas* need to acknowledge families who have fully vaccinated their children in prominent meetings – reviews / GP sabhas.
- Improve healthcare providers ability to make strong vaccine recommendations through training on BRIDGE

e. Engagement with key influencers at the local level:

- States need to Identify local champions/community influencers/

faith-based leaders who are popular in the region/ district to promote immunization, encouraging parents to seek services. Use audio/ video bytes of the identified local champions to mobilize communities

- Disseminate immunization messages through religious platforms eg: temples, sunday church meetings, friday prayers and announcements through their infrastructure.
- Pre-recorded appeals from the religious leaders to be played as part of miking announcements
- Monthly meetings of counsellors/ facilitators by occupational leaders (such as contractors, *munshis* for Brick Kiln, sugar cane, construction sectors)

f. Religious leaders' involvement:

- State/ districts to involve key religious leaders and ensure their active participation (dissemination of immunization messages through their platforms, participation and support for events and rallies, mobilize resistant families)

g. Convergence with other programmes within the RMNCH+A landscape to leverage visibility and acceptability of immunization services especially in HRAs:

- Mothers'/community meetings for Swacch Bharat Abhiyan may be utilized to disseminate information on immunization
- RI Counselling as part of ANCs and Family Planning counselling
- Immunization as part of the Nutrition program
- Orientation of AYUSH/private practitioners to promote RI messages

Interpersonal Communication (IPC) at Family Level

The government has invested and created cadres of FLWs and capacitated them on the use of IPC skills to deliver key health (including immunization) messages and actions driven to protect every child and every family.

- Use a pool of BRIDGE Master Trainers (MT) to build capacities of FLWs– ASHAs, AWWs, and ANMs and Link workers
- Ensure availability of communication tools and IEC (leaflet/ invitation card etc) to engage with families (especially left-out/drop-out/ resistant)
- Deploy the master trainers to provide supportive supervision and monitor mobilization activities during IMI 2.0

Media Engagement and Partnership for Social Change

Media outreach activities will be done before, during and after the IMI 2.0. The media strategy includes a comprehensive media management plan, which includes the following:

- Mass media (broadcast and print media): Maximize the reach of IMI campaign using different mass media channels
- Newspaper advertisement
- TV/Radio spots/ audio jingles on immunization to promote IMI 2.0
- Use local cable TV channels to promote IMI/ Immunization

a. IMI 2.0 Launch:

States need to ensure the following preparedness measures are undertaken prior to the campaign launch:

- Media info kit to be developed with all relevant materials on IMI 2.0
- Identify and brief guests and invitees
- Identify a suitable venue in consultation with officials concerned.
- Prepare materials for launch event from prototypes provided.
- Prepare/adapt talking points for key speakers.
- Identify the photographer and equipment required for the launch.
- Ensure availability of IEC materials for dissemination at the launch

b. Media outreach

- Conduct Media workshops on immunization IMI 2.0 and AEFI.
- Seed positive media coverages, key opinion articles by immunization experts in national and regional dailies.
- Sensitize and engage Radio Jockeys (RJs) for buzz creation interventions for IMI 2.0
- Utilize community radio to engage with communities on local issues, using locally relevant examples
- Identify and train media spokesperson (at state and district level).
- Regular monitoring of news media reports

c. IEC/ mid media and promotional materials:

IMI 2.0 communication material package contains materials for mass media, mid-media and IPC and needs to be strategically utilized throughout IMI 2.0 rollout

The package contains:

- TV spots/radio spots/ audio jingles
- Posters/Banners/hoardings
- Messages for Miking/ announcements
- Leaflets for caregivers, influencers, teachers and FLWs
- Social media package - including creatives, GIFs and audio/visual files.

Open files of these prototypes will be shared with states along with guidelines for effective use.

d.Social media

The platforms of social media - Facebook, Twitter, YouTube and WhatsApp need to be used to generate positive conversations around IMI 2.0 and amplify advocacy interventions and create buzz.

In alignment with the IMI 2.0 campaign, a new hashtag will be introduced for a social media campaign. States need to ensure that the promotional collaterals carry this hashtag.

Social media activities to be undertaken by states:

- Create a Facebook page and Twitter handle, with a dedicated staff assigned for screening and populating posts on a daily basis.
- Use What's App groups at the district and block level to share positive messages, pictures, creatives on IMI 2.

e. Documentation of IMI 2.0

States need to ensure the successes and innovations identified during IMI 2.0 are well documented in the form of best practices, human interest stories, impactful photographs, videos and write-ups.

f. Crisis and AEFI management

Campaigns due to their nature of being recognized as a mass public intervention, may give rise to rumors and misinformation (escalated through electronic / social media), hampering vaccine confidence among the community. Parents/caregivers who have inadequate awareness about immunization are prone to get influenced by them. The lessons learned from erstwhile crisis situations underscore the need for preparedness for crisis. Hence it is essential to plan and design a comprehensive crisis communication plan, prepared at the state and district level to avert or counter any adverse event or a crisis during IMI 2.0.

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

1. Training on AEFI protocol: For key implementers of IMI 2.0
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 that may or may not be associated with immunization. Hence, having a preparedness plan with the media is always useful. Therefore, states need to prepare frameworks for media briefs/ press releases need (using the templates provided in the AEFI Media Communication Protocol).

Communication Monitoring and Evaluation for IMI 2.0 Campaign:

The M&E framework supports implementing the communication plans effectively, make mid-course corrections and measure the impact of the communication interventions implemented during the campaign.

States need to identify supportive supervisors and monitors at all levels to collate findings / data through the S4i application.

As shared above, monitoring line ministries and partner engagement will be undertaken through a IMI 2.0 portal with support of NHP.

Other critical communication components of IMI 2.0 campaign monitored through the national dashboard (and S4i app.) have been enlisted in the table below

Communication Components	Indicators
Communication Planning (Annexure 13)	• Numbers of IMI districts with communication plans • Numbers of planning units with communication plans
Capacity Building	• Numbers of IMI districts completed BRIDGE trainings for FLW (ASHA, ANM and AWW)
IEC Visibility	• Numbers of IMI session sites with IEC • Numbers of parents who bring the MCP cards to the sessions
Media Engagement	• Numbers of IMI districts with media workshops organized • Numbers of districts with trained spokespersons in media handling

Roles and responsibilities in operationalizing communication at national, state and district level for IMI 2.0 and timeline for communication activities are in Annexure 14 & 15

2.3.5 Real-time recording and reporting through the portal

IMI 2.0 recording and reporting of coverage data and key dashboard indicator on immunization

Recording and reporting data of vaccination during Intensified Mission Indradhanush rounds will be done in the standardized formats on a daily basis to the next higher level. The ANM will report to the block PHC in the tally sheet for IMI manually (Annexure 15), block PHC will report to the district manually (Annexure 16). The district-level coverage data (antigen wise data and daily vaccine and diluents utilization reporting) will then be entered in the googlesheet (Annexure 17). After the entry is completed for district level, the state and national level output (key immunization coverage indicator report) will be generated automatically. The data flow for IMI 2.0 recording and reporting of coverage data and key dashboard indicator on immunization (manual and googlesheet) is illustrated in the Figure 15

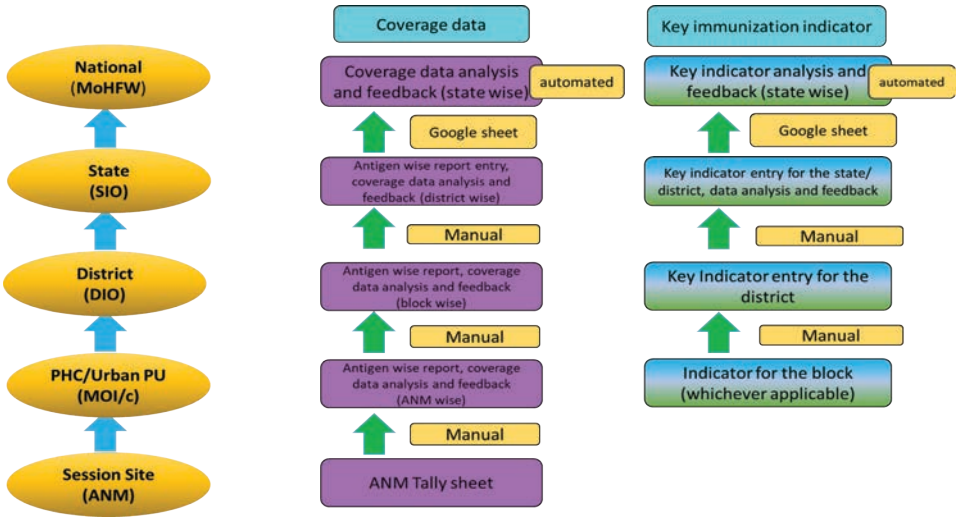


Figure 15:
IMI 2.0 data flow

A framework is developed on key indicators on program implementation, AEFI, data recording and reporting and communications (Annexure 18). These are the dashboard indicators which will help measure the broader activities including organization of STFI/ DTFI meetings, the participation of stakeholders in the meetings, AEFI meetings, microplan preparation, communication plan preparation, BRIDGE training, IEC materials display etc. These data for these indicators will be reported in the google sheet for each round or as per the frequency outlined in the framework.

IMI 2.0 PORTAL

Introduction

To manage the data reporting and analysis and to update the activities being performed by various ministries/departments, a portal (in the name of IMI 2.0) will be developed in consultation with MoHFW, immunization partners and National Health Portal. The IMI 2.0 portal will capture block-wise IMI coverage while this data will be entered at the district level. Also, activities for all the line ministries will be enumerated and reflected on the dashboard.

Development and hosting of the portal

Login credentials specific for each district will be provided with rights of data entry, editing, viewing, report and dashboard visualization. The credentials will also be provided to the state and national level users with rights of visualizing report and dashboard on immunization coverage and key indicators. The activities of the line ministries will also be entered at the district level and the ministries will be provided state and national level credentials.

Orientation on the portal

During the national, state and district level workshop, an orientation on the portal will be done and key features of the portal (including data entry, dashboard, reports) will be discussed. During the partner coordination meeting at the national level, the use and importance of the portal will be discussed. The line ministries will also be oriented on the various modules and use of the portal during the convergence meeting.

Data flow and reporting

The standardized data collection formats developed by the Government of India will be used and data entry will be done in those formats. Along similar lines, targets and achievement will need to be entered by the designated officials of the line ministries.

The State Immunization officer will be responsible to ensure data entry for immunization coverage and for coordinating the reporting of line ministries in the state. The data entry will be done as per the flow matrix in Figure 16.

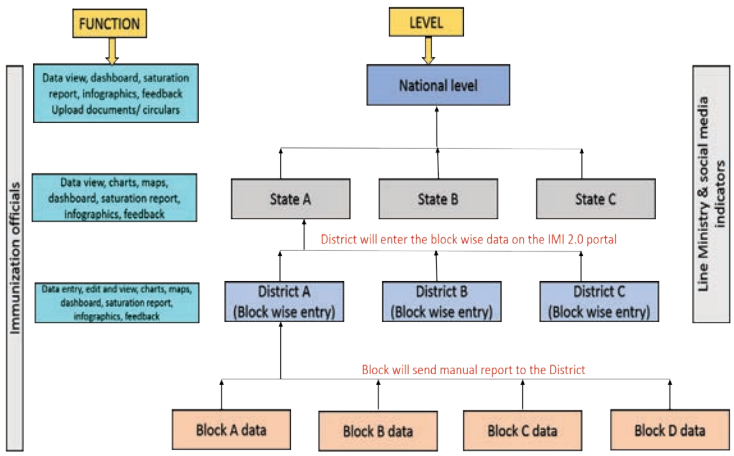


Figure 16:
IMI 2.0 Portal data flow

Features of the IMI 2.0 portal

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

Data input module

During the preparatory phase, target population of children, pregnant women and session planned will be entered block wise separately for urban and rural area (Annexure 19). This will be uploaded in the portal immediately on completion of head count survey. The portal will freeze/block the target entry a week before the start of the activity. Apart from these, coverage data and status of saturation of blocks for children and PW need to be entered block wise (Annexure 20). The portal will have options to upload images/ documents/ other resources in the field at the district level. The district immunization officer need to collate, review and ensure data uploading at the district. Similarly, the designated official for line ministry need to upload at the district. A team at the national level will screen the images and documents before uploading on the dashboard. The portal will also have key data elements to be entered by line ministries (Annexure 21). The framework for data entry for immunization and reporting by line Ministry is depicted in Annexure 21.

Output module

The performance of the activities will be extensively monitored at each level of the functions including the highest level in the Ministry at the national level.

There will be provision for generating output reports of immunization coverage data, social media indicators along with the key

indicators a of the line ministries. Dynamic reports and Info graphics, maps and charts will be included in the dashboard displaying analytical information. To have a summarized overview of the performance of all the line ministries during the IMI activity, a dashboard will be developed. The dashboard will provide simple cumulative performance through data and visual analytics with reason wherever possible to drive measures for course corrections.

All the ministries will need to ensure updation of the activities conducted for IMI on the portal. An official will be designated at each level by each ministry for reporting, data analysis and providing feedback.

The activity-wise timeline for data entry in the portal is discussed as under

S No.	Activity	Timeline
1	Target no of children, pregnant women and session	• 1 week before the start of each IMI round
2	Coverage data entry	• Coverage data for daily activity under IMI needs to be entered on the same day • Data entry will be frozen for the block by midnight daily if entry is made in any field • Under special circumstances, for blocks without data entry, the data entry will be frozen within two days of the completion of round or data entry whichever earlier
3	Saturation status	• Saturation status needs to entered for each block • Block status will be auto saturated if 100% of target achieved. • For the other blocks, saturation status entry will be frozen after two days of the completion of round.
4.	Entry of activities of Line ministry	• Entry will be frozen within seven days of the completion of round

Key pointers to be considered for reporting in the IMI 2.0 portal

a. Target to be entered before the activity
b. Block wise IMI 2.0 coverage data will be captured and data entry to be done at district level.
c. Upload images/ events.
d. Indicators for each line ministry will be reflected on the dashboard.
e. SIO to ensure data entry in the state for immunization, social media indicators and the line ministry

2.3.6 Monitoring and Evaluation

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

Self-assessment of gaps by the districts

A self-assessment check list has been shared 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.

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 November 2019. 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 the achievement of target. On the basis of assessment, a decision will be taken for IMI drive in the respective districts.

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 the 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 of 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 subcenters with the 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.

The Information generated from concurrent monitoring will be utilized at the 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.

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.
- Availability of district-level communication plans: 100%.
- Convergence with ICDS: at least 90% of the sessions.

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 April-May 2020 to assess the sustainability of the achievements of Intensified Mission Indradhanush.

2.3.7 System Strengthening Immunization Week

World Immunization week is celebrated in the last week of April every year with the aim of provide vaccines to protect people of all ages against diseases.

The theme for the year 2019 is Protected Together: Vaccines Work, and the campaign will celebrate Vaccine Heroes around the world– from parents and community members to health workers and innovators– who help ensure we are all protected through the power of vaccines. The objective for the 2019 campaign by WHO is to raise awareness about the critical importance of full immunization throughout life.

With the aim of reaching each and every child in our country, this period should be utilized for assessment of the achievements, identification of gaps and promotion of immunization activities in community. This week should be celebrated as week of vaccination awareness with focus on reviewing the progress and system strengthening.

Key Activities

To achieve and sustain the gains of IMI 2.0, health system strengthening activities are to be undertaken by the district/block/planning unit. In the longer term, it is hoped that the lessons learned from IMI will be incorporated into routine immunization program which will contribute to the overall development for reducing vaccination inequities through social change. Thus, strengthening of the system could help in increasing the immunization coverage and make the program more effective.

In 2019-20, IMI 2.0 will be held across identified districts from December 2019- March 2020. In the month of April 2020, CES will be conducted to assess the achievement of IMI 2.0. States and districts should ensure that all system strengthening activities mentioned in this guideline should be implemented by the last week of April 2020.

In the last week of April 2020 (Immunization week), the national mentors/monitors will visit the state/UT in identified districts to assess system strengthening measures such as updation of RI microplans, AVD and supervisory plan, cold chain and logistics, data recording and reporting, VPD surveillance, AEFI

State/District Immunization Officer

Critical review of microplans should be ensured prior to IMI 2.0, the review must include following points:

- 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?
- HRAs with no routine immunization service delivery included?
- Areas where VPD outbreaks reported are included;
- 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?

reporting system, Program communication and urban immunization. Communication plan for RI at every level to be assessed for its planning and implementation of planned activities and identification of further scope of activities. Also, the mentors/monitors to verify that the district gap assessment has been conducted and based on which, immunization coverage improvement plan has been developed or not.

Celebration of immunization achievements and awareness of immunization in the society at every level (block, districts and state) should be held with support and involvement of other departments like ICDS, Education, PRI. Education department can play an active role in spreading immunization awareness among students in schools and through them in the society. The students can act as Heroes of the vaccine awareness campaign during this week and afterwards also. Political leadership can take a lead in this community awareness for immunization. Other community/religious leaders, organization like IMA/IAP and NCC/ NYK and development partners like Rotary International, UNICEF, WHO and other partners in areas should play an active role and promotive role for community awareness for immunization during this Immunization Week.

A review at national/state/district/blocks should be held to assess progress on key system strengthening activities.

2.4 Steps for Roll-Out of IMI 2.0

IEC materials to be developed and displayed/ utilized for maximum visibility of the Immunization Awareness Campaign at each level. Communication activities are described in detail in the next section.

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 Program. A letter has been issued from MoHFW to all the states/ UTs. (Annexure 22, 23) Regularly scheduled meetings of all planned committees are 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

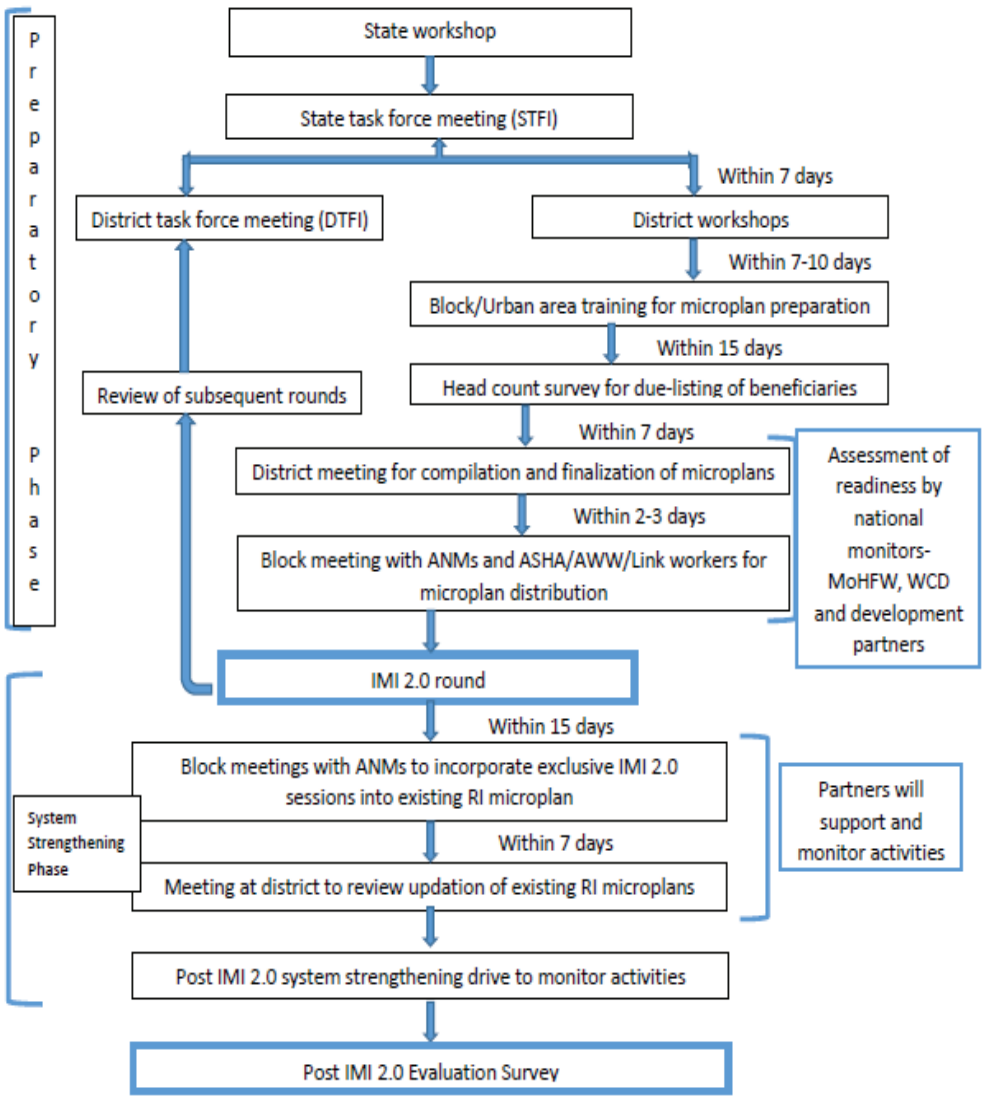


Figure 17:
Steps for roll out of training and implementation of IMI

2.5 State- Level Activities for IMI 2.0

shared with all participants timely. It should be ensured that the tasks are completed in a time bound manner to avoid any loose ends.

Review mechanism: Reviews will be conducted under "PRAGATI".

The following activities should be undertaken at the state level for the successful implementation of Intensified Mission Indradhanush 2.0:

Meeting of State Steering Committee for Immunization

The meeting of the state steering committee for immunization to be conducted ;

Chairperson: Chief Secretary

Convener: Principal Secretary (Health)

Members:

Government Departments: Health, Women and Child Development, (WCD), Panchayati Raj , Minority Affairs, Human Resource Development (HRD), Information and Broadcasting, Urban Affairs, Housing and Urban Poverty Alleviation, Defense, Home Affairs, Youth Affairs and Sports,Railways, Labour and Employment, Tribal Affairs, Rural Development, Drinking water and Sanitation and any other relevant departments.

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

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

Activities to be conducted:

- Ensure accountability framework – Regular STFI, DTFI
- Ensure active engagement of other line departments for IMI 2.0.
- Mobilize human/other resources and coordinate planning and other activities with relevant departments.
- Institute reward/recognition mechanism for the achievement of best performing district/block/ urban ward

Role of key government departments at the State level in Intensified Mission Indradhanush 2.0:

The non-health departments may identify their HR at the state level and district level that may support the IMI 2.0 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, especially in urban areas.

The detailed roles expected from other departments is given at Annexure 1.

Meeting of State Task Force for Immunization (STFI)

The task forces for immunization at the state level were constituted on the polio model to critically review the current status of routine immunization.

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

Critical activity: Intensified Mission Indradhanush 2.0 preparedness / progress review

A video conference by Principal Secretary/ Mission Director with Intensified Mission Indradhanush 2.0 districts (DM/CMO/DIO/ Urban Nodal officer/ poor 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

immunization Program performance through a detailed review of self-assessment activities, development of coverage improvement plan status and its implementation, 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.

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 the preparation phase, and once during IMI 2.0 rounds for mid-course corrections.

Review mechanism: The state task force and MoHFW will review the activity. Activities to be conducted:

- Review the status of district wise self-assessment activities, reasons of low coverage and development of coverage improvement plan
- Facilitating support in terms of HR, Funds and logistics for sustained improvement in the coverage. Review the conduct of DTFI at the district level. Involve other relevant departments including ICDS, PRI and key immunization partners such as WHO India- 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 coordination of urban health bodies, microplanning in urban areas of the district.
- Review media plan and ensure adequate number of IEC materials in local languages if required. (as per prototypes) and updated planning and reporting formats are available and disseminated to districts in time.
- 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 2.0, 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 IMI 2.0.
- 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 be the 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 of districts through supplementary PIPs:

- ◊ Mobility support to health workers/mobilizers for conducting vaccination sessions in places outside the 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 the level of frontline HW and mobilizers
- ◊ Any other support needed by the districts

- Review each round of IMI 2.0 and guide corrective actions.
- Ensure inclusion of IMI 2.0 sessions in regular routine immunization plans.
- Minutes and actions taken in the meeting should be circulated to the officials concerned and communicated to MoHFW, GoI.

State workshops and review

The objective of state workshops is to build the capacity of district officials. These workshops also aim at strengthening social mobilization among communities, and ensuring the accountability and effectiveness of government programs.

Responsibility: State Immunization Officer NPSP, UNICEF, UNDP and others

Financial support: Through the NHM

Timeline: October 2019

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-level 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 2.0, 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 RCH portal, immunization tracking bag (one per session site to be used by ASHA/AWW), use of IMI 2.0 portal
  - ◊ State health authorities and partners should intensively monitor training for quality and attendance and share findings with STFI.
  - ◊ Post the district-wise progress of training status on the website of the state health department.

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

S No.	Trainees/ Participants	Trainers/ facilitators	Duration	Timeline
1.	DIO and one MO from each district (two persons per district). Also include SMOs of WHO India NPSP, UNICEF, UNDP district coordinators and others such as state Program 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 RCH portal coordinators, IEC consultant and partners such as WHO India NPSP, UNICEF, UNDP and others	One-day workshop	October

S.No.	Trainees/ Participants	Trainers/ facilitators	Duration	Timeline
2.	Intensified Mission Indradhanush 2.0 media sensitization meeting: Workshop for sensitization of media (print/ electronic). **Financial support: NHM**	SIO with support from UNICEF,UNDP, Rotary, WHO India NPSP and other partners, state IEC consultant and media officer. Principal Secretary to the chair and MD NHM to co-chair the meeting.	Half-day workshop	At least 1 week prior to the launch
3.	Intensified Mission Indradhanush 2.0 review workshops: Review of districts to be done in between the rounds of Intensified Mission Indradhanush 2.0 by meetings/ video conferencing with DIOs. **Financial support: NHM**	SIO with support from UNICEF, UNDP, Rotary, WHO India NPSP and other partners. Principal Secretary to the 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 RCH: Reproductive and Child Health; MD NHM: Mission Director, National Health Mission; MO: Medical Officer; SIO: State Immunization Officer; SMO: Surveillance Medical Officer

2.6 District- Level Activities for IMI 2.0

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

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 Program, ensure inter-sectoral coordination, review the quality of routine immunization microplans, tracking and mobilization efforts, plan for vacant sub-centers, training status and vaccine logistics, with a special focus on high-risk areas.

Chairperson: District Magistrate

Member Secretary: DIO

Responsibility: CS/CMO

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
- Ensure identification and accountability of senior officers in the blocks and the urban cities.
- Involve other relevant departments including ICDS, PRI and key immunization partners such as WHO India NPSP, UNICEF, UNDP, Rotary International, RMNCH+A lead partners and other organizations at district levels. CSOs, including professional bodies such as IMA and IAP, should be involved. Involve the local and religious leaders.

Role of District Magistrate/District Commissioner/Municipal Commissioner in Intensified Mission Indradhanush 2.0:

District Magistrate/District Commissioner/Municipal Commissioner will lead planning, convergence with other departments, implementation and review of IMI 2.0 activities followed by integration of IMI 2.0 sessions into Routine immunization microplans for the 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 the IMI.
10. Review the performance of activities and support the 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 an adequate number of printed IEC materials (as per prototypes) and updated reporting and recording tools (MCP cards, registers, due lists, tally sheets) and disseminate to blocks/ planning units in time. Ensure that these materials are discussed and used in the sensitization workshops.
- 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 the roll-out of Intensified Mission Indradhanush 2.0, 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.
- Track blocks and urban areas for adherence to timelines.
- Communicate to Principal Secretary (Health) in case dates of Intensified Mission Indradhanush 2.0 rounds need to be changed due to exceptional circumstances.
- Review microplans to ensure engagement of all ANMs for 7 working days for IMI 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 RCH Portal data entry for each enlisted beneficiary and validated HMIS reporting by blocks/district.
- Ensure timely data entry in IMI 2.0 portal
- 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 the subcenter 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 2.0 sessions in regular routine immunization plans
- Conduct daily evening feedback meetings during the round at the district for sharing feedback and initiating corrective actions.

Critical activity: Intensified Mission Indradhanush 2.0 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.

- Minutes and action taken at each meeting should be documented and circulated to officials concerned and communicated to MoHFW, GoI

District Review Committee

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

Convener: District Immunization Officer

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

Timeframe: To meet twice each month during the IMI 2.0 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, the 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.

District workshops

The objectives of district workshops are to train block- level officers on the strategy of micro-planning for Intensified Mission Indradhanush 2.0, 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 the next table and communicate the same to the DTFI.

Technical support: Key development partners such as WHO India NPSP, UNICEF, UNDP 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 workshops.

Timeline: To be completed in October'19.

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

Review mechanism: DTFI and STFI. Activities to be conducted:

- Train block-level trainers on the use of updated planning formats for Intensified Mission Indradhanush 2.0, 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 2.0.
- Submit progress on training status of each level of functionary to the state immunization officer before the first round of the Intensified Mission Indradhanush. Repeat trainings in weak performing areas, with focus on weak performing vaccinators/mobilizers.

Details of trainings to be conducted at the district level are given in the below table

S.No.	Trainees/ Participants	Trainers/ facilitators	Duration	Timeline
1.	Two MOs per block/urban planning unit. Nominations to be forwarded to DIO. Others include district Program manager (NHM), district IEC consultant, district ASHA coordinator, district cold chain handler, district data manager, district M&E coordinator (NHM), district accounts manager (NHM) **Technical support : WHO** **Financial support: NHM**	DIO and another MO trained at the state level and partners (WHO India NPSP, UNICEF, UNDP and others	One-day workshop	October 19

S.No.	Trainees/ Participants	Trainers/ facilitators	Duration	Timeline
2.	**Program/Accounts managers (NHM)**: District and block Program and accounts managers and other officials handling NHM funds **Financial support: NHM**	DIO and trained MO, with support from district Program 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, RCH data and IMI portal) per district/block/planning unit **Financial support: NHM**	DIO and other MO trained at the state level. District M&E Coordinator (NHM) and partners (WHO India NPSP, UNICEF, UNDP 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, UNDP 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, UNDP, 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

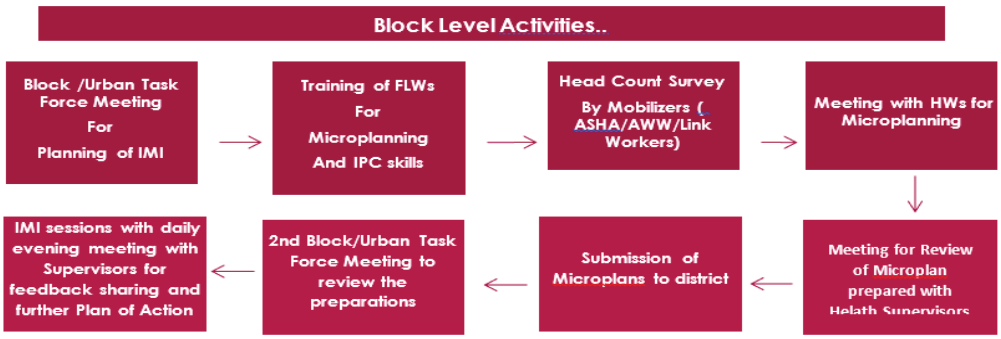
ASHA: Accredited Social Health Activist; DIO: District Immunization Officer; HMIS: Health Management Information System; IEC: Information, Education And Communication; RCH: Reproductive and Child Health, NHM: National Health Mission

Note: Refer to Annexures 24 A, 24 B, 24 C and 24 D for agenda for trainers at Serials 1, 2, 3 and 4, respectively.

2.7 Block- Level Activities for IMI 2.0

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

- Identification of Supervisors in block / Planning Unit: Supervisory manpower to be identified with clear cut roles and responsibilities with fixed accountability for IMI activities.
- Proper documentation of meetings/ workshops/ training/ supervison to be maintained at the block.
- Microplan including Communication plan as per the prescribed formats.
- Monitoring of Communication activities with proper documentation
- Daily evening review meeting during IMI for timely action for improvement of IMI activities



Details of trainings to be conducted at the Block level are given in the table below;

S.No.	Trainees/ Participants	Trainers/ facilitators	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 the 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 November 2019

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 25E and 25F 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.

2.8 Urban Activities for IMI 2.0

For large urban areas, Urban /Corporation Task Force will hold meetings as done by BTF in Blocks in rural areas

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 oversee 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.

2.9 Role of other Line Ministries and Departments

S. No.	Ministry/Department	Expected Areas of Support
1	Ministry of Defence	• Support in provision of immunization services in cantonment areas. • Support the border districts for delivery of vaccines in hard to reach areas. • involvement of NCC for: – Generating awareness on immunization. – Support in social mobilization. – Mobilizing families resistant/reluctant for vaccination
2	Ministry of Drinking Water & sanitation	• Involvement of Swachhagrahis for informing, communicating and mobilizing the community for availing vaccination services.
3	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 the border districts for delivery of vaccines in hard to reach areas.
4	Ministry of Human Resources & Development	• Convergence with health department to generate awareness about immunization through school curriculum/extra-curricular activities during the planning phase of Intensified Mission Indradhanush. • Active involvement of school children in mobilizing the community during the campaign
5	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.
6	Ministry of Information & Broadcasting	• Involvement of MoIB 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
7	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.
8	Ministry of Minority Affairs	• Generating awareness on immunization among minority communities and ensuring their mobilization to ensure full coverage of all children. • Inclusion of immunization details in the pre-matric scholarship forms. • Involvement of religious leaders in giving message on importance of immunization

S. No.	Ministry/Department	Expected Areas of Support
9	Ministry of Panchayati Raj	• Nomination of Panchayat secretary as nodal person for community mobilization and engagement with Self Help Groups for IMI 2.0. • Support community meetings for awareness on importance of immunization with involvement of the Panchayats and Self Help Groups. • Proactive involvement of Gram sabhas for IEC activities and social mobilization of the community for availing vaccination services. • Co-ordination with and supporting health department in mobilization of beneficiaries and influencing the resistant families. • Review of RI activities during Gram Sabha & Zila Parishads meetings
10	Ministry of Railways	• Utilization of spots on trains & railway stations etc. for immunization related messages. • Provision of immunization services through railway hospitals and dispensaries in areas of railway colonies and adjoining areas.
11	Ministry of Rural Development	• Active engagement of Self Help Groups under NRLM in coordination with Health department for reaching and mobilizing vulnerable communities for availing vaccination services. • Utilizing the platform of NRLM for establishing linkages between PRIs and Community Based Organization (CBOs) for effective implementation of vaccination drives.
12	Ministry of Tribal affairs	• Support the communication plan developed as a part of the Tribal Immunization strategy in selected states. • Involvement of states and district level Tribal Welfare offices for improving immunization reach specially to vaccine hesitant communities
13	Ministry of Urban Development	• Complete support of urban local bodies to support immunization. • Oversight and review by Municipal Commissioners of the Intensified Mission Indradhanush in their respective areas. • Specific directions to big municipal corporations for involvement in the campaign. • Identification of nodal persons from urban local bodies for convergence with health department for immunization. • Involvement of Self Help Groups and local CSOs in the urban areas
14	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 • Mobilizing the pregnant women and children for vaccination • Monitoring of AWWs by CDPOs and DPOs.
15	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. • Mobilizing families resistant/reluctant for vaccination.

2.10 Role of Partners

The technical and monitoring support of partner agencies such as WHO, UNICEF, UNDP, 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.
- Strategic communication unit of ITSU will take a lead on communication plan activities. ITSU will formalise the communication plan with inputs and support from UNICEF, 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 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 should be identified from medical colleges and trained to create a pool of master trainers for conducting MO and Health worker trainings.
- The trained staff from Nursing colleges/ ANM training centers should be engaged to support immunization sessions where required.
- 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. Any funding support if required should be projected in the PIP.

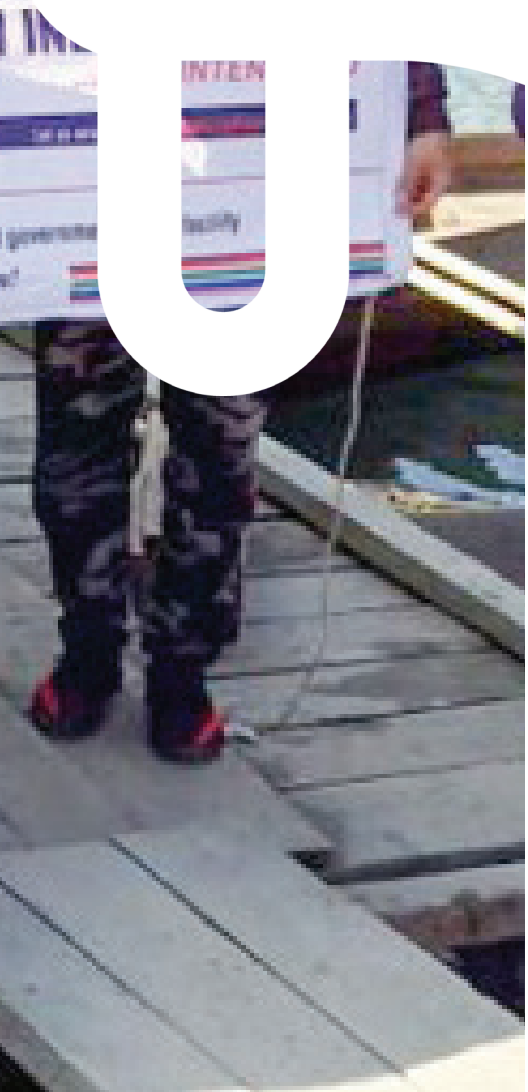
2.11 Appreciation & Awards in IMI 2.0

In efforts to recognize the exemplary immunization coverage performance at all levels of governance, an appreciation and award mechanism will be established at the Gram Panchayat level to recognize and felicitate fully immunized model panchayats, followed by the Block, District and State level during IMI 2.0. Besides coverage, key performance indicators will include robust communication and social mobilization interventions led by influencers, mothers & community meetings, rallies/ drives, and innovative use of print, mass, social media & other IEC methods.

The below table details the criterion (performance target), source of data validation and felicitation recipient at all levels for IMI 2.0:

Level	Award criterion	Team members	Source of data validation	Felicitation officer
Panchayat	**All children either fully immunized or age appropriately immunized. These Panchayats will be felicitated as "Child-friendly" or "Full-immunized" Panchayats.**	ANM, ASHA and AWW and Panchayat members	HMIS/RCH portal	DM/ CMHO
Block	**Blocks with more than 80% Child-friendly Panchayats**	Block members and MOiC	HMIS/RCH portal	DM/ CMHO
District	**Full Immunization coverage more than 90%** or **More than 30% increase in FIC as compared to NFHS-4**	DM/DIO/ CMHO	• NFHS-4/NFHS-5/IMI 2.0 survey • Innovative communication achievements	Health Minister, Principal Secretary-Health, Mission Director (NHM)
State	**Maximum districts with more than 30% increase in FIC as compared to NFHS-4** **or** **Maximum districts with more than 90% FIC** **or** **State total FIC more than 90%**	Principal Secretary-Health, Mission Director, SEPIO	• NFHS-4/ NFHS-5/IMI 2.0 survey • Innovative communication achievements	MoHFW


AMBU LANCE
MISSION



OBJECTIVE 3

COMMUNICATION STRATEGY FOR THE UIP

- 3.1 Advocacy through collaborations
- 3.2 Social mobilization for routine immunization
- 3.3 Community engagement and empowerment
- 3.4 Capacity Building for RI Communication
- 3.5 Communication to address Vaccine Hesitancy
- 3.6 Media Engagement
- 3.7 Communication Monitoring
- 3.8 Building Partnership for UIP

COMMUNICATION STRATEGIES FOR UIP

The immunization landscape of the country is dynamic and rapidly evolving with the introduction of new vaccines and inclusion of new approaches to enhance the provision of quality services which deliver them. Government of India's Universal Immunization Program (UIP) has reached 62 percent (NFHS 4 2015-16) coverage. However, a large proportion of children are still missing their vaccine doses due to demand side issues. Almost 35 percent of parents are not aware of immunization benefits, 26 percent drop out due to fear of side effects or adverse events following immunization (AEFI) and another 13 percent are "missed" because children were not available at home to receive services.

The recently released national vision documents, the comprehensive multiyear plan (cMYP) (2018-2022) and the MoHFW's Immunization Road Map[3] emphasize the need to focus on strategic communication to build vaccine confidence, strengthen demand generation and expand and institutionalize partner support for greater accountability.

The communication activities carried out under UIP need to build on the learnings from the successful implementation of communication strategies from polio eradication efforts, MI, IMI and Measles-Rubella (MR) campaigns. Key interventions guiding the UIP communication strategies have been outlined in the sections below.

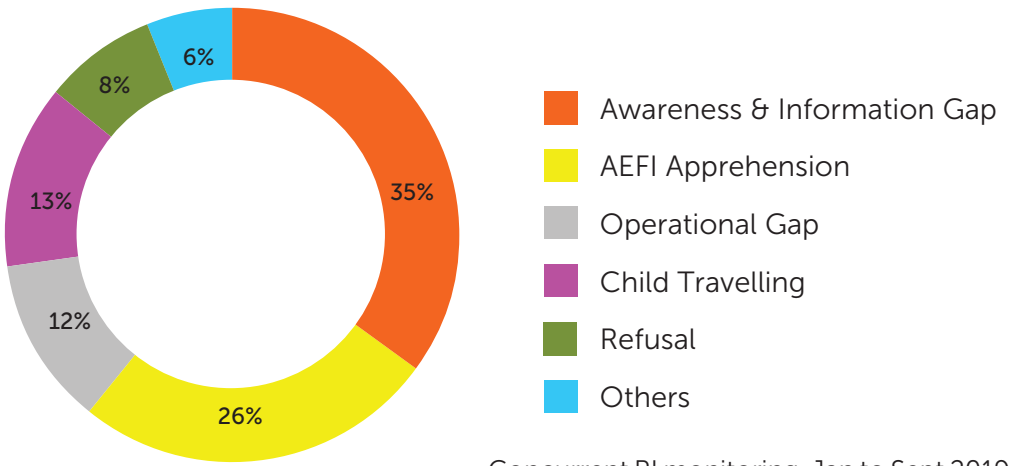


Figure 18: Reasons for missing vaccine doses

Concurrent RI monitoring, Jan to Sept 2019

PROGRAM GOAL:

- Reduce under-5 mortality and morbidity related to vaccine-preventable-disease through uptake of high-quality immunization services

OVERALL COMMUNICATION OBJECTIVES:

- Increase awareness and knowledge of parents/caregivers and families on the benefits and value of immunization
- Improve interpersonal skills of health care providers particularly the frontline workers
- Increase demand for quality immunization/health services

Promote positive social norms on routine immunization

[3]Road Map for achieving 90% full immunization coverage in India and by December 2018 and sustaining thereafter

KEY PARTICIPANT GROUP:

Primary	Parents, caregivers and other influential family members (husbands / fathers, grand-parents, mother-in-laws, father-in-laws, siblings and others)
Secondary	AWW, ASHA, ANM and other health service providers (including doctors and Ayush doctors), government / community / traditional / religious leaders, NGO and civil society organization (CSO) partners, medical students and interns, school teachers, local media and youth organizations
Tertiary	Line departments, international organizations and donors, national networks, professional bodies/coalitions, and national media

STRATEGIC APPROACHES

Based on the learnings of the previous national immunization campaigns, five strategic interventions have been tailored to complement the national vision of addressing the social and behavioural barriers to immunization uptake.

3.1 ADVOCACY

Successful advocacy efforts during the polio campaign, MI and IMI brought together multiple voices of 'advocates' and 'influencers' and created allies to steer the cause of attaining the national immunization coverage goal. States need to implement the following critical interventions to garner support for UIP.

- **Sustaining and Building on Inter-ministerial Partnerships**: Continuing with IMI 2.0's momentum, states need to sustain and build on key partnerships to foster a greater sense of co-ownership and joint accountability.

Of the 15 line ministries and departments who will collaborate and steer IMI 2.0 campaign, six key line ministries will further support in strengthening UIP interventions namely, Ministry of Education, Ministry of Urban Affairs, Ministry of Tribal Affairs, Ministry of Minority Affairs, Ministry of Women and Child Development and Ministry of Information and Broadcasting (through Directorate of Field Publicity). These ministries through their national/state departments need to continue to extend support RI interventions through their networks.

- **Continued advocacy with Medical Colleges and Nursing Schools**: Medical colleges and nursing schools are a vital resource bank to identify and train a competent pool of master trainers to support immunization advocacy, mobilization and service delivery interventions, especially in urban, hard to reach and vaccine hesitant pockets. States must leverage engagement with the master trainers utilized during IMI 2.0, for capacity building in immunization based on a cascade model.

Note: States need to ensure the availability of communication tools for RI with medical colleges and nursing schools to support advocacy interventions.

Identified trainers from medical colleges and nursing schools need to be utilized for:

- Supporting FLW to sensitize communities during house to house visits, community meetings
- Mobilize communities at the RI session site and support sessions where ANMs are required
- Facilitate sessions in RWAs, schools and other institutions on the importance of RI using communication material on Immunization
- Serve as AEFI committee members

- **Leverage Public-Private-Partnerships**: Advocacy and engagement with private sector partners must be built beyond campaigns. States need to advocate with key corporate players to position immunization and health as a key priority for CSR engagement.
- **Media's role in positioning and securing confidence around RI**: States need to ensure sustained dialogue and engagement with key media channels within the print/ mass/social media landscape to ensure RI message dissemination (through positive stories, opinion articles and programs) is acknowledged and forms part of the routine media intervention.

3.2 SOCIAL MOBILIZATION

Social mobilization as a strategy under RI will facilitate to bring together a diverse range of stakeholders to create an enabling environment for parents, caregivers and the community at large, and make informed decisions related to immunization. While frontline workers will take the lead on mobilization efforts, states need to ensure the engagement of other key partners to expand and further strengthen UIP interventions.

Note: Refer to Annexure 11 for list of key social mobilization partners

Key social mobilization interventions under UIP needs to focus on the following:

Make vaccines more accessible to adolescents by strengthening school-based immunization interventions. Offering immunization in the school setting is an opportunity to provide legitimate vaccine education and boost immunization rates by taking the vaccines directly to the children.

States need to **leverage the school health platforms** to disseminate immunization information/ services and support positive decision making and actions with regard to immunization among children and adolescents.

Enhanced engagement of children and adolescents through school-based interventions on RI

School activities such as immunization quizzes, debate and art competitions and utilizing the morning prayer meets need to be utilized as platforms to mobilize students and disseminate information on the benefits of immunization

Strengthen school community interphase through outreach visits and *Bulawa Toli*. States need to continue with the school outreach interventions undertaken during IMI 2.0 which includes awareness generation through immunization advocates (students) and community mobilization through *Bulwala Toli*'s prior to rollout of RI sessions in urban slums, migrant pockets and villages.

School Community interphase through outreach interventions and *Bulawa Toli*

Identify and optimize engagement of youth advocates who champion the IMI 2.0 mission and cause to further support mobilization

interventions in hard to reach urban and rural pockets and in hesitant/ resistant areas.

Gaining CSO-CBO support to ensure last mile reach: Key identified CSOs who have been instrumental during IMI 2.0 must further capacitate local CBOs (SHGs/ MAS/ PRI) to strengthen and improve the RI engagement platforms. Enhanced CSO engagement will also facilitate **to address rumors, misinformation and counter incorrect stories** on immunization. Utilize NGOs and CSOs support to implement state-level strategies for targeting low immunization coverage. In addition, CBOs such as self-help groups (SHGs), *Mahila Arogya Samitis* (MAS), Village Health Sanitation and Nutrition Committee (VHSNCs) and *Panchayati Raj* Institutions (PRIs) have a significant local presence and role, which needs to be utilized for building partnerships and to LODOR communities.

Other key social mobilization partnerships to be leveraged for strengthening RI:

- **Involve Red Cross and Red Crescent members and volunteers** through their state chapters
- **Where available, involve nodal representative from Forest Protection Committees** to support interventions in tribal areas
- **Engage with private sector partners** to support funding needs, provision of in-kind donations or other resources related to RI communication
- **Explore social media and social accountability mechanisms** (Whatsapp, U-Report) to reach adolescents, youths, frontline workers and communities to reinforce the key messages.

Refer to Annexure 11 for partnership support by key stakeholders

3.3 COMMUNITY ENGAGEMENT AND EMPOWERMENT

Participatory engagement of communities can address demand-side barriers while also mobilizing the community to advocate for better immunization service delivery. The role of partners in strengthening RI interventions through community engagement and empowerment will include (but not be limited to):

- Enhancing engagement with hard to reach communities identified for IMI 2.0, through their information networks. e.g - hard to reach areas, high risk, mobile/ migrant population, communities and children in brick kiln and construction sites through their contractors, *Munshis* and *Sardars*.

Community Puppet show to steer demand generation for immunization

- Increasing demand for immunization through counselling
- Integrating information on immunization as part of community activities / events (such as mic announcements, role-plays and skits

Mosque announcements on RI

Key interventions for states to implement under this strategy include:

- **Community mobilization with focus on pregnant women and mothers in HRAs** that includes updating information on pregnant women and mothers of children aged 0-2 years and undertaking household visits (**5-10 households to be covered by each ASHA/AWW per day**) in families having children aged 0-2 years

of age to disseminate information on immunization and address queries/ myths

- **Continued engagement and empowerment of PRI/MAS/ SHG/VHSNC** in promotion, adoption and maintenance of positive practices in strengthening routine immunization through **monthly mothers' meetings facilitated by ASHA and AWW with the support of identified influential women** from the community
- **Continued engagement and support of SMNet in Uttar Pradesh and Bihar** to facilitate communication and social mobilization interventions in RI
- **Amplify engagement with key community and religious influencers at the local level**: Capitalizing the trust earned during IMI 2.0 and previous immunization campaigns, advocacy with community influencers and faith-based leaders must further be utilized into building sustainable demand generation systems.

States need to ensure the **continued engagement and support of local influencers as advocates for immunization** in public forums, meetings and events and utilize religious sites (temples/ mosques/ churches) to **undertake announcements in support of immunization during RI sessions**. **Amplify convergence opportunities utilized during IMI 2.0** and explore new avenues of partnership within the RMNCH+A landscape to leverage visibility and acceptability of immunization.

Support from Gram Sabha for organizing session site

- Provide a suitable place for session site
- Ensure session site is a covered space to protect vaccines from direct sunlight
- Provide basic amenities like chairs, tables, drinking water and hand-washing facility
- Display IEC at schools, anganwadi centers, Panchayat Ghar, session site and community hall
- Display signage at prominent places (bus stand, religious sites and local markets)

3.4 INSTITUTIONALIZING CAPACITY BUILDING FOR RI COMMUNICATION

Capacity building for RI communication includes building on the knowledge and skills of Health Service Providers (HSPs) and FLWs to effectively engage with families and communities on issues regarding child health and immunization, deliver key messages, mitigate fears and engage with influencers for reaching out to resistant/ hesitant families.

In order to ensure that a capacitated and well-oriented health workforce forms the backbone of effective RI communication interventions, states need to implement the following activities:

- Institutionalize BRIDGE (Boosting Routine Immunization Demand Generation) training in the existing resource institutions (NHSRC/SHSRC/ NIHFW/SIHFW/ANMTCs) and plan for refresher trainings
- Undertake communication orientation / workshops to build capacities of the Immunization Program managers and IEC/Communication staff on a quarterly / bi-annual basis.
- Monitor institution strengthening initiatives undertaken by state master trainers (trained under BRIDGE during IMI 2.0)
- Utilize the state master trainers to provide supervision and monitoring support before, during and after RI sessions and new vaccine introduction with a focus on hard-to-reach and resistant pockets

3.5 ADDRESSING VACCINE HESITANCY

States need to leverage the learnings of IMI 2.0 as an opportunity to solidify support

for strengthening the communication interventions for RI among parents, community groups, media, and political leaders in vaccine resistant / hesitant areas.

Local administration with support from partner agencies may undertake a route cause analysis of key determinants in areas with low-coverage/ VPD outbreaks, perceived to be vaccine hesitant / resistant and determine key strategies / interventions to address and counter the same.

Suggested communication interventions in vaccine hesitant areas have been enlisted below for states to adopt and adapt:

- Building Vaccine Confidence
  - An effective means to garner trust and confidence will be to highlight real-life experiences through parents whose children have fallen ill or suffered fatal repercussions to a vaccine-preventable disease.
  - ANM/ASHA/AWWs need to orient resistant mothers and pregnant women through mothers' meetings, house-to-house visits during RI sessions in schools/ *anganwadi* centers and during ANC sessions.
  - States need to develop and disseminate and refer to the mobile-clips with FLWs through WhatsApp, to stimulate discussions on perceptions and risks associated with VPDs.
  - *Gram panchayat*/ ward members with the support of FLWs need to orient fathers on AEFI as they prohibit mothers to return to the health facility for consecutive immunization doses.
  - *Gram Panchayats*/*Gram Sabhas* need to acknowledge families who have fully vaccinated their children in prominent meetings – reviews / *GP sabhas*.
- Improve healthcare providers ability to make strong vaccine recommendations:
  - Capacity building of FLWs will play a critical role in encouraging parents and care-givers to ensure children are available or are brought for immunization services and increase engagement with communities or groups who may be reluctant.
  - FLWs orientation need to emphasize the importance of follow-up visit post day of immunization of pregnant women and infants and counselling and management in the advent of an adverse event.
- Engage with local leaders and community influencers to identify, monitor and gauge threat or risk in vaccine hesitant areas

Involving community influensers

Engaging local leaders

3.6 MEDIA ENGAGEMENT

Media outreach activities need to be on-going to support RI intensification efforts and will include:

3.6.1. Media Advocacy

- States/districts need to develop and maintain a database of journalists (including both print and electronic) covering health issues and their contacts.

- Organize quarterly state/district level media workshops/briefings to sensitize the media on immunization and new vaccines under UIP.
- Seed positive media coverages, key opinion articles by immunization experts in regional dailies.
- Provide opportunities for field visits and hold regular updates and briefings for media workers.
- Organize a 'Critical Appraisal Skills' (CAS) course for health journalists at the state and district level for entry and mid-level health reporters to enhance capacities to generate factual and non-sensational reports.
- Sensitize and engage Radio Jockeys (RJs) to advocate for benefits of immunization during radio shows and events
- Ensure media spokespersons are identified and trained
- Monitor news media reports using free online tools like Google Alerts.

3.6.2. Mass Media

States need to set aside specific funds in PIP for immunization for mass media activities

- TV and Radio – Ensure free airtime to run spots, advertising on immunization during primetime; re-broadcast national programs. Organize immunization talk shows
- Print – Publish immunization stories and activities from states and districts state-level print media. Print open editorials, positive coverage on immunization, and press advertisements on special days and campaigns.
- Outdoor Advertising through hoarding, bus panels, posters, wall paintings

Community radios: Broadcast locally relevant stories of positive deviants. Engage state artists as ambassadors to create and perform entertaining immunization content.

3.6.3. IEC/ mid media and promotional materials:

Open files of RI Communication media package with prototypes are shared with states along with guidelines for effective use. States need to prepare a UIP IEC dissemination plan and ensure the availability of all print and audio-visual material at prominent places

3.6.4. Social media

Social media platforms of i.e. Facebook, Twitter, YouTube and WhatsApp should be used to generate positive conversations around the benefits of immunization. States must also share documented success stories of IMI 2.0 to advocate for sustained efforts directed towards RI.

Key points to note:

- States must tag @vaccinate4life in all their RI posts. Other recommended handles: @MoHFW_INDIA, @UNICEFIndia, @WHO, @drharshvardhan, @AshwiniKChoubey, @WHOSEARO, @Gavi, @ForChildHealth, @PMOIndia
- Follow the national RI handle/page on Twitter and Facebook i.e. Vaccinate4life
- Activate WhatsApp groups to share regular updates
- Make use of materials developed by the MoHFW (such as the digital campaign for social media as part of the RI Communication Kit).
- Social media package on RI will include the creatives, GIFs and audio/visual files.
- Document the success stories, innovative approaches, best practices, through photography, videography and write-ups

3.6.5. Crisis and AEFI Management:

- A crisis in immunization may escalate to rumors (through word of mouth or through social media) and threaten vaccine confidence among the community. Therefore, states need to ensure the development and availability of a comprehensive crisis communication plan.

Crisis preparedness will include:

- Roles and responsibilities: Who will do what in details during a crisis
- Orient the health officials on anticipated on the crisis during RI
- Training on the AEFI protocol for all key implementers.
- Orient state/district level media spokespersons
- Prepare key messages on RI based on available FAQ's
- Be alert and closely monitor the media
- Have a well-coordinated internal communication channel to counter any negative communication by conveying it to appropriate authorities to take immediate action.
- Ensure prompt and timely response to the crisis using the AEFI media protocol.
- Ensure strong media relations, and sensitize media on the impact of negative media reporting
- Keep a media kit ready with press release, FAQ's and media briefs.

3.7 COMMUNICATION MONITORING

Strengthening communication monitoring and evaluation of interventions under routine immunization will be critical to sustaining the gains of IMI 2.0. Key performance indicators for strengthening RI communication activities have been enlisted below

Monitoring Components	Key Indicators
Communication planning	• Number of districts with communication plans
Institutionalizing capacity building for RI	• Number of states where 80% of health HR are trained on BCC and strategic communication • Number of ASHAs / ANMs / AWWs trained on BRIDGE • Number of sessions where 4 key messages are given by ANM • Number of ANMs asking caregivers to wait with the child for 30 minutes following vaccination
Strengthen IEC visibility	• Number of RI session sites with IEC visibility (posters, banners, wall writings etc.)
Enhanced awareness of Immunization among caregivers	• Number of caregivers who received the 4 key messages and who have carried the MCP card to session sites
Organize Media workshops	• Number of State / Districts with media workshops held
Strengthen Advocacy for RI	• Number of policy makers who attended immunization events in the state/ districts • Number of influencers who supported with statements, messages during crisis
Strengthen Social mobilization	• Number of partners engaged in school / community-based mobilization for RI sessions and activities / workshops / events • Number of action plans implemented and monitored by partners on immunization
Community engagement and empowerment	• Number of caregivers/ families visited by the community leaders/ partners to mobilize for immunization sessions • Number of community activities organized by the frontline workers
Addressing Vaccine Hesitancy	• Number of PRI/ SHG/ CBO/ religious leaders engaged in the mobilization for RI in vaccine hesitant areas • Number of identified hesitant families who have opted for immunization • Number of community activities (like mothers 'meetings) held in vaccine hesitant areas

The S4i tool needs to be utilized by states and monitored through designated state / district IEC official, DPM, BPM and health supervisors.

A detailed framework comprising of measurable indicators has been developed for rigorous monitoring of RI interventions.

Reviewing Results:

Review and assessment of results related to the use of strategic communication work needs to be undertaken at the end of the three-year strategy period (or during the second half of 2022). States need to also ensure that communication monitoring findings are discussed during DTFIs.

3.8 Building Partnerships for UIP

The communication strategies outlined in this document requires to build on existing and new partnership models to maximize impact to meet the desired immunization outcomes. Collective action anchored by key line-ministries, professional bodies, and other advocacy and mobilization partners (see table below) needs to be leveraged to facilitate in strengthening the government's interventions targeted towards bolstering demand generation for routine immunization.

Key Partners / Stakeholders	Objective of Partnership	How to best engage
Key line ministries: Ministry of Education, Ministry of Urban Affairs, Ministry of Tribal Affairs, Ministry of Minority Affairs, Ministry of Women and Child Development, Ministry of Panchayati Raj Institution and Ministry of Information and Broadcasting	• Facilitate dialogue • Mobilize planning	• Planning and coordination meetings • Media Bytes • Orientations and briefings
Medical fraternity from the Indian Medical Association (IMA) /Indian Academy of Paediatrics (IAP) and private medical practitioners	• Advocacy through their private networks	• Orientations and briefings • Outreach to the private sector and professional associations
Medical colleges and Nursing schools	• Awareness generation on RI and Mobilization interventions	• Support immunization sessions where additional ANMs are required • Serve as AEFI committee members • Disseminate positive messaging through their networks and social media portals
NGOs and CSOs including community and traditional leaders, and local councils	• Raise awareness and develop knowledge • Address any concerns and rumours	• Orientations and briefings • Coordination platforms • Mobilization of communities/ beneficiaries
Community Based organizations (CBOs) including Self- Help Groups, Mahila Mandals, Rogikalyan Samiti, Jeevika Group, Urban Local bodies/ VHSNC	• Awareness generation and mobilization in HRA/vaccine hesitant areas	• Supporting mapping and mobilization interventions in HRA/vaccine hesitant areas / LODOR families
Youth networks (NYKS/NCC/NSS/ Scouts/Guides/ youth clubs)	• Awareness generation and mobilization	• Support urban (outreach/ school) interventions (awareness generation and mobilization) • Undertaking headcount survey
Media	• To create a positive media landscape on immunization	• Participation in orientations, briefings and events

ANNEXURES

Annexure 1: Format for DWR Meeting Minutes

Minutes of District Weekly Review (DWR) Meeting (VPD Surveillance)					
State:			District:		
Date of DWR meeting:					
Review conducted for week no:					
Meeting chaired by:			Designation:		
Sr. No.	Name		Designation		Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
Follow up of decisions taken in last DWR meeting:					
Name of system	No. of weekly reports expected	No. of weekly reports received	Name of reporting sites from where weekly report not received		
WHO-NPSP Case based surveillance					
IDSP					
Reporting by		Suspected Measles	AFP	Suspected Diphtheria	Suspected Pertussis
Through IDSP					
Through WHO-NPSP Case based Surveillance					
Final case count after matching the cases from two systems (remove duplicate records)					
*Final: (to be filled in D001 and district level P form)					
*NOTE: Match the cases reported through both systems and come at the final number of case/s; check that filled CIF available at DIO/SMO office for cases reported through both system					

MEASLES-RUBELLA OUTBREAK SURVEILLANCE:			
Review the last 4 weekly reports for flagging of any suspected outbreak			
OBSERVATIONS:		ACTIONS TAKEN:	
Issues	Outbreak IDs	Block	Action taken
Outbreak pending for Preliminary Investigation (after 48 hrs. of notification)			
Outbreak pending for Detailed Investigation (after 48 hrs. of preliminary investigation)			
Outbreak pending for sample collection			

VPD SURVEILLANCE (Source: Case Based Surveillance _ WHO-NPSP)				
1. Measles - Rubella Surveillance:				
Suspected cases / death	*Cases reported	Cases investigated using CIF within 48 hrs. of notification	Sample collection	ACS in neighborhood
Measles / Rubella				
Observations:				

2. AFP Surveillance:					
Disease	Cases reported	Cases investigated using CIF within 48 hrs. of notification	Sample collection	ACS in community	Remark
AFP Cases					

3. VPD Surveillance: (Applicable to states with case-based VPD Surveillance)					
Disease	Cases reported	Cases investigated using CIF within 48 hrs. of notification	Sample collection	Public health response	Remark
Diphtheria					
Pertussis					
Neonatal Tetanus					

Annexure 2: Lists of District and Blocks for IMI 2.0

List of districts and blocks for IMI 2.0					
S. No.	State Name	No.	District Name		
1	Andhra Pradesh	3	Vishakhapatnam	Vizianagaram	YSR(Cuddapah)
2	Arunachal Pradesh	16	Anjaw	Lower DibangValley	Tirap
			Dibang Valley	Lower Subansiri	Upper Subansiri
			East Kameng	Namsai	West Kameng
			KraDaadi	Papum Pare	West Siang
			Lohit	Siang	
			Longding	Tawang	
3	Assam	18	Baksa	Dibrugarh	Nagaon
			Barpeta	Goalpara	DimaHasao
			Bongaigaon	Golaghat	Sibsagar
			Darrang	Hailakandi	Sonitpur
			Dhemaji	Karimganj	Tinsukia
			Dhubri	Kokrajhar	Udalguri
4	Chhattisgarh	7	Bastar	Korba	Sukuma
			Dantewadha	Mahasammund	
			Kondagaon	Narayanpur	
5	Dadra & Nagar Haveli	1	Dadra And Nagar Haveli		
6	Delhi	1	North East		
7	Gujarat	23	Ahmedabad	Junagadh	Rajkot
			Amreli	Kachchh	SabarKantha
			Anand	Mahesana	Surat
			Bharuch	Morbi	Surendranagar
			Dahod	Narmada	Tapi
			DevbhumiDwarka	Navsari	Vadodara
			GirSomnath	Patan	Valsad
			Jamnagar	Porbandar	
8	Haryana	2	Mewat	Palwal	
9	Himachal Pr	1	Chamba		
10	Jammu And Kashmir	2	Baramula	Kupwara	
11	Jharkhand	24	Bokaro	Gumla	Palamu
			Chatra	Hazaribagh	Pashchimi Singhbhum
			Deoghar	Jamtara	PurbiSinghbhum
			Dhanbad	Khunti	Ramgarh
			Dumka	Kodarma	Ranchi
			Garhwa	Latehar	Sahibganj
			Giridih	Lohardaga	Saraikela
			Godda	Pakur	Simdega
			Chamrajnagar	Dharwad	Shimoga

List of districts and blocks for IMI 2.0					
S. No.	State Name	No.	District Name		
12	Karnataka	19	Bangalore Rural	Dharwad	Ramanagar
			Chamrajnagar	Hassan	Shimoga
			Chikkaballapur	Kodagu	Tumkur
			Chikmagalur	Mandya	Udupi
			Chitradurga	Mysore	Uttara Kannada
			Dakshina Kannada	Raichur	Yadgir
			Davanagere		
13	Kerala	2	Kozhikkode	Wayanad	
14	Madhya Pradesh	43	Agar Malwa	Dindori	Neemuch
			Alirajpur	Guna	Rajgarh
			Anuppur	Gwalior	Satna
			Balaghat	Harda	Sehore
			Barwani	Hoshangabad	Seoni
			Betul	Indore	Shahdol
			Bhind	Jabalpur	Shajapur
			Bhopal	Jhabua	Sheopur
			Burhanpur	Katni	Sidhi
			Chhatarpur	Khandwa	Singroli
			Chhindwada	Khargone	Tikamgarh
			Damoh	Mandla	Ujjain
			Datia	Mandsaur	Vidisha
			Dewas	Morena	
			Dhar	Narsinghpur	
15	Maharashtra	26	Ahmadnagar	Jalgaon	Raigarh
			Akola	Jalna	Ratnagiri
			Amravati	Latur	Satara
			Aurangabad	Brihan Mumbai	Sindhudurg
			Bid	Nandurbar	Solapur
			Buldana	Nashik	Thane
			Chandrapur	Osmanabad	Wardha
			Gondiya	Palghar	Washim
			Hingoli	Parbhani	
16	Manipur	2	Tamenglong	Chandel	
17	Meghalaya	7	East Garo Hills	RiBhoi	West Khasi Hills
			East Khasi Hills	South West Khasi Hills	
			North Garo Hills	West Garo Hills	
18	Mizoram	5	Champhai	Lawngtlai	Mamit
			Kolasib	Lunglei	

List of districts and blocks for IMI 2.0					
S. No.	State Name	No.	District Name		
19	Nagaland	8	Kiphire	Phek	Wokha
			Longleng	Peren	Zunheboto
			Mon	Tuensang	
20	Odisha	5	Gajapati	Koraput	Rayagadha
			Kandhamahal	Malkangiri	
21	Punjab	1	Ferozpur		
22	Rajasthan	32	Ajmer	Dausa	Karauli
			Alwar	Dhaulpur	Kota
			Banswara	Dungarpur	Nagaur
			Baran	Ganganagar	Pali
			Barmer	Hanumangarh	Pratapgarh
			Bharatpur	Jaipur	SawaiMadhopur
			Bhilwara	Jaisalmer	Sikar
			Bikaner	Jalor	Sirohi
			Bundi	Jhalawar	Tonk
			Chittaurgarh	Jhunjhunun	Udaipur
			Churu	Jodhpur	
23	Tamil Nadu	2	Ramananthapuram	Virudhunagar	
24	Telangana	3	Bhoopalpalli	Asifabad	Khammam
25	Tripura	6	Dhalai	Khowai	Sipahijala
			Gomati	North Tripura	Unakoti
26	Uttarakhand	10	Almora	Haridwar	Udham Singh Nagar
			Chamoli	Pithoragarh	Uttarkashi
			Champawat	Rudraprayag	
			Garhwal	Tehri Garhwal	
27	West Bengal	2	Maldah	Murshidabad	

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
Bihar	ARARIA	9	ARARIA RURAL	ARARIA URBAN	BHARGAMA
			FORBESGANJ	JOKIHAT	NARPATGANJ
			PALASI	RANIGANJ	SIKTI
	ARWAL	4	ARWAL	BANSI	KARPI
			KURTHA		
	AURANGAABAD	2	AURANGABAD URBAN	HANSPURA	
	BEGUSARAI	7	BACHHWARA	BAKHRI	BARAUNI
			BEGUSARAI	BEGUSARAI URBAN	BIRPUR
			SAMHO		
	BHAGALPUR	3	BHAGALPUR URBAN	JAGDISHPUR	PIRPAINTI
	BHOJPUR	13	AGION	ARA SADAR	ARA URBAN
			BIHIYA	GARHANI	JAGDISHPUR
			KOILWAR	PEERO	SAHAR
			SANDESH	SHAHPUR	TARARI
			UDWANTNAGAR		
	CHAMPARAN EAST	16	BANJARIA	BANKATWA	CHAKIA
			CHHAURADANO	CHIRAIYA	DHAKA
			KOTWA	MADHUBAN	MOTIHARI SADAR
			MOTIHARI URBAN	PIPRA KOTHI	RAMGARHWA
			RAXAUL	SANGRAMPUR	SUGAULI
			TETARIA		
	CHAMPARAN WEST	14	BAGAHA (I and II)	BAGAHA-I	BAIRIA
			BETTIAH	BHITAHA	CHANPATIA
			JOGAPATTI	MADHUBANI	MAINATANR
			MAJHAULIA	NARKATIAGANJ	NAUTAN
			PIPRASI	SIKTA	
	DARBHANGA	11	ALINAGAR	BAHADURPUR	BAHERI
			BIRAUL	DARBHANGA	HAYAGHAT
			JALEY	KIRATPUR	KUSHESHWAR ASTHAN EAST
			MANIGACHHI	SINGHWARA	
	GAYA	7	FATEHPUR	GAYA TOWN	GURARU
			IMAMGANJ	KHIZERSARAI	MUHRA
			WAZIRGANJ		

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
Bihar	GOPALGANJ	10	BAIKUNTHPUR	BARAULI	BHOREY
			BIJAIPUR	GOPALGANJ SADAR	GOPALGANJ URBAN
			KUCHAIKOTE	PANCHDEORI	SIDHWALIA
			UCHKAGAON		
	JAMUI	4	ALIGANJ	CHAKAI	JAMUI URBAN
			JHAJHA		
	JEHANABAD	6	JEHANABAD	JEHANABAD URBAN	KAKO
			MAKHDUMPUR	OKARI	RATANI FARIDPUR
	KAIMUR	2	BHABUA RURAL	NUAN	
	KATIHAR	5	AZAMNAGAR	BARSOI	HASANGANJ
			KADWA	MANSAHI	
	KHAGARIA	1	ALAULI		
	KISHANGANJ	6	DIGHALBANK	KISHANGANJ URBAN	KOCHADHAMAN
			POTHIA	TERHAGACH	THAKURGANJ
	LAKHISARAI	1	LAKHISARAI SADAR		
	MADHEPURA	7	ALAMNAGAR	GWALPADA	MADHEPURA SADAR
			MADHEPURA URBAN	MURLIGANJ	SHANKARPUR
			UDAKISHUNGANJ		
	MADHUBANI	14	BABUBARHI	BISFI	GHOGARDIHA 1
			GHOGARDIHA 2	HARLAKHI	KHAJAULI
			KHUTAUNA	LADANIA	LAKHNAUR
			LAUKAHI	MADHEPUR	MADHUBANI URBAN
			PHULPARAS	RAJNAGAR	
	MUNGER	2	DHARHARA	TETIAH BAMBAR	
	MUZAFFARPUR	6	AURAI	BOCHAHA	KURHANI
			MUZAFFARPUR URBAN	PAROO	SAHEBGANJ
	NALANDA	2	BIHARSHARIF URBAN	ISLAMPUR	
	NAWADA	11	AKBARPUR	GOVINDPUR	HISUA
			KAUWAKOL	NARDIGANJ	NAWADA RURAL
			NAWADA URBAN	PAKRIBARAWAN	RAJOULI
			ROH	WARSALIGANJ	
	PATNA	5	BAKHTIYARPUR	BARH	DHANARUA
			FATUHA	PHULWARISHARIF	
	PURNIA	6	AMOUR	BAISA	BAISI
			DAGARWA	DHAMDAHA	PURNEA URBAN

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
Bihar	ROHTAS	4	KARAKAT	NASRIGANJ	NAWHATTA
			SASARAM URBAN		
	SAHARSA	5	BANMA	SALKHUA	SATTARKATIYA
			SIMRI BAKHTIARPUR	SONBARSA	
	SAMASTIPUR	6	BITHAN	KALYANPUR	SAMASTIPUR URBAN
			SINGHIA	TAJPUR	UJIARPUR
	SARAN	6	CHAPRA URBAN	LAHLADPUR	MANJHI
			MARHAURA	MASHRAKH	PANAPUR
	SHEIKHPURA	1	SHEIKHPURA URBAN		
	SHEOHAR	2	PIPRARHI	PURNAHIYA	
	SITAMARHI	12	BAIRGANIA	BAJPATTI	BATHNAHA
			BOKHARA	DUMRA	MAJORGANJ
			NANPUR	PARIHAR	PARSAUNI
			PUPRI	RIGA	RUNNISAIDPUR
	SIWAN	1	GORIAKOTHI		
	SUPAUL	7	BASANTPUR	CHHATAPUR	KISHANPUR
			MARAUNA	PRATAPGANJ	RAGHOPUR
			SUPAUL URBAN		
	VAISHALI	9	BHAGWANPUR	GORAUL	HAJIPUR
			HAJIPUR URBAN	MAHNAR	PATEPUR
			PATERHI BELSAR	RAGHOPUR	SAHDAI BUZURG
UTTAR PRADESH	AGRA	14	AGRA CITY	BAH	BARAULI AHEER
			BICHPURI	ETMADPUR	FATEHABAD
			FATEHPUR SIKRI	JAGNER	JAITPUR KALAN
			KHANDAULI	KHERAGARH	PINAHAT
			SAIYAN	SHAMSHABAD	
	ALIGARH	8	ATRAULI	BIJAULI	DHANIPUR
			GANGIRI	GONDA	JAWAN
			KHAIR	TAPPAL	
	ALLAHABAD	18	ALLAHABAD CITY	BAHRIA	CHAKA
			DHANUPUR	HANDIA	HOLAGARH
			JASRA	KARCHANA	KAURIHAR
			KORAON	KOTWA	MANDA
			MAUAIMA	MEJA	PHULPUR
			PRATAPPUR	RAMNAGAR	SHANKARGARH
	AMBEDKAR NAGAR	2	AKBARPUR	RAMNAGAR	
	AMETHI	11	AMETHI	BHADAR	BHETUA
			FURSATGANJ	GAURIGANJ	JAGDISHPUR
			JAMON	MUSAFIR KHANA	SHUKUL BAZAR
			SINGHPUR	TILOI	

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
UTTAR PRADESH	AMROHA	3	AMROHA	HASANPUR	REHRA
	AURAIYA	2	ACHHALDA	AIRWAKATRA	
	AZAMGARH	4	BILIRIAGANJ	MARTINGANJ	MIRZAPUR
			MOBARAKPUR		
	BADAUN	9	BILSI	BINAWAR	DEHGAWAN
			ISLAMNAGAR	JAGAT	MIAON
			QUADER CHOWK	SAHASWAN	UJHANI
	BADOHI	2	BHADOI	SURIYAWAN	
	BAGHPAT	3	BAGHPAT	BINAULI	PILANA
	BAHRAICH	14	BAHRAICH URBAN	BALHA	CHITTAURA
			FAKHARPUR	HUZOORPUR	JARWAL
			KAISARGANJ	MAHSI	MIHINPURWA
			NAWABGANJ	RISIA	SHIVPUR
			TEJWAPUR	VISHESHWARGANJ	
	BALLIA	5	BALLIA URBAN	BANSDIH	HANUMANGANJ
			MURLI CHHAPRA	RASRA	
	BALRAMPUR	5	BALRAMPUR RURAL	GAINDAS BUZURG	GAINSARI
			SHEOPURA	TULSIPUR	
	BANDA	5	BISANDA	KAMASIN	MAHUVA
			NARAINI	TINDWARI	
	BARABANKI	6	BARABANKI URBAN	FATEHPUR	GHUNGHTAIR
			RAMNAGAR	SIDHAUR	SURATGANJ
	BAREILLY	5	AONLA	FARIDPUR	KUANDANDA
			MUNDIA NABI BAKSH	SHERGARH	
	BASTI	7	BANKATI	GAUR	KUDARAHA
			MARWATIA	SALTAUA	SAUGHAT
			VIKRAMJOT		
	BIJNOR	5	BIJNOR URBAN	HALDAUR	KOTWALI (Nagina)
			NAJIBABAD	NOORPUR	
	BULANDSHAHAR	6	ANUPSHAHR	BULANDSHAHR	DEBAI
			GULAWATHI	KHURJA	SIKANDRABAD

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
UTTAR PRADESH	CHANDAULI	2	CHANDAULI	SAHABGANJ	
	CHITRAKOOT	5	KARVI	MANIKPUR	MAU
			RAMNAGAR	SHIVRAMPUR	
	DEORIA	5	BARHAJ	DEORIA URBAN	DESAHI DEORIA
			GAURI BAZAR	MAJHGAWA	
	ETAH	2	ALIGANJ	JAITHARA	
	ETAWAH	5	BASREHAR	BHARTHANA	ETAWAH
			JASWANT NAGAR	MAHEWA	
	FAIZABAD	5	BIKAPUR	KHANDASA	MAVAI
			RUDAULI	TARUN	
	FARRUKHABAD	6	FAIZBAG	FARRUKHABAD CITY	KAIAMGANJ
			KAMALGANJ	MOHAMDABAD	RAJEPUR
	FATEHPUR	9	ASOTHAR	BAHUWA	BHITAURA
			DEVMAI	FATEHPUR CITY	GOPALGANJ
			HASWA	HATHGAON	KHAJUHA
	FEROZABAD	9	ARAON	FIROZABAD	FIROZABAD URBAN
			JASRANA	KHERGARH	MADANPUR
			NARKHI	SHIKOHABAD	TUNDLA
	GAUTAM BUDH NAGAR	4	BISRAKH	DADRI	DANKAUR
			NOIDA		
	GHAZIABAD	3	BHOJPUR	GHAZIABAD URBAN	LONI
	GHAZIPUR	3	GONDAUR	MOHAMMADABAD	SAIDPUR
	GONDA	13	BABHANJOT	BELSAR	COLONELGANJ
			GONDA URBAN	HALDHARMAU	ITIYATHOK
			KATRA BAZAR	MANKAPUR	PANDARIKRIPAL
			PARASPUR	QUAZIDEWAR	RUPAIDEEH
			TARABGANJ		
	HAMIRPUR	1	DHAGWAN		
	HAPUR	4	DHAULANA	GARH MUKTESHWAR	HAPUR
			SIMBHAWALI		

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
UTTAR PRADESH	HARDOI	14	AHIROURI	BAWAN	BHARAWAN
			BHARKHANI	BILGRAM	HARDOI CITY
			HARIYAWAN	HARPALPUR	KACHOUNA
			PIHANI	SANDI	SHAHABAD
			TADIYAWAN	TONDARPUR	
	HATHRAS	4	HATHRAS	MAHO	MURSAN
			SAHPAU		
	JALAUN	3	JALAUN	KADAURA	RAMPURA
	JAUNPUR	13	DHARAMAPUR	JALALPUR	JAUNPUR URBAN
			KARANJKALA	KHUTHAN	MACCHHLISHAHR
			MAHARAJGAANJ	MARIYAHU	MUFTIGANJ
			MUNGARA BADASHAPUR	SHAHGANJ	SOINTHAKALA
			SONDHI		
	JHANSI	5	BABINA	BAMORE	BARAGAON
			CHIRGAON	MAURANIPUR	
	KANNAUJ	7	CHHIBRAMAU	JALALABAD	KANNAUJ CITY
			SARAIMEERA	SAURIKH	TALGRAM
			UMARDA		
	KANPUR(DEHAT)	2	AKBARPUR	SANDALPUR	
	KANPUR(NAGAR)	4	GHATAMPUR	KAKWAN	KANPUR CITY
			PATARA		
	KASGANJ	4	GANJ DUNDWARA	PATIYALI	SIDHPURA
			SORON		
	KAUSHAMBI	3	CHAIL	KANELI	NEWADA
	KHERI	9	BANKEYGANJ	BIJUA	ISANAGAR
			KHUMBHI	MOHAMMADI	NAKAHA
			NIGHASAN	PASGAWAN	RAMIABEHAR
	KUSHINAGAR	4	HATA	KASIA	KUBERNATH
			NEBUA NAURANGIA		
	LALITPUR	6	BAR	BIRDHA	JAKHAURA
			LALITPUR URBAN	MADAWARA	TALBEHAT
	LUCKNOW	4	GOSAINGANJ	LUCKNOW CITY	MALL
			MOHANLAL GANJ		

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
UTTAR PRADESH	MAHARAJGANJ	5	BAHADURI	DHANI	LAKSHMIPUR
			RATANPUR	SISWA	
	MAINPURI	4	BEWAR RURAL	JAGIR	KISHNI
			MAINPURI RURAL		
	MATHURA	10	BALDEO	CHAUMUHAN	CHHATA
			FARAH	GOVERDHAN	MANT
			MATHURA	NANDGAON	NAUJHEEL
			RAYA		
	MAU	1	MAU CITY		
	MEERUT	7	DAURALA	JANIKHURD	MACHRA
			MEERUT	PARIKSHIT GARH	RAJPURA
			SARURPUR KHURD		
	MIRZAPUR	3	GURSANDI	HALLIA	VIJAYPUR
	MORADABAD	8	BHOJPUR	BILARI	DILARI
			KANTH	KUNDERKI	MORADABAD URBAN
			MUNDAPANDEY	TAJPUR	
	MUZAFFARNAGAR	4	BAGHARA	JANSATH	MEGHAKHERI
			MUZAFFAR NAGAR		
	PILIBHIT	5	BARKHERA	BISALPUR	LALAURIKHERA
			PILIBHIT URBAN	PURANPUR	
	PRATAPGARH	9	BABAGANJ	KUNDA	LAKSHAMANPUR
			LALGANJ	MANDHATA	MANGRORA
			PRATAPGARH BELHA	SANDWA CHANDRIKA	SHIVGARH
	RAEBARELI	8	BELA BHELA	DEEH	HARCHANDPUR
			JAGATPUR	MAHRAJ GANJ	SALONE
			SARENI	SHIVGARH	
	RAMPUR	3	BILASPUR	RAMPUR URBAN	SWAR
	SAHARANPUR	2	MUZAFFARABAD	NAKUR	

List of districts and blocks for IMI 2.0					
State Name	District Name	No. of Blocks	Block Name		
UTTAR PRADESH	SAMBHAL	8	BAHJOI	GUNNAUR	JUNAWAI
			MANHOTA	NAROLI	PANWASA
			RAJPURA	SAMBHAL	
	SANT KABIR NAGAR	3	MEHDAWAL	SANTHA	SEMARIYAWAN
	SHAHJAHANPUR	4	JAITIPUR	JALALABAD	KALAN
			NIGOHI		
	SHAMLI	4	KAIRANA	KANDHLA	THANA BHAVAN
			UN		
	SIDDHARTH NAGAR	6	BARHNI	DOMARIYAGANJ	KHUNIYAON
			MITHWAL	NAUGARH	USKA BAZAR
	SITAPUR	13	BEHTA	GONDLAMAU	KASMANDA
			KHAIRABAD	LAHARPUR	MAHMUDABAD
			MAHOLI	PARSENDI	RAMPUR MATHURA
			REUSA	SANDA	SIDHAULI
			SITAPUR URBAN		
	SONBHADRA	4	CHOPPAN	GHORAWAL	NAGAWA
			ROBERTSGANJ		
	SRAWASTI	5	GILAULA	HARIHARPUR RANI	IKAUNA
			JAMUNAHA	SIRSIYA	
	SULTANPUR	7	BALDI RAI	DHANPATGANJ	DUBEY PUR
			JAI SINGH PUR	KADIPUR	KURWAR
			SULTANPUR URBAN		
	UNNAO	6	ACHALGANJ	BANGARMAU	BICHHIYA
			HILAULI	SIKANDARPUR SARAUSI	UNNAO CITY
	VARANASI	4	ARAZILINE	KASHI VIDHYA PEETH	PINDRA
			SEWAPURI		

Annexure 3: List of Urban Cities identified under NUHM in selected districts

List of urban cities			
State Name	District Name	No.	NUHM City Name
ANDHRA PRADESH	CUDDAPAH	6	Kadapa
			Proddatur
			Rayachoty
			Badvel
			Pulivendula
			Rajampeta
	VISAKHAPATNAM	2	Visakhapatnam
			Narsipatnam
	VIZIANAGARAM	4	Vizianagaram
			Bobbili
			Parvathipuram
			Saluru
ARUNACHAL PR.	PAPUMPARE	1	Itanagar
ASSAM	BONGAIGAON	1	Bongaigaon
	DHUBRI	1	Dhubri
	DIBRUGARH	1	Dibrugarh
	GOALPARA	1	Goalpara
	KARIMGANJ	1	Karimganj
	NAGAON	1	Nagaon
	SIBSAGAR	1	Sibsagar
	SONITPUR	1	Tezpur
	TINSUKHIA	1	Tinsukia
CHHATTISGARH	BASTER	1	Jagdalpur
	KORBA	1	Korba
	MAHASAMUND	1	Mahasamund
D&N HAVELI	D&N HAVELI	1	Silvassa
Delhi	New Delhi	1	North East
GUJARAT	AHMEDABAD	3	Ahmedabad
			Viramgam
			Dholka
	AMRELI	2	Amreli
			Savarkundala
	ANAND	4	Anand
			Petlad
			Borsad
			Khambhat
	BHARUCH	2	Bharuch
			Ankleshwar
	DAHOD	1	Dahod
	DEVBHUMI DWARKA	2	Jamkhambhaliya
			Okha
	GIR SOMNATH	2	Veraval-patan
			Una

List of urban cities			
State Name	District Name	No.	NUHM City Name
GUJARAT	JAMNAGAR	1	Jamnagar
	JUNAGADH	3	Junagadh
			Mangrol
			Keshod
	KUTCH	4	Bhuj
			Mandvi (K)
			Anjar
			Gandhidham
	MEHSANA	4	Mahesana
			Unjha
			Kadi
			Visnagar
	MORBI	1	Morbi
	NARMADA	1	Rajpipla
	NAVSARI	3	Navsari
			Bilimora
			Vijalpor
	PATAN	2	Patan
			Sidhdhapur
	PORBANDAR	1	Porbandar
	RAJKOT	5	Rajkot
			Upleta
			Dhoraji
			Gondal
			Jetpur-navagadh
	SABARKANTHA	1	Himmatnagar
	SURAT	2	Surat city
			Bardoli
	SURENDRANAGAR	3	Surendrangar
			Wadhvan
			Dhagadhra
	TAPI	1	Vyara
	VADODARA	2	Vadodara
			Dabhoi
	VALSAD	2	Valsad
			Vapi
HARYANA	PALWAL	2	Palwal
			Hodal
JAMMU & KASHMIR	BARAMULA	2	Baramulla
			Sopore

List of urban cities			
State Name	District Name	No.	NUHM City Name
JHARKHAND	BOKARO	1	Bokaro
	CHATRA	1	Chattra
	DEOGHAR	1	Deoghar
	DHANBAD	1	Dhanbad
	DUMKA	1	Dumka
	EAST SINGHBHUM	1	Purbi Singhbhum
	GARHWA	1	Garhwa
	GIRIDIH	1	Giridih
	GODDA	1	Godda
	GUMLA	1	Gumla
	HAZARIBAGH	1	Hazaribagh
	KHUNTI	1	Khunti
	KODERMA	1	Kodarma
	LOHARDAGA	1	Lohardaga
	PAKUR	1	Pakur
	PALAMU	1	Palamu
	RAMGARH	1	Ramgarh
	RANCHI	1	Ranchi
	SAHIBGANJ	1	Sahibganj
	SARAIKELLA	1	Saraikela-Kharsawan
	SIMDEGA	1	Simdega
	WEST SINGHBHUM	1	Pashchimi Singhbhum
KARNATAKA	BANGALORE(R)	2	Bangalore rural-Doddabalapur
			Bangalore rural-Hoskote
	CHAMARAJNAGAR	2	Chamarajanagara
			Chamarajanagara-Kollegal
	CHICKABALLAPUR	4	Chikbalapur
			Chikbalapur-Chintamani
			Chikbalapur-Gowribidanur
			Chikballapur-Sidlagatta
	CHIKMAGLUR	1	Chikmagalur
	CHITRADURGA	3	Chitradurga
			Chitradurga-Chellekere
			Chitradurga-Hiriyur
	DAKSHIN KANNAD	5	Mangalore
			Ullal Town
			D.Kannada-Puttur
			Bantwal
			Karwar-Sirsi
	DAVANAGERE	3	Davanagere
			Davanagere-Harihar
			Davanagere-Harpanahalli
	DHARWAD	1	Hubli-Dharwad
	HASSAN	2	Hassan
			Hassan-Arsikere

List of urban cities			
State Name	District Name	No.	NUHM City Name
KARNATAKA	KODAGU(COORG)	1	Kodugu-Madikeri
	MANDYA	1	Mandya
	MYSORE	3	Mysore
			Mysore-Hunsur
			Mysore-Nanjagud
	RAICHUR	2	Raichur
			Raichur-Sindhnur
	RAMANAGARA	3	Ramanagara
			Ramanagara-Channapatna
			Ramanagara-Kanakapura
	SHIMOGA	4	Shimoga
			Shimoga-Bhadravathi
			Shimoga-Sagar
			Shimoga - Shikaripura
	TUMKUR	3	Tumkur
			Tumkur-Sira
			Tumkur-Tiptur
	UDUPI	1	Udipi
	UTTAR KANNAD	2	Karwar
			karwar-Dandeli
	YADGIR	3	Yadgir
			Yadgir-Shorapur
			Yadgir-Shahpur
KERALA	KOZHIKODE	3	Kozhikkode
			Koyilandy
			Vadakara
	WAYANAD	1	Kalpetta
Madhya Pradesh	AGAR MALWA	1	Agar
	BALAGHAT	1	Balaghat
	BARWANI	2	Barwani
			Sendhwa
	BETUL	2	Betul
			Sarni
	BHIND	2	Bhind
			Gohad
	BHOPAL	1	Bhopal
	BURHANPUR	1	Burhanpur
	CHHATARPUR	1	Chattarpur
	CHHINDWARA	1	Chindwara
	DAMOH	1	Damoh
	DATIA	1	Datia
	DEWAS	1	Dewas
	DHAR	3	Dhar
			Pithampur
			Nagda

List of urban cities			
State Name	District Name	No.	NUHM City Name
Madhya Pradesh	GUNA	2	Guna
			Raghogarh
	GWALIOR	2	Gwalior
			Dabra (Pichhore)
	HARDA	1	Harda
	HOSANGABAD	2	Hoshangabad
			Itarsi
	INDORE	2	Indore
			Mhow
	JABALPUR	1	Jabalpur
	JHABUA	1	Jhabua
	KATNI	1	Katni
	KHANDWA	1	Khandwa
	KHARGONE	1	Khargone
	MANDLA	1	Mandla
	MANDSAUR	1	Mandsour
	MORENA	1	Morena
	NARSINGPUR	2	Narsingpur
			Gadarwara
	NEEMUCH	1	Neemuch
	RAJGARH	1	Biaora
	SATANA	1	Satna
	SEHORE	2	Sehore
			Ashta
	SEONI	1	Seoni
	SHADOL	1	Shahdol
	SHAJAPUR	2	Shajapur
			Shujalpur
	SHEOPUR	1	Sheopur
	SIDHI	1	Sidhi
	SINGRAULI	1	Singrauli
	TIKAMGARH	1	Tikamgarh
	UJJAIN	1	Ujjain
	VIDISHA	3	Vidisha
			Basoda
			Sironj
MAHARASHTRA	AHMEDNAGAR	4	Ahmadnagar
			Shrirampur
			Sangamner
			Kopargaon
	AKOLA	2	Akola
			Akot
	AMRAVATI	3	Amravati
			Achalpur
			Anjangaon

List of urban cities			
State Name	District Name	No.	NUHM City Name
MAHARASHTRA	AURANGABAD	2	Aurangabad
			Sillod
	BEED	3	Beed
			Parli
			Ambejogai
	BULDHANA	5	Buldhana
			Khamgaon
			Malkapur
			Shegaon
			Chikhli
	CHANDRAPUR	3	Chandrpur
			Ballarpur
			Bhadravati
	GONDIA	1	Gondia
	GR. MUMBAI	1	Mumbai
	HINGOLI	2	Hingoli
			Wasmath
	JALGAON	5	Jalgaon
			Bhusawal
			Chalisgaon
			Chopda
			Pachora
	JALNA	1	Jalna
	LATUR	2	Latur
			Udgir
	NANDURBAR	2	Nandurbar
			Shahade
	NASIK	6	Nashik
			Malegaon
			Amlerner
			Manmad
			Sinnar
			Deolali Cantonment Board
	OSMANABAD	1	Osmanabad
	PALGHAR	3	Palghar
			Vasai Virar City
			Dahanu
	PARBHANI	1	Parbhani
	RAIGAD	4	Alibaug
			Kharghar
			Panvel
			Khopoli

List of urban cities			
State Name	District Name	No.	NUHM City Name
MAHARASHTRA	RATNAGIRI	2	Ratnagiri
			Chiplun
	SATARA	3	Satara
			Karad
			Phaltan
	SOLAPUR	3	Solapur
			Barshi
			Pandhrpur
	THANE	8	Thane
			Kalyan Dombiwali
			Navi Mumbai
			Mira Bhaindar
			Bhivandi Nijampur
			Ulhasnagar
			Ambarnath
			Badlapur
	WARDHA	2	Wardha
			Hinganghat
	WASIM	2	Washim
			Karanja
MEGHALAYA	EAST KHASI HILL	1	Shillong
	WEST GARO HILLS	1	Tura
	WEST KHASI HILL	1	Nongstoin
MIZORAM	LUNGLEI	1	Lunglei
NAGALAND	TUENSANG	1	Tuensang
	WOKHA	1	Wokha
ODISHA	GAJAPATI	1	Paralakhemundi
	KANDHAMAL	1	Phulabani
	KORAPUT	3	Koraput
			Jeypore
			Sunabeda
	MALAKANGIRI	1	Malkangiri
	RAYAGADA	1	Rayagada
PUNJAB	FEROZEPUR	1	Ferozepur
RAJASTHAN	AJMER	4	Ajmer
			Kishangarh
			Beawar
			Nasirabad
	ALWAR	2	Alwar
			Bhiwadi
	BANSWARA	1	Banswara

List of urban cities			
State Name	District Name	No.	NUHM City Name
RAJASTHAN	BARAN	1	Baran
	BARMER	2	Barmer
			Balotra
	BHARATPUR	1	Bharatpur
	BHILWARA	1	Bhilwara
	BIKANER	3	Bikaner
			Nokha
			Dungargarh
	BUNDI	1	Bundi
	CHITTAURGARH	2	Chittaurgarh
			Nimbahera
	CHURU	5	Churu
			Sujangarh
			Sardarshahar
			Ratangarh
			Rajgarh
	DAUSA	1	Dausa
	DHAULPUR	2	Dhaulpur
			Bari
	DUNGARPUR	1	Dungarpur
	GANGANAGAR	2	Ganganagar
			Suratgarh
	HANUMANGARH	2	Hanumangarh
			Nohar
	JAIPUR	3	Jaipur
			Chomu
			Kotputli
	JAISALMER	1	Jaisalmer
	JALOR	1	Jalore
	JHALAWAR	1	Jhalawar
	JHUNJHUNU	2	Jhunjhunu
			Nawalgarh
	JODHPUR	2	Jodhpur
			Phalodi
	KARAULI	2	Karauli
			Hindaun
	KOTA	1	Kota
	NAGAUR	5	Nagaur
			Makrana
			Ladnu
			Kuchaman City
			Didwana

List of urban cities			
State Name	District Name	No.	NUHM City Name
RAJASTHAN	PALI	1	Pali
	PARTAPGARH	1	Pratapgarh
	SAWAI MADHOPUR	2	Sawai Madhopur
			Gangapur City
	SIKAR	3	Sikar
			Fatehpur
			Laxmangarh
	SIROHI	2	Sirohi
			Abu Road
	TONK	1	Tonk
	UDAIPUR	1	Udaipur (RJ)
TAMIL NADU	RAMANATHAPURAM	2	Ramanathapuram
			Paramakudi
	VIRUDHUNAGER	5	Virudhunagar
			Aruppukkottai
			Sivakasi
			Thiruthangal
			Rajapalayam
TELANGANA	KHAMMAM	2	Khammam
			Paloncha
	BHUPALPALLY	1	Bhupalpally
	KOMARAM BHEEM ASIFABAD	1	Khagaznagar
TRIPURA	GOMATI	1	Udaipur (TR)
	TRIPURA NORTH	1	Dharmanagar
UTTARAKHAND	GARHWAL	1	Kotdwar
	HARDWAR	2	Haridwar
			Roorkee
	UDHAMSINGH NAGAR	3	Rudrapur
			Kashipur
			Jaspur
WEST BENGAL	MALDAH	2	English Bazar
			Old Malda
	MURSHIDABAD	5	Berhampur (WB)
			Dhulian
			Jangipur
			Jiaganj- Azimganj
			Kandi

Annexure 4. IMI 2.0 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 5. IMI 2.0: 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 6. ANM micro plan roster for IMI 2.0 (Format 3) Round I/II/III/IV For ANM

(One format for each ANM in the district)

District_____Block/planningunit:_____AEFImanagementcentrename&Telno:_____

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 7. Financial norms under IMI 2.0

For operational activities of routine immunization, funds are available under 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 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 Programme Implementation Plans (PIP) of the NHM
To develop sub-centre and PHC microplans using bottom up planning with participation of ANMs, ASHAs, AWWs	@ Rs 100 per sub-centre (For 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 75 per child for ensuring complete immunization up to second year of age of child
ASHA incentive for DPT booster at the age of 5-6 years	Rs. 50 per child for ensuring DPT booster at the age of 5-6 years
Supervisory visits by state and district level officers for monitoring and supervision of routine immunization	@ Rs 3,00,000 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 * 1. For small states/ UTs @ Rs 1,80,000 per year 2. For medium states @ Rs. 3,60,000 per year 3. For larger & NE states @ Rs. 5,40,000 per year
Printing and dissemination of immunization cards, tally sheets, monitoring forms, etc.	@ Rs 20 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 Programme Implementation Plans (PIP) of the 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 entry operators by DIO and district cold chain officer on reporting formats of immunization and NRHM	As per revised norms for trainings under RCH
Cold chain maintenance	@ Rs 1000 per CCP per year @ Rs 20,000 per district per year @ Rs 50,000 per SVS/ RVS per year
POL for vaccine delivery from state to district and from district to PHCs/CHCs	Rs 2,00,000 per district/year
Alternative vaccine delivery (AVD)	Very Hard-to-reach areas @ Rs 450 per routine immunization session
	Hard-to-reach areas @ Rs 200 per routine immunization session
	For routine immunization session in other areas @ Rs 90 per session
Red/black plastic bags, etc.	@ Rs 3/bag/session
Bleach/hypochlorite solution and twin bucket	Rs 1500 per PHC/CHC per year
Safety pits	Rs 6000/pit
Support for quarterly state level review meetings of district officers	@ Rs 1500/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 150 per participant for meeting expenses (lunch, organizational expenses)
Quarterly review meeting exclusive for routine immunization at block level	@ Rs 75 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
Line listing of households done twice a year at six-month interval	Rs 300 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 link worker/AWW, subject to a total ceiling of Rs 300.
Preparation of due list of children to be immunized to be updated on a monthly basis	Rs 300 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 subject to a total ceiling of Rs 300.
Mobilization of beneficiaries to session sites	Rs 150 for ASHAs	Two mobilizers will be present at each session site (ASHA/AWW/link worker). Each mobilizer may be paid Rs 75 with a maximum limit of Rs 150 per session site.

Activity	Existing Norms	For Intensified Mission Indradhanush
Mobilization of beneficiaries to session sites	Rs 150 for ASHAs	Two mobilizers will be present at each session site (ASHA/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		These need to be costed and funded.
Mobility support for supervision of these activities		
Mobility support for mobile teams in far-flung/ scarcely populated/ scattered areas.		

*Details of categorization of States

Larger +NE states	Uttar Pradesh,Maharashtra, Bihar, West Bengal, Madhya Pradesh, Tamil Nadu,Rajasthan , Karnataka, Gujarat, Odisha, Assam, Tripura, Manipur, Mizoram, Meghalaya, Nagaland, Arunachal Pradesh, Sikkim,
Medium	Andhra, Telangana, , Kerala, Jharkhand, Punjab, Chhattisgrah, Haryana, Uttarakhand, Jammu & Kashmir, Himachal Pradesh , Andaman & Nicobar Islands and Lakhsadweep
Small	Delhi, Goa, Daman & Diu, Dadar & Nagar Haveli, Chandigarh, , Pudducherry

Annexure 8. Mobile team planning for IMI 2.0

For Block/ Urban area

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

District: _____ Block/planning unit: _____

AEFI management centre name & Tel no: _____

Name and mobile no. of MOIC_____Supervisor_____ANM_____

Day	Vehicle details		Site 1	Site 2	Site 3	Site 4
1		Timing of visit				
		Name of mobilizer				
		No. of 0–2 year old children				
		Name of influencer				
		No. of pregnant women				
2		Timing of visit				
		Name of mobilizer				
		No. of 0–2 year old children				
		Name of influencer				
		No. of pregnant women				
3		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
4		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
5		Timing of visit				
		Name of mobilizer				
		Name of influencer				
		No. of 0–2 year old children				
		No. of pregnant women				
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 9. Advocacy for IMI 2.0: Inter-ministerial Collaboration

<table>
<tr><td></td><td colspan="2">• Support mobilization and service delivery interventions, especially in resistant and urban areas where ASHAs are not present
• Support IPC interventions and build vaccine trust by informing community on importance of vaccines</td></tr>
<tr><td>Activities

Pre-Campaign:
• Mobilize network of AWWs and their supervisors
• Ensure participation of ICDS supervisors / AWWs in IMI 2.0 Orientation
• Share beneficiaries ‘data with ANM/ASHA.
• Support headcount survey updation
• Sensitization of beneficiaries especially in urban areas where ASHAs are not present or resistant areas
• IPC through AWW with pregnant women

Campaign Phase
• Ensure mobilization support in RI sessions / resistant areas
• Monitoring of AWWs by CDPOs and DPOs.
• Participation in DTFI</td><td>Advocacy Methods

Posters, leaflets, FAQs on Immunization</td><td>Monitoring Indicators

• # of DTFI held with participation of DPO-ICDS
• # of IMI sessions monitored by DPO, CDPOs and Supervisor
• # of mother meeting held before each round by AWW</td></tr>
<tr><td>Ministry of Panchayati Raj Institution</td><td colspan="2">Key Role:
• Build vaccine trust at community level by informing community on importance of vaccines
• Support effective immunization service delivery at Gram Panchayat level</td></tr>
<tr><td>Activities
Pre-Campaign
• Identification of resistant / hesitant pockets with support of FLWs
• Support conducting community meetings for awareness on importance of immunization
• Support ASHA/ANM in influencing resistant /hesitant families and motivate them to get their children immunized
• Participate in VHSNC / RKS meetings
• Facilitate planning of village health plans
Campaign Phase
• Provide suitable place for session site along with basic amenities
• Ensure display of IEC at schools, AWCs, Session sites, Panchayat bhawan, community halls etc
• Ensure record keeping of RI coverage in standard templates (with the support from ANMs /health workers)
• Facilitate monitoring of village health plans
• Mobilization of beneficiaries and influencing the resistant families</td><td>Advocacy Methods

• FAQs and guidance note for GP / ZP members
• Community radio to disseminate advocacy messages on immunization from local celebrities and influencers</td><td>Monitoring Indicators

• # of DTFI held with participation of key PRI members
• # of VHSNC held with participation of PRI/ GP members
• # of IMI 2.0 sessions attended by PRI/ GP members for mobilization
• # of villages declared fully immunized</td></tr>
</table>

• Review RI activities in VHSNC meetings, Gram Sabha and Zila Parishads • Undertake miking and announcements around prominent areas • Reward / incentives / acknowledgement to villages declared fully immunized		
Ministry of HRD	**Key Role:** • Mobilize schools and educational institutions to support the IMI 2.0 in-school and outreach interventions	
Activities **Pre-Campaign** • Assign and orient nodal teachers from all schools - on IMI 2.0 and School Education Plan (SEP) • Orientation of school monitors / captains on IMI 2.0 mission/ cause and SEP • Ensure availability of IEC in schools and other educational institutions • Organize school / outreach activities (prayer meets / debates / competitions / rallies etc.) **Campaign Phase** • Support mobilization of schools for rallies / drives/ events • Reward and recognition to schools with proactive participation in IMI 2.0 activities from nodal government officials (DM/DC)	**Advocacy Tools:** • FAQs on immunization • IEC on immunization School Education Plan Tool PPT on IMI Mission /Cause and messages	**Monitoring Indicators** • # of nodal teachers trained in IMI orientations • # of DTFI held with participation of DEO • # of rallies held
Ministry of Minority Affairs	**Key Role:** • Support mobilization and awareness generation interventions on IMI 2.0 in urban and rural minority settlements	
Activities **Pre-Campaign** • Map minority settlements (urban / rural IMI districts / areas) with support of FLWs • Identify key influencers within the minority communities / settlements to support awareness generation through community meetings and mobilization interventions for IMI 2.0 • Ensure participation of key influencers from minority community in VHSNC / RKS / Gram Sabha meetings • Ensure display of IEC at prominent places in minority settlements. **Campaign Phase** • Session site mobilization support in areas with minority communities / settlements • Ensure participation in district level reviews	**Advocacy Tools:** • FAQs and guidance note for GP / ZP members • Miking and announcements Community radio to disseminate advocacy messages on immunization from local celebrities and influencers	**Monitoring Indicators** • # of DTFI held with participation of District Nodal officer • # of community meetings held at block level including minority community leaders
Ministry of Information and broadcasting (through Directorate of Field Publicity)	**Key Role:** • Provide publicity and awareness generation support of IMI 2.0 interventions through satellite / radio channels / cable networks	
Activities **Pre-Campaign** • Issue letters to Private Satellite TV Channels, F.M. Radio Channels, cable operators and cinema halls to showcase IMI 2.0 successes	**Advocacy Tools** • FAQs on Immunization • IEC Package (TV Spots / radio	**Monitoring Indicators** • # of satellite channels airing IMI 2.0 spots

and updates through spots / scrolls and advertisements; and facilitate talk shows on Immunization • Ensure IMI Communication Package (TV / Readio Spots / Jingles / Messages) disseminated with all satellite / FM/ Cable channels and cinema halls	Jingles) on immunization	
Ministry of Urban Development	**Key Role:** • Provide mobilization and awareness generation support for effective RI service delivery in urban areas, municipal corporations, RAWs etc	
Activities **Pre-Campaign** • Issue letters to Lions, Rotary, Red Cross Society, RWA members, Counsellors, Municipal Corporation to hold weekly meetings on progress of IMI 2.0 in urban areas • Identify and designate a nodal official to coordinate for urban interventions • Explore engagement with local municipal bodies, CSOs, corporate sector, trader's union • Involvement of Swacchagrahis under Swachh Bharat Mission for generating awareness on immunization • Develop urban specific IEC/ communication resources • Orientation of representatives from trader's union and corporators of construction sites, munshis and sardars in brick kilns **Campaign Phase** • Utilize Urban Health Posts, Postpartum centers, Family Welfare Centers as immunization sites • Mobilization and awareness generation interventions with support of local municipal bodies, CSOs, corporate sector, trader's union, Swacchagrahis • Participation in district level reviews	**Advocacy Tools** • FAQs • PPT on IMI msission / Cause and messages	**Monitoring Indicators** • # of CTFUI held with participation of DUDO • # of IMI orientations held with participation of Lions, rotary, red cross society, RWA members, and members of municipal corporation • # of IMI sessions attended by MAS members for mobilization
Ministry of Housing and Urban Poverty Alleviation	**Key Role:** • Support engagement of SHGs under National Urban Livelihood Mission to increase awareness on importance of immunization in urban areas	
Activities **Pre-Campaign:** • Orientation of SHGs to support in areas with limited access of ASHAs in urban settings • Involvement of Zila Preraks under Swachch Bharat Mission for generating awareness on immunization • Identify and encourage involvement of local CSOs **Campaign Phase:**	**Advocacy Tools** • FAQs on Immunization • PPT on IMI mission/ cause and messages	**Monitoring Indicators** • # of IMI 2.0 orientations attended by SHGs members (in urban areas)

<table>
<tr><td>

- Continue awareness generation through SHGs especially among resistant families in Urban areas

</td><td></td><td></td></tr>
<tr><td>Ministry of Défence</td><td colspan="2">Key Role:
• Support cantonment boards and state directors of NCC to achieve targets of IMI 2.0</td></tr>
<tr><td>Activities
Pre-Campaign
• Ensure participation of state directors of NCC and members of cantonment board in IMI Orientation
• Ensure visibility of IMI 2.0 IEC in cantonment colonies and schools

Campaign Phase
• Facilitate IMI sessions in cantonment colonies
• Facilitate IMI drives and rallies
• Assist civil health authorities in remote and field areas</td><td>Advocacy Tools
• IEC on IMI 2.0 (Posters / banners, Leaflets)
• FAQs</td><td>Monitoring Indicators
• # of areas where vaccine is supplied with defence support
• #-of IMI session held in identified cantonment areas
• # of DTFI's attended by NCC members held
• # of rallies / events held with participation of NCC members</td></tr>
<tr><td>Ministry of Home Affairs</td><td colspan="2">Key Role:
• Support / facilitate immunization sessions in residential areas of Central Police Organizations and Central Armed Police Force</td></tr>
<tr><td>Activities
Pre-Campaign
• Ensure visibility of IMI 2.0 IEC in residential areas of Central Police Organizations and Central Armed Police Force

Campaign Phase
• Facilitate IMI sessions in residential areas of Central Police Organizations and Central Armed Police Force.
• Facilitate IMI IPC interventions (drives and rallies)</td><td>Advocacy Tools
• FAQs and guidance note for GP / ZP members
• Community radio to disseminate advocacy messages on immunization from local celebrities and influencers</td><td>Monitoring Indicators
• # of rallies / IMI drives held</td></tr>
<tr><td>Ministry of Youth Affairs and Sports</td><td colspan="2">Key Role:
Support in mobilization and awareness generation interventions (school and outreach)</td></tr>
<tr><td>Activities
Pre-Campaign
• Ensure participation of NYKS/NCC/NSS/Scouts/Guides/ youth club in district level IMI orientations
• Facilitate / Participate in panel discussions on TV channels on students' support to Immunization programme
• Support in Identifying prominent sights to conduct rallies, flash mobs, and other promotional activities as part of school / adolescent / youth activation plan.
• Mobilize volunteers from schools / colleges / vocational institutions to facilitate promotional events and programmes on IMI 2.0
• Coordinate with RWAs/local business houses/clubs/NGOs/corporates to seek support IMI 2.0 activities in urban areas</td><td>Advocacy Tools
• FAQs, Factsheets on Immunization
• Detailed brochures</td><td>Monitoring Indicators
• # of DTFI's attended by NYKS/NSS/Scouts/Guides/ youth club members held
• # of rallies / events held by NYKS/NSS/with participation of Scouts/Guides/ youth club members</td></tr>
</table>

• Support FLWs and community influencers in mobilizing resistant / hard-to-reach / underserved population • Ensure the availability of IEC materials for pre-launch and launch interventions **Campaign Phase** • Facilitate mobilization and awareness generation interventions (rallies, drives, booths) with support of schools, educational institutions • Support mobilization in RI sites		
Ministry of Railways	**Key Role:** Support in immunization service delivery interventions for IMI 2.0	
Activities **Pre-Campaign** • Undertake screening of IMI 2.0 AV spots on railways • Ensure availability of IMI IEC and use IMI branding on the tickets / railway boggies **Campaign Phase** • Provide immunization services through railways and railway colonies during IMI 2.0	**Advocacy Tools** • FAQs, Factsheets on Immunization • Detailed brochures	**Monitoring Indicators** • # -IMI sessions held in identified railway colonies during IMI 2.0 • # of railway stations where announcements are made
Ministry of Labour Employment	**Key Role:** • Support capacity building and service delivery interventions for IMI 2.0 through MOLE networks	
Activities **Pre-Campaign** • Support training and capacity building intervention for IMI 2.0 through their networks - Employees'' State Insurance Corporation (ESIC), Central Board for Workers Education etc. • Facilitate identification of unvaccinated and partially vaccinated children among the registered beneficiaries of ESIC. **Campaign Phase** • Provide immunization services through ESIC hospitals and dispensaries	**Advocacy Tools** • FAQs, Factsheets on Immunization • Detailed brochures	**Monitoring Indicators** • # of district IMI 2.0 orientations facilitated by MOLE • # of IMI sessions organized in ESIC hospitals / dispensaries
Ministry of Tribal Affairs	**Key Role:** • Leverage visibility and service delivery interventions in tribal districts of IMI 2.0	
Activities **Pre-Campaign** • Identify key influencers within the tribal communities / settlements to support mobilization and awareness generation interventions for IMI 2.0 • Ensure participation of key influencers from minority community in VHSNC / RKS / Gram Sabha meetings • Ensure display of IEC at prominent places in tribal settlements. • Organize miking / announcements / rallies on IMI prior campaign sessions\ disseminate information on immunization and IMI 2.0 publicity **Campaign Phase** • Facilitate miking/ announcements / rallies during IMI 2.0 • Support mobilization efforts in session sites	**Advocacy Tools** • FAQs, Factsheets on Immunization • Detailed brochures IEC on IMI 2.0 (Posters / Banners)	**Monitoring Indicators** • # of DTFI with attendance of district nodals from tribal affairs • # -IMI sessions held in tribal areas / districts during IMI 2.0

Annexure 10. Advocacy with professional bodies/medical colleges and other groups

Medical Association (IMA) /Indian Academy of Paediatrics (IAP) and private medical practitioners	**private networks**	
Activities **Pre- Campaign phase** • Promote use of MCP card and four key messages • Advocate for IMI 2.0 during events and seminars • Prepare guidance note on how IAP / IMA can support IMI 2.0 and system strengthening initiatives • Develop a list of district level IMA/IAP members and their networks • Include senior IMA/IAP members in advisory committees for Immunization • Invite IMA/IPA members for workshops and reviews • Use IEC (though print / social media) showcasing support from private practitioners **Campaign Phase** • Support onsite vaccination in outreach areas especially areas lacking in ANMs / urban areas • Provide incentives such as recognition certificates, rewards and media acknowledgement for support extended by IAP / IMA • Organize media / radio interviews with senior IAP / IMA members on immunization • Report / support AEFIs	**Advocacy Tools** • Detailed brochure on IMI 2.0 (in English / Hindi / Local language) • Customized messages • FAQs on IMI 2.0 • Mobi-videos on Immunization to circulate through WhatsApp groups	**Monitoring Indicators** • Number of IMI 2.0 orientations with participation of IAP / IAP members against • Number of DTFI attended by IMA/IAP members • Number of supportive supervision visits facilitated of IMA / IAP members
Advocacy Partner: Medical colleges and Nursing schools	**Key Role: Support sensitization and mobilization interventions for IMI 2.0**	
Activities **Pre-campaign and Campaign Phase** • Identify / train staff to create a pool of master trainers for conducting Medical Officers' (MO) and Health worker (HW) trainings. • Identify / train staff (State / district ToTs) from nursing colleges and ANM training centers to support immunization sessions where additional ANMs are required (especially for urban, hard to reach and high-risk areas) • Ensure participation of identified staff from medical colleges and nursing schools in AEFI protocol training • Identify medical college faculty to serve as AEFI committee members	**Advocacy Tools** • FAQs, Brochures, Factsheets on Immunization • Immunization posters for clinics • Mobi-videos on Immunization to circulate through WhatsApp groups	**Monitoring Indicators** • No of state / district level IMI orientations organized for MOs and HWs • No of state / district Tots attended by staff from nursing collage and ANM training centres • No of AEFI protocol trainings attended by staff from nursing colleges and ANM training centres

• Disseminate information / positive messaging on immunization through their networks and social media portals		
Advocacy Partner: Religious and community leaders	**Key Role: Support sensitization and mobilization interventions for IMI 2.0**	
Activities **Pre-campaign phase** Support FLWs in sensitization of communities especially left out, resistant, tribal, migrant populations **Campaign Phase** Participate in campaign rallies, drives and events	**Advocacy Tools** • FAQs, Brochures, Factsheets on Immunization • GIFs / Messages on immunization	**Monitoring Indicators** • No of IMI 2.0 meetings attended by religious / community leaders • No of rallies / drives attended by religious / community leaders
Advocacy Partner: Media	**Key Role: Leverage IMI awareness and disseminate positive massaging through varied media channels**	
Activities **Pre-Campaign** • Participate in media sensitization workshops / orientations on IMI 2.0 • Utilize IMI 2.0 media kit (Factsheets on Immunization data and benefits / WhatsApp messages / FAQs / Brochures / Key messages on IMI .2.0) to develop positive stories on the mission / cause **Campaign Phase** • Utilize IMI 2.0 media kit to publish daily / weekly updates, success stories of IMI 2.0 • Cover rallies and drives as part of IMI 2.0	**Advocacy Tools** • FAQs, Brochures, Factsheets on Immunization • IMI 2.0 media kit	**Monitoring Indicators** • No of IMI 2.0 orientations attended by media against • No of rallies / drives covered by media

Annexure 11. Social mobilization partners and their key roles

<table>
<tr><td>Social Mobilization Partner: National, Regional, Local celebrities</td><td colspan="2">Key role: Promote IMI 2.0 brand visibility and services</td></tr>
<tr><td>Pre-Campaign and Campaign Phase

Promote key messages and call to action for IMI 2.0 through television / radio talk shows, meetings, launch events, rallies, drives etc.
Promote key messages on IMI 2.0 through their social media handles (Facebook / twitter)</td><td>Advocacy / Mobilization Tools
• Public speeches in support of RI during IMI 2.0
• Key messages on IMI 2.0</td><td>Monitoring Indicators
• # celebrity participation in IMI pre-launch /launch rallies / drives against total planned</td></tr>
<tr><td>Social Mobilization Partner: Civil Society Organizations (CSOs working in education, health, children's issues, water and sanitation)</td><td colspan="2">Key Role
• Support mobilization activities (beneficiaries, transport during outreach camps, provide volunteers
• Undertake capacity building to increase awareness and collective action among local leaders, women's groups, hard to reach, resistant and vulnerable population</td></tr>
<tr><td>Pre-Campaign
• Identify list of state / district level CSOs
• Enlist the support they and their networks can offer
• Call for meetings thrice a week and take feedback
• Engage them in planning and community mobilization interventions: Organize public talks/ gatherings/ large events at the block and district level on immunization before, during and post sessions organized under IMI 2.0
• Prepare capacity development plan for CSOs based on their identified capacity development needs
• Promote visibility of IMI 2.0 through strategic use of IEC materials

Campaign Phase
• Set up IMI 2.0 branded immunization information booths/kiosks in village weekly markets (haats)/ fairs/melas/ and in identified hard to reach areas (HRAs) and conduct community meetings with Left Out, Drop Out and Resistant (LODOR) families by engaging their network of CSO partners.
• Support FLWs identify resistant / hesitant families and conduct guided discussions</td><td>Mobilization Tools
• Detailed brochure on IMI 2.0 (in English / Hindi / Local language)
• Customized messages
• FAQs on IMI 2.0
• IEC package on IMI 2.0</td><td>Monitoring Indicators
• # IMI orientations attended by CSOs
• # of CSOs facilitating mobilization and awareness generation for immunization sessions during IMI 2.0</td></tr>
<tr><td>Social Mobilization Partner: Community Based organizations (CBOs) including Self-Help Groups, Mahila Mandals, Rogikalyan</td><td colspan="2">Key Role:
Support the national IMI 2.0 goal target interventions</td></tr>
</table>

Samiti, Jeevika Group, Urban Local bodies/ VHSNC		
Activities **Pre-Campaign:** - Support FLWs in mapping resistant families - Support FLWs in conducting community mobilization/ special community meetings activities and create awareness amongst LODOR families to avail services at RI sessions **Campaign Phase** - Organize *Bulawa Tolis* with children in their communities to mobilize families for IMI 2.0 sessions - Promote visibility of IMI 2.0 through strategic use of IEC materials	**Mobilization Tools** • Detailed brochure on IMI 2.0 (in English / Hindi / Local language) • Customized messages • FAQs on IMI 2.0 • IEC package on IMI 2.0	**Monitoring Indicators** • # of IMI 2.0 meetings attended by CBOs • # of *bulawa toli's* organized during IMI 2.0
Social Mobilization Partner: Youth networks (NYKS/NCC/NSS/Scouts/Guides/ youth clubs)	**Key Role: Promote IMI 2.0 as a 'people's movement' by working closely with communities (especially young people)**	
Activities **Pre-Campaign** - Orient members of the youth groups on IMI 2.0 - Participate in the state/ district task force meetings - Support the DIO/MOs in facilitating the survey of the community for the head count survey. - Support the IMI 2.0 in mobilizing communities through drum beating - Undertake mobilization activities in their respective areas along with local influencers for ensuring full immunization of all due children. - Coordinate with RWAs/local business houses/clubs/NGOs/corporates to seek their support for immunization activities in urban areas. - Support in distribution IEC materials and provide information on importance of full immunization to the caregivers at the IMI session. - Work closely with the local Influencers/ASHAs and AWWs to	**Mobilization Tools** • FAQs on IMI 2.0 • IEC package on IMI 2.0	**Monitoring Indicators** • # of IMI 2.0 orientations attended by NYKS/NCC/NSS/Scouts/Guides/ youth club members • # of DTFIs attended by NYKS/NCC/NSS/Scouts/Guides/ youth club members

visit the homes of drop-outs and left-outs and other resistant families and mobilize them for vaccination. **Campaign Phase:** - Participate in and facilitate IMI rallies, drives and other events - Support mobilization of beneficiaries in session sites during IMI .20		

Annexure 12 A. State Level Communication Plan for IMI 2.0

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 crisis communication	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….			
	Orientation of Religious leaders or key influencers	Date…… Responsible person…….		Date…… Responsible person…….				Date…… Responsible person…….			
	Media 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 communication 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	**Hoarding**	No.		Responsible person…….				Date			
	Banners	No.		Responsible person…….				Date			
	Poster	No.		Responsible person…….				Date			
	Film Shows in Cinema 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 12 B. District Level Communication Plan for IMI 2.0

	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	Block 3	Block	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 2.0

Annexure 12 C. Health Facility/PHC level communication plan for IMI 2.0

	Health Facility/PHC level communication plan for IMI 2.0 (form no. ___)											
	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 12 D. Health Facility/PHC level communication plan for IMI 2.0

Sub-center level communication plan for IMI 2.0 (form no. __)																
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.																

Annexure 13. Roles and responsibilities in operationalizing communication at national, state and district level for IMI 2.0

National Level roles for communication

(Responsible Person: Deputy Commissioner, Immunization division, MoHFW)

The Immunization division, Ministry of Health and Family Welfare, will lead all advocacy efforts to steer integration, convergent action and smooth coordination at the national level. The Deputy Commissioner, Immunization Division will be the national nodal person for IMI 2.0 and the focal point person for stewarding, guiding, planning, reviewing all communication activities for the campaign.

Other key actions steered at the national level include

- Organizing meetings with IMA/IAP chapters, national-level development partners, national-level CSO members, trade and industry bodies such as CII, and seek their support; share communication material with them and information factsheet.
- Seek support from Media Cell to prepare a social media plan, and include links to access / download IEC material, templates, guidelines from the Ministry's official webpage
- IEC Division to prepare a national broadcast plan for IMI2.0 on various channels
- Prepare messages for spokespersons, and Spokesperson FAQ on IMI 2.0.
- Plan for media launch event of the IMI 2.0 ensuring all necessary approvals are in place

State-level roles for communication (Refer to state-level communication planning template)

(Responsible persons: Secretary (Health) Mission Director, SEPIO)

- Support districts in carrying out a situational analysis; fill any strategic communication gaps observed
- Ensure STFI is organised with the participation of key partners/ line departments
- Follow-up with relevant departments from other line departments along with state-level CSOs, CBOs, State chapters of IMA-IAP, Lions, Scouts and Guides, medical colleges, nursing schools, private practitioners and prepare an action plan with their roles and responsibilities. Have IMI 2.0 concept note ready before hand.
- Ensure all advocacy and communication tools are available in open file formats with a dissemination plan with guidelines on how to use them; and translated/adapted to match the local context
- Ensure that messages on social media are technically correct and accurate and vetted by experts before dissemination.
- Identify and support the necessary trainings of trainers for district-level communications team on development of communications plan and operationalization
- 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
- Prepare a broadcast plan for IMI 2.0 on state channels after reviewing national dissemination plan and district plans for the same.
- As required, develop short videos of influencers (religious / community / influential women) appealing to communities, short testimonial videos of parents who have full confidence in vaccines and have completed immunization for their children. Budget for same.

- Prepare a district monitoring plan.

District-level roles for communication (Refer to District level communication planning template)

- Responsible persons: District Magistrate / Collector, CMHO/CMO, DIO and team
- Develop the District Communication Plan:
- Ensure Sub-centre level plans are ready and compiled into preparing block level plans; submitted to the District communication in-charge for preparing the District Action Plan for IMI 2.0.
- 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 2.0.
- 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
- Hold training for District / Block communication nodal on planning and monitoring tools. Trainings to be facilitates by state ToT trainers
- Ensure BRIDGE (IPC Skills training of FLWs) has been budgeted well with a clear training and monitoring plan.
- Remember to factor in all communication support activities by various partners.
- Start documenting and monitoring communication activities from Day One of planning.

Annexure 14. Timeline of Communication Activities for IMI 2.0

Day	Activity	Timeline
1	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	Oct-Nov 2019
2	Trainings on communication planning and monitoring tools / templates	Oct 2019
3	Develop State-specific district, planning unit and sub centre level communication plans which comprise of activities related to mass media, IPC and social mobilization	Oct 2019
4	Advocacy with FLWs, community / religious influencers, celebrities, professional bodies and other key groups	Oct-Nov 2019
5	Mapping of mass media channels (TV/Satellite channels / radio)	Oct 2019
6	Media orientation / sensitization (which includes spokespersons training and AEFI sensitization workshop for media)	Nov 2019 (last week)
7	Availability of standardized advocacy and IEC materials/tools (includes banners, posters, AVs, testimonial videos, GIFs and WhatsApp videos for social media platforms, mass media (TV & radio spots)	Oct 2019
8	Pre-Buzz social mobilization activities (rallies, drives, nukkad nataks, talk shows, school activities)	Nov 2019
9	Media activation activities (media workshops, sensitization meetings, media outreach)	October
10	Preparedness Assessment of planned communication activities	Nov 2019

Annexure 15. Tally sheet for IMI 2.0

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

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

Name of ANM: _____ Name of mobilizer(s): _____ Designation: ASHA/AWW/Other_____

S. No	Name of beneficiary	Father/ husband name	Age	Sex	Whether child vaccinated for the first time in life	Pregnant Women			CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENERCIARY																	Full immunization achieved (Y/N)	CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY								Complete immunization achieved (Y/N)	DPT-B (5-6 years)
						TT/Td -1	TT/Td -2	TT/Td -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	MCV/MR-1	JE-1	PCV-B	Vit A-1		*DPT-1	*DPT-2	*DPT-3	OPV-B	DPT- B	MCV/MR-2	JE-2	Vit A-2		
Total																																			

Summary		
Full immunization 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 after head count)	
Total Children vaccinated	
No. of target Pregnant Women for the session (as per due list after head count)	
Total Pregnant Women vaccinated	
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	

Total no of beneficiaries that could not be vaccinated		Reason for beneficiaries not vaccinated															
		House locked		Out of village		Sickness		Fear of AEFI		Not aware of vaccination / campaign		Refused vaccination		Already Vaccinated after the head count survey in IMI till the day of vaccination		Others	
Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women	Children	Pregnant Women

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 16. Block Daily reporting format for IMI 2.0

Date of Activity ___________

For Block/ Urban Cities

Block/ planning unit: ______________________________ Round: I / II / III / IV

S. No	Name of ANM	Urban/Rural	No of sessions Planned for the day	No of sessions held during the day	Session site address	No. of target children for the day (as per the due lists based on head count)	No. of children vaccinated	No. of children vaccinated for the first time in life: 0 - 11 mo	No. of children vaccinated for the first time in life: 12 - 23 mo	No. of target Pregnant Women for the day (as per the due lists based on head count)	Pregnant Women: TT/Td -1	Pregnant Women: TT/Td -2	Pregnant Women: TT/Td -B	No. of PW vaccinated	Record number of vaccinations for each antigen: BCG	OPV1	Penta 1	RVV1	fIPV-1	PCV-1	OPV 2	Penta 2	RVV 2	OPV3	Penta 3	RVV 3	fIPV-2	PCV-2	MCV/MR-1	JE-1	PCV-B	Vit A-1	Full immunization achieved: 9 - 11 months Male	9 - 11 months Female	12 - 23 months Male	12 - 23 months Female	Record number of vaccinations: DPT-1	DPT-2	DPT-3	OPV-B	DPT- B	MCV/MR-2	JE-2	Vit A-2	Complete immunization achieved	DPT-B (5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed	Total no of beneficiaries that could not be vaccinated: Children	Total no of beneficiaries that could not be vaccinated: Pregnant Women	Reason for beneficiaries not vaccinated: House locked: Children	House locked: Pregnant Women	Out of village: Children	Out of village: Pregnant Women	Sickness: Children	Sickness: Pregnant Women	Fear of AEFI: Children	Fear of AEFI: Pregnant Women	Not aware of vaccination / campaign: Children	Not aware of vaccination / campaign: Pregnant Women	Refused vaccination: Children	Refused vaccination: Pregnant Women	Already Vaccinated after the head count survey in IMI till the day of vaccination: Children	Already Vaccinated after the head count survey in IMI till the day of vaccination: Pregnant Women	Others: Children	Others: Pregnant Women
1		U																																																																
		R																																																															
2		U																																																															
		R																																																															
3		U																																																															
		R																																																															
4		U																																																															
		R																																																															
5		U																																																															
		R																																																															
6		U																																																															
		R																																																															
7		U																																																															
		R																																																															
8		U																																																															
		R																																																															
9		U																																																															
		R																																																															
10		U																																																															
		R																																																															
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 17. District daily reporting format for IMI 2.0

Date of Activity _____

For District

District Name: _____ Round: I / II / III / IV

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

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

Annexure 18. Key Indicator for immunization report

Annexure 20: Key dashboard indicators on Immunization (Google-sheet reporting)

Sl	Activity	Indicators	Numerator	Denominator	Source of data and Means of verification	Responsibility (Reporting)	Reporting level	Frequency
1	Organize State Steering committee meeting	Number of States where Steering Committees meeting held (Oct 2019 and Jan 2020)	Number of State Steering Committees meeting held (Yes/ No)	No of Steering Committees meetings planned (2)	Meeting report	SEPIO	State	Once before initiation of IMI phase (Oct 2019) and one in Jan 2020 (tentative)
2	Organize State Task Force meeting	% of States where Task Force meeting held	Number of States where Task Force meetings held	No of districts implementing IMI 2.0	Meeting report	SEPIO	State	Once in preparatory phase before every round
3	Organize DTFI	% of districts where DTFI held	Number of districts where DTFI held	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round
4	Participation of Department of HRD officials in DTFI meeting	% of districts where HRD Department official participated in the DTFI	Number of districts where HRD Department official participated in the DTFI	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round
5	Participation of Urban Development Authority officials in DTFI meeting	% of districts where Urban Development Authority official participated in the DTFI	Number of districts where Urban Development Authority official participated in the DTFI	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round
6	Participation of Department of Tribal Affairs	% of districts where Tribal Affairs Department official	Number of districts where Tribal Affairs Department official	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round

7	Participation of Department of Minority Affairs in DTFI meeting	% of districts where Minority Affairs Department official participated in the DTFI	Number of districts where Minority Affairs Department official participated in the DTFI	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round
8	Participation of Department of Women and Child Development (WCD) in DTFI meeting	% of districts where WCD Department official participated in the DTFI	Number of districts where WCD Department official participated in the DTFI	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round
9	Participation of Department of Panchayati Raj Institution (PRI) in DTFI meeting	% of districts where PRI official participated in the DTFI	Number of districts where PRI official participated in the DTFI	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round
10	Participation of Department of Youth Affairs and Sports in DTFI meeting	% of districts where Youth Affairs and Sports Department official participated in the DTFI	Number of districts where Youth Affairs and Sports Department official participated in the DTFI	No of districts implementing IMI 2.0	Meeting report	DIO	District	Once in preparatory phase before each round
11	Microplan prepared	% of block/ PUs submitted updated IMI 2.0 microplan at district	No of block/ PUs submitted updated IMI 2.0 microplan at district	No of block/ PUs where IMI 2.0 is planned	District report	DIO	District	Once before each round
12	Self-Assessment by districts	% district completed self-assessment	No. of district completed self-assessment	No. of District where IMI	Self-assessment tool	DIO	District	Before start of the IMI round

13	iCIP developed by districts	% district completed iCIP	No. of district completed iCIP	No. of District where IMI 2.0 is planned	iCIP tracking tool	DIO	District	Before start of the IMI round
14	Organize State AEFI committee meeting	% of states where State AEFI committee meeting held	No of State where AEFI committee meeting held	One meeting before start of IMI 2.0 (No of states where IMI 2.0 planned)	Minutes of meeting	SEPIO	State	one meeting
15	Organize District AEFI committee meeting	% of districts where District AEFI committee meeting held	No of District where AEFI committee meeting held	One meeting before start of IMI 2.0 (no. of districts where IMI 2.0 is planned)	Minutes of meeting	DIO	District	one meeting
16	District Communication plans	% of IMI 2.0 districts with communication plans prepared	No of IMI 2.0 districts with Communication plans prepared	No. of districts where IMI 2.0 is planned	Hard / soft copies of District communication plans	DIO and immunization partners	District	One before each round
17	Block/ Planning Unit Communication Plans	% block/ planning units with communication plans prepared	No of block/ planning units with Communication plans prepared	Number of block/ planning units where IMI 2.0 is planned	Hard / soft copies of planning communication plans	MOIC's/ BMO's/ DIO and immunization partners	District	One before each round
18	Conduct BRIDGE trainings for the FLWs (ASHA, ANM and AWW)	% of IMI 2.0 districts completed BRIDGE trainings for FLW (ASHA, ANM and AWW)	Number of IMI 2.0 districts that completed BRIDGE trainings for all FLWS	No. of districts where IMI 2.0 is planned	Training reports	DIO / UNICEF	District	At least once before the round

			(ASHA, ANM and AWW)					
19	Improve the visibility of IMI 2.0 by ensuring display of IEC materials in session sites	% IMI 2.0 session sites with IEC material displayed	Number of IMI 2.0 session sites with IEC visibility (posters, banners, wall writings etc.)	Number of IMI 2.0 session sites visited by district officials	Photographs of session sites Monitoring data	District IEC nodal	District	For every session site held
20	Organize district level media workshops	% IMI 2.0 districts with media workshops organized	Number of IMI 2.0 Districts with media workshops held	No. of districts where IMI 2.0 is planned	Meeting minutes, photographs	UNICEF/IEC consultant/ DIO	District	One prior to IMI 2.0

Annexure 19. State /UT target format for Intensified Mission Indradhanush 2.0

District Name: _____

Sl	Block name	Urban/Rural	No. of target children - total for the round (as per the due lists based on head count)	No. of target pregnant women - total for the round (as per the due lists based on head count)	No of sessions planned (total for the round)
1		U			
		R			
2		U			
		R			
3		U			
		R			
4		U			
		R			
5		U			
		R			
6		U			
		R			
7		U			
		R			
8		U			
		R			
9		U			
		R			
10		U			
		R			
Total		U			
		R			

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

U= Urban, R=Rural

Annexure 20. IMI 2.0 portal Daily reporting format

Date of Activity _____

District Name: _____

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

Annexure 21. Framework for data entry by Line Ministries

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

Annexure 22. Letter to States from Secretary Health for IMI 2.0

प्रीति सूदन
सचिव
PREETI SUDAN
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 and Family Welfare
Do No. Z-33014/05/2019-Imm
14th September, 2019

Dear Chief Secretary,

I would like to congratulate you and your team for making remarkable improvements in Full Immunization Coverage (FIC) during the earlier Intensive Mission Indradhanush drive. Under your able mentorship and guidance, your team of health officials have put in considerable efforts to reach out to the missed out and left out children for vaccination.

Intensified Mission Indradhanush (IMI) had offered a huge opportunity to make our immunization services more equitable; strengthen delivery mechanisms; enhance accountability and foster intersectoral collaboration in reaching out to the missed children and pregnant women in the country

Though the pace of immunization coverage has shown significant improvement, but the Goal of achieving Full Immunization Coverage of >90% so as to save our children from the Vaccine Preventable Diseases, is yet to be achieved. To carry forward this vision, our focus needs to be on reaching this goal through Routine immunization strengthening supplemented by Special campaigns. While efforts are ongoing for RI strengthening, it is important to take up catch up campaigns to reach the difficult and hesitant pockets, to vaccinate the unreached or partially reached children. Therefore another phase of Intensified Mission Indradhanush (IMI) 2.0 is being planned with four rounds to be conducted from December 2019 to March 2020. The list of districts selected for your state is enclosed at Annexure 1.

I request you to personally monitor the implementation of IMI and especially forge coordination between all related departments/organizations. I am sure your leadership will ensure that no child in our country is bereft of immunization services and together we are able to reach the goal of 90% full immunization coverage. This will be our very first assured and affirmative step towards Universal Health Coverage.

Warm regards.
Yours sincerely

(Preeti Sudan)

Chief Secretary (All states except Andaman & Nicobar, Chandigarh, Daman & Diu, Goa, Lakshadweep, Pondicherry, and Sikkim)

Copy to: Principal Secretary, H&FW(above mentioned states)

Room No. 156, A-Wing, Nirman Bhawan, New Delhi-110 011
Tele : (O) 011-23061863, 23063221, Fax : 011-23061252, E-mail : secyhfw@nic.in

Annexure 23. Letter to States from Joint Secretary Health for IMI 2.0

वन्दना गुरनानी, भा.प्र.से.
संयुक्त सचिव
VANDANA GURNANI, I.A.S.
JOINT SECRETARY
Tel. : 011-23061706
Telefax : 011-23061398
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 Bhawan, New Delhi - 110011

D.O. No. Z-33014/05/2019-Imm
Dated : 7th October 2019

Dear Mission Directors,

Government of India is highly appreciative of the efforts put in by your state to ensure that each child is vaccinated against the vaccine preventable diseases. The earlier phases of Mission Indradhanush and Intensified Mission Indradhanush (IMI) have been instrumental in making our immunization services more accessible with strengthened delivery mechanisms, enhanced accountability and fostering inter-sectoral collaboration to reach out to all missed / left-out / drop out children and pregnant women in the country.

In order to enhance the gains of your efforts under routine immunization and Mission Indradhanush campaign , another phase of Intensified Mission Indradhanush (IMI 2.0) has been planned. As earlier there will be four months of activity to be conducted for seven working days in each month, starting on 2nd December 2019, 6th January 2020, 3rd February 2020 and 2nd March 2020. The list of districts and blocks selected in your state is enclosed at **Annexure 1**.

For effective implementation of IMI 2.0 holding of State task force meetings, assessment of system gaps and taking corrective measures will be critical. Focus on quality head count survey, preparation of due list of the left out/drop out children and good microplanning is key for a successful campaign. Similar activities in urban areas/ NUHM cities which are part of the identified IMI 2.0 districts and blocks should be converged well in the campaign.

Communication strategy that needs special attention under IMI 2.0, has been designed by MoHFW to complement and steer operational interventions. This 360 degree communication strategy includes advocacy, social mobilization, interpersonal communication and media (with special focus on social media) needs to be tailored for your state with local innovations and implemented across all levels involving the other departments, SHGs, youth organizations etc.

It is requested to ensure that State & District Task force meetings, district and block level workshops and FLWs trainings, are completed before the IMI Campaign. Robust monitoring & supervision should be planned to guide mid-course corrections. To ensure that the gains made during the drive are incorporated in the routine immunization activities, system

strengthening activities are to be carried out during World Immunization Week celebrated in the last week of April 2020.

The State Governments are requested to apply the lessons learnt from previous phases of Mission Indradhanush and Intensified Mission Indradhanush, follow a strategic direction to achieve >90% Full immunization coverage and work towards sustaining the gains achieved till date. I am sure your leadership will ensure that no child in our country is bereft of immunization services and suffers from vaccine preventable diseases.

with regards

Yours sincerely

(Vandana Gurnani)

To,
Mission Directors (All states except Andaman & Nicobar, Chandigarh, Daman & Diu, Goa, Lakshadweep, Pondicherry, and Sikkim)

Copy to: SEPIOs (above mentioned states)

Annexure 24 A. Agenda for district workshop on IMI 2.0 for medical officers

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

Duration: 1 day

Time	Session	Facilitator
	Registration	
1 hour	Welcome and introduction	
	System Strengthening for UIP-Key activities and Introduction to Intensified Mission Indradhanush 2.0	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 IMI 2.0	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 with focus on IMI 2.0 portal	WHO India
30 minutes	Overview of Communication campaign, media wise plan, communication plan and media handling	UNICEF
30 minutes	Adverse events following immunization	WHO India
15 minutes	Overview of activities for Immunization week	DIO
30 minutes	Frequently asked questions	DIO/WHO India
15 minutes	Discussion	
TEA		
45 minutes	Financial guidelines for IMI 2.0	District Accounts Manager/ DIO
15 minutes	Way forward for IMI 2.0 – Timeline of activities and support available	District Magistrate
Closing remarks		

Annexure 24 B. Agenda for distict orientation of district and block level program/ accounts managers on financial guidelines for IMI 2.0

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

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

Time: 1 hour

Time	Session	Facilitator
15 minutes	Introduction to Intensified Mission Indradhanush 2.0	DIO/Partners
30 minutes	Financial guidelines for IMI 2.0 • 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 IMI 2.0– Timeline of activities and support available	DIO

Annexure 24 C. Agenda for district workshop on IMI 2.0 for data handlers

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

Training material: Reporting formats for Intensified Mission Indradhanush 2.0

Duration: Half day

Time	Session	Facilitator
15 minutes	Introduction to Intensified Mission Indradhanush 2.0	DIO
30 minutes	Planning process and forms with focus on IMI 2.0 portal	DIO/Nodal officer for urban area/ Partners
15 minutes	Data flow from ANM to district for IMI 2.0	DIO/Partners
45 minutes	Daily reporting process in IMI 2.0 and forms and IMI 2.0 portal	DIO
15 minutes	Day-wise key indicators generated through reported data to be submitted to DIO during IMI 2.0 round	DIO/WHO India
30 minutes	Role of data handlers in IMI 2.0	DIO
15 minutes	Way forward for IMI 2.0– Timeline of activities and support available	DIO

Annexure 24 D. Agenda for distict workshop on IMI 2.0 for vaccine and cold chain handlers

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 2.0	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 IMI 2.0	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 IMI 2.0	DIO/Nodal officer for urban area
10 minutes	Day-wise vaccine and diluent utilization report to be submitted to DIO during IMI 2.0 round	DIO/Partners
15 minutes	Way forward for IMI 2.0 – Timeline of activities and support available	DIO
15 minutes	Way forward for IMI 2.0– Timeline of activities and support available	DIO

Annexure 24 E. Agenda for block/ urban area training of health workers for IMI 2.0

Time	Session	Facilitator
15 minutes	Welcome and introduction	
	Introduction to Intensified Mission Indradhanush 2.0	Medical Officer-in charge
	TEA	
1 hour 30 minutes	Microplanning for IMI 2.0	Medical Officer (trained for IMI 2.0)
15 minutes	Importance of head count for preparing due list of beneficiaries	Medical Officer (trained for IMI 2.0)
15 minutes	Use of immunization tracking bag and revised counterfoil of MCP card	Medical Officer (trained for IMI 2.0)
10 minutes	Discussion	
	LUNCH	
15 minutes	Reporting and recording with focus on IMI 2.0 portal	Block Data Manager
15 minutes	IEC and social mobilization	Block Community Mobilizer/Any other official trained for IMI 2.0
10 minutes	Open vial policy and implications for health workers	Medical Officer (trained for IMI 2.0)
15 minutes	Adverse events following immunization	Medical Officer (trained for IMI 2.0)
10 minutes	Discussion	
	TEA	
15 minutes	Financial guidelines for IMI 2.0	Block Accounts Manager
15 minutes	Frequently asked questions	Medical Officer (trained for IMI 2.0)
45 minutes	Preparing microplans – prioritizing areas for IMI 2.0 sessions	Group work
1 hour	Preparing ANM rosters for working in the block	Medical Officer (trained for IMI 2.0)
10 minutes	What to do after this workshop: their role in sensitizing the social mobilizers: ASHAs and AWWs	Medical Officer (trained for IMI 2.0)
	WRAP UP	

Annexure 24 F. Agenda for block/urban area training of mobilzers for IMI 2.0

Time	Session	Facilitator
15 minutes	Welcome and introduction	
	Introduction to Intensified Mission Indradhanush 2.0	Medical Officer-in charge
15 minutes	Current immunization schedule	Medical Officer (trained for IMI 2.0)
15 minutes	Conducting head count for preparing due list of beneficiaries (exercise)	Medical Officer (trained for IMI 2.0)
15 minutes	Use of immunization tracking bag and revised counterfoil of MCP card	Medical Officer (trained for IMI 2.0)
10 minutes	Discussion	
15 minutes	Frequently asked questions	Medical Officer (trained for IMI 2.0)
45 minutes	IEC and social mobilization (role play)	Block Community Mobilizer/Any other official trained for IMI 2.0
10 minutes	Discussion	
10 minutes	What to do after this workshop	Medical Officer (trained for IMI 2.0)
TEA & WRAP UP		

ITSU

IMMUNIZATION
TECHNICAL SUPPORT UNIT
Ministry of Health & Family Welfare